PREVENTING RELAPSE AMONGST SOUTH AFRICAN PSYCHIATRIC PATIENTS

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PREVENTING RELAPSE AMONGST SOUTH AFRICAN PSYCHIATRIC PATIENTS

THESIS SUBMITTED IN FULFILMENT FOR THE REQUIREMENT OF MASTERS DEGREE IN PSYCHOLOGY.

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DECLARATION

I **BASSY BEPATIENT CHAWANE** declare that " Preventing relapse amongst South African psychiatric patients" in this study is of my origin. All source of references contained herein, have been indicated and acknowledged by means of complete references.

Signed by:

B.B Chawane

ACKNOWLEDGEMENTS

DEDICATIONS

This work is dedicated to:

1. My loving father (Ralph, Zwangendaba); my empathetic mother (Evelyn, N'yakwavi); my lovely sisters (Knowly & Irene); my only brother (Begreat); my precious daughters (Memory, Nsuku, Ehleketani, and Luanda) and my dear sons (Nhalnhla and Diamond).

2. The psychiatric institutions, professionals, community and mental health patients in Mpumalanga province with the hope that it will improve the problem of relapse in psychiatric patients.

ABSTRACT

The present investigation is a descriptive experimental study with two conditions (experimental and control conditions). The main aim was to develop, implement and evaluate a program directed at educating health professionals and families to accept and manage people presenting with mental health problems. The second aim was to teach mental health promotion strategies. To this end, a questionnaire was administered to a group of health professionals and relatives. Results suggest that the participants' training programme significantly improved attitudes and increased knowledge and understanding about mental illness.

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CHAPTER 1

1. An overview of the study

1.1 Introduction

Disabilities associated with chronic mental illness constitute major social, economic, and public health problems (Kendrick, Tylee, & Freeling, 2001, Kaplan & Sadock, 1998). These disabilities afflict more than 3 million people in the United State, and 0.5 million in South Africa. The most common are anxiety disorders followed by depressive disorders and alcohol or other substance abuse. Surveys also found that 15 percent of non-psychiatric patients have an associated emotional disorder (Kaplan & Sadock, 1998). Higher rates of mental disorder are found in persons under age 45 than in those over 45. Women are significantly higher than males for all depressive and generalized anxiety disorders. Men, however, have higher rates of substance-related disorders and antisocial personality disorders. Although schizophrenia affects 1 percent of the population show similar rates for both males and females (Kaplan & Sadock, 1998).

Traditionally, chronic mental illness has been associated with older patients who have a long history of mental hospitalization; recently it includes young adults with a variety of mental disorders that have grown up in the era of deinstitutionalization. Deinstitutionalization is a process by which large numbers of patients are discharged from public psychiatric hospitals and put back into the community to receive outpatient care (Kaplan & Sadock, 1998). Lefley (1997), defined deinstitutionalisation as the replacement of long stay psychiatric hospitals with smaller, less isolated community-

based service alternatives for the care of mentally ill people, or provision of alternative services for mentally ill people. These people need extensive social support, such as vocational and recreational counseling, comprehensive psychiatric treatment, paying jobs and affordable housing (Uys, Pietersen & Middleton, 1994). A major problem faced by chronically ill patients is that their illnesses interfere with their coping skills and render them particularly likely to drift downward into even more stressful, impoverished environments (Bean & Mounser, 1993, & Newton 1989 &1992). Furthermore, people tend to label, isolate, reject, disempower and devalue individuals with mental health problems. Usually, this affects their self-esteem, job opportunities, self-worth, social skills, confidence, and state of recovery from their illness. However, the psychoeducational model can improve mental health through primary, secondary and tertiary prevention. People should develop positive attitudes towards mental health problems; accept mental health problems as illness that can be cured like any other illness and develop knowledge and understanding about mental health problems and their management. This has to be done with a goal of decreasing the onset, duration, residual disability and improve the effectiveness of public mental health professionals and family services in working with mental disability (Newton 1989 &1992). Models of prevention are discussed as follows.

1.1.1 Primary prevention

The primary preventive model is concerned with the identification and modification of known risk factors for the development of illness (Kendrick, et al. 1996). Its primary goal is to prevent the onset of a disease and reduce its incidence (Kaplan & Sadock 1998).

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Eliminating causative agents, reducing risk factors, enhancing host resistance, and interfering with disease transmission reach this goal. This model helps people cope with life including mental health education programs, efforts at competence building, development and use of social support systems to reduce the effect of stress on those at high risk and anticipatory guidance programs to assist people to prepare for expected stressful situations & crisis intervention after stressful life events (Newton, 1992).

1.1.2 Secondary prevention

Kendrick et al. (1996) defined secondary prevention as the early identification of problems and interventions to prevent the development of illness, with the hope of shortening the severity and duration of illness and limiting impairment. Kaplan & Sadock (1998) emphasize that public education and crisis intervention are the basic components of secondary models of prevention.

1.1.2 Tertiary prevention

This model prevents the development of complications for patients with established conditions and of recurrence inpatients with relapsing conditions. While the prevention of mental illness in primary care is an important topic, it has not been addressed sufficiently in the past (Kaplan & Sadock, 1998). Therefore, the concept of prevention used in this context, is defined as an action intended to reduce the incidence of relapse or readmission of patients after a partial recovery. This is a concern, which has wider implications for the family, place of work and society. Also of concern is the health and well being of the

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relapsee himself and the cost of providing these people with recurrent services (Newton, 1989).

1.2 Background and motivation of the study

In South Africa wealthy patients with mental disorders were usually cared for at home. Patients were free to come and go in the community as long as they were not a burden or dangerous (Uys et al 1994). In 1846 the first psychiatric hospital (Robben Island) in South Africa was opened for chronically sick and psychiatric patients. Due to overpopulation in psychiatric institution and shortage of staff, reform in mental health care has led to the closure of long stay mental hospitals and the development of community mental health services of outpatients (Bean & Mounser, 1993 & Uys et al., 1994)). This was termed "deinstitutionalisation."

In 1963 under the leadership of President John F. Kennedy, the United States of America (USA) Congress passed the Community Health Act, which provided funds for the construction of community mental health centers within specified catchments areas. Basic psychiatric services were required in each community: consultations, day care and education. In 1975, children and older adult services, prehospitalization and follow-up services were developed. By that time, 800 centers were operating, more than half in urban areas. Because of financial constraints, community centers were severely limited and were considered by many to be ineffective (Kaplan & Sadock, 1998).

In 1978, The South African government accepted the primary development of health care approaches during a meeting in Alma-Ata (a town in Soviet Kazakhstan). Furthermore,

they suggested that, for health services to be effective, the health system must work as a team, so that they can identify the needs of the community, resources that will meet these needs, provide a system of care, and include all citizens in planning programmes of prevention. Effective integration and balance within health care services improves the effectiveness of treatment services and reduce relapse in mental health patients. Health care teams include psychiatrists, clinical psychologists, psychiatric social workers, psychiatric nurses, administrative and clerical staff members, occupational therapists, recreational therapists and links to welfare workers, family agencies, schools, and other human services groups (Uys et al., 1994).

In South Africa, mental health associations throughout the country started to give after-care to psychiatric patients in the community. The first effort by a psychiatric hospital itself to work outside the confines of the institution was made in 1957 by Tara hospital under the guidance of Dr M.B Feldman, Miss I. Marwick and Miss C. Haines of the local government of Johannesburg. This was initiated for discharged patients of Tara hospital.

Furthermore, community health staff who provide services to these clients often lack the time expertise or interest needed to provide special assistance. With shortage of psychiatric services and support systems for both inpatient and after-care, rehabilitation efforts to keep patients in the community become ineffective. The knowledge and attitudes of patients' relatives towards the patients are not conducive to patient's rehabilitation and maintenance within the community (Hatfield & Lefley, 1993).

Therefore, it is suggested that removal of stigma of mental illness, ensuring adherence to maintenance of medication, reducing inequality of health, lowering the impression of

emotions and ensuring preventive model health care through an educational programme for relative groups and mental health practitioners (Kendrick et.al, 1996) will change attitudes towards mentally ill patients and will also prevent family disorganization as a result of separation from the patient during the period of hospitalization. The involvement of the patient and his family in his/her treatment programme will ensure cooperation and longer lasting control over the condition as well as reduce re-admission or relapse of patients in psychiatric institutions. Such ideas have influenced the writer to investigate this problem and its context. Why do people who have been treated and discharged to go and live with the family relapse and become re-admitted? This frustrates the family, society and professionals dealing with these people, as their efforts seem wasted. Therefore this investigation will focus on developing and implementing a psychoeducational model programme to establish how the chances of success of treatment can be maximized to reduce the incidence of relapse behavior.

1.3 Statement of the problem

The interaction between family, health practitioners and mentally ill patients is very important. It is assumed that family, health practitioners and community support motivates and helps to mould patients to recover. Therefore there is a great need to educate the family, health practitioners and the community about the problems of the mentally ill. The problems are posed in the following questions? What do people understand by mental illness? Are there any identifiable causes, which always or very often contribute to the development of any given disorder. If there are, do helpers know

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how to intervene to interrupt the causal process? And if they do, are there strategies that can be implemented by health care workers, family groups or individuals themselves.

The present investigation is important and useful to establish a psychoeducational model to help the families and health practitioners gain knowledge and understanding of mentally ill patients. A second aspect of the proposed study is to teach mental health promotion strategies. Health promotion has been defined as a process by which people are enabled to increase control over their health and improve it (Macrina, 1999). As poor mental health can have potential debilitating and life long consequences for communities, teaching parents or caregivers, via nurses, strategies such as developing life skills, or improving self-esteem, can help to reduce negative effects and contribute to positive mental health (Tudor, 1996). The proposed study will therefore focus not only on developing a psycho educational model, but also on preventive and promotive measures that can be implemented in the community.

1.4 Aims of the investigation

The major aim of the investigation is to develop, implement, and evaluate a program directed at educating health professionals and families to accept and manage people presenting with mental health problems.

1.5 Hypotheses

The following is the hypothesis of this study:

❑ There will be a significant improvement in both health professional and family knowledge and understanding of mental health problems and their management.

1.6 Definition of terms

The following terms are explained according to the meaning they have for the study.

1.6.1 Relapse

Relapse is defined as deterioration in a patient's condition after partial recovery, (Oxford dictionary 1976).

1.6.2 Prevention

The concept of prevention used here is defined as action intended to reduce the incidence of relapse in psychiatric patients (The Mcgraw- Hill-Nursing Dictionary (1979).

1.6.3 Mental illness

Mental illness is viewed as a long-term condition, which can be managed successfully mainly in the community if the rehabilitation approach is used and if adequate resources are available in the community.

1.6.4 Psychoeducation

Psychoeducation refers to patients' education about the nature of their disorder, ensuring that both the clinician and patient agree about the nature of the problem, identify a list of target symptoms to be treated, explore automatic negative thoughts about the proposed medication. Frequent supportive contacts are techniques likely to increase patient satisfaction and improve treatment compliance (Kendrick et.al 1996).

1.6.5 Rehabilitation

Rehabilitation is the process by which a person is helped to adjust to the limitations of his disability and where lost skills can be regained through the development of coping strategies (Bean & Mounser 1993).

1.6.6 After- care

After-care refers to the assistance given to the psychiatric patient and his family or relatives at the conclusion of a period of treatment in a mental health care center. The main aim of after-care is to assist those who are involved in mental health problems to readjust to community living.

1.6.7 In-patient treatment

In-patient treatment refers to the treatment of psychiatric patients in the hospital environment, which requires the patient to reside for some period in the hospital.

1.6.8 Outpatient treatment

Outpatient treatment refers to the treatment of mental health patients in the mental health services while the patient is living in the community.

1.6.9 Mental health

Mental health is a state of being in which a person is simultaneously successful at working, loving and resolving conflicts by coping and adjusting to the recurrent stresses of everyday living. This doesn't mean that a mentally healthy person has no problems. He/she might at certain times experience severe distress, but she/he is generally able to cope with the distress (Uys et.al 1994).

1.6.10 Social skills

Social skills are behaviors that help us to communicate our emotions and needs accurately and allow us to achieve our interpersonal goals (Liberman, Derisi & Mueser, 1989).

1.7 Plan of the study

This study is organized as follows:

Chapter 1

This chapter consists of introduction, motivation, and statement of the problem, aims/purposes of the study, hypothesis, methodology and plan of the study.

Chapter 2

Chapter two provides a theoretical background to the study. This background chapter reviews previous work done in this field.

Chapter 3

In this chapter details of the program, methods and procedures are introduced.

Chapter 4

Chapter 4 includes a presentation of data, results and discussions.

Chapter 5

Program evaluation and recommendations for further study

CHAPTER 2

2. Literature review

2.1 Introduction

There have been many studies of attitudes towards mental illness, but little is known about the malleability of public attitudes or their effects on patients' general well being or social integration (Lefley, 1997). However, the mission of the National Institute of Mental Health (MIMH) is to diminish the burden of mental illness. This public health mandate demands that we harness powerful scientific tools to achieve better understanding, treatment and, eventually, prevention of mental illness. Through research in basic neuroscience, behavioral science and genetics, individuals gain an understanding of fundamental mechanisms underlying thought, emotion, behavior as well as profound insight into themselves as a species. But we must, at the same time, hasten the translation of this basic knowledge into psychoeducation that will lead to better treatments that ultimately must be effective in our complex world with its diverse population and evolving health care systems.

According to the landmark " Global Burden of Disease" study, commissioned by the World Health Organization and the World Bank, mental disorders represent four of the ten leading causes of disability for person's age 5 and older. Among "developed" nations, including the United States, major depression is the leading cause of psychiatric disability, followed by manic depression, schizophrenia, and obsessive-compulsive disorders. Furthermore, the World Health Organization estimated that about 400 million

people in the world suffer from mental illness. More than 12% percent of the total burden of disease is presented by mental disorders. The South African census (1996) reported that 2.7 million or 6.7% of the country residents (excluding institutions), reported that they were disabled. Five percent of the population have mental disability. However, the true extent of the problems is difficult to measure. Mental health problems tend to remain undiagnosed and unreported because of stigma and exclusion (WHO, 2001). About 24% of patients who seek primary health care suffer from mental health problems. However, the majority of these patients (69%) usually present to health personnel with physical symptoms. Consequently many of them are not correctly diagnosed for mental illness and thus not treated.

In South Africa there are few studies on the subject of relapse prevention, as well as lack of understanding and knowledge about mental illness. With increasing international emphasis on care in the community and pressure on resources, the prevention of mental illness within primary health is becoming an important consideration (Kendrick, et al, 2001). Today Africans are faced with the problem of rapid change in many spheres of social life. It is important that members of disciplines relevant to psychiatry (general practitioners, psychologists, occupational therapists, social workers, and psychiatrists) work together for preventing relapse and strengthening support systems needed to be initiated from the community (Newton 1989).

Over the past decade, professional concern about assisting families of people with severe psychiatric disability has grown considerably. Given that the majority of individuals with

a severe psychiatric disorder live with relatives (Zipple, Spaniol & Rodgers 1990), families play a large and significant role in these individuals mental health care. However, the responsibility and demands of care giving are often difficult and complex. Affected families must respond to their relative's symptoms of psychiatric disorder and problematic behaviors while at the same time negotiate treatment for potentially problematic relationships with their local mental health service system.

Furthermore, these families are often the primary source of support for their family member with a severe disorder and serve as a safety net when other sources of help fail to respond (Greenberg, Greenly & Brown, 1997). The burden associated with assuming greater responsibility for the care of a relative with a psychiatric disability places family members at risk for experiencing high levels of grief, stress, frustration and pain, as they attempt to care for their loved one (Falloon, Boyde & McGill, 1985; Zipple et al 1990; Thompson & Weisberg, 1990). Individuals with a severe psychiatric disorder may display unpredictable and unfamiliar behaviors and consequently, families are unable to adjust to their new role of caring for their loved one. In fact, families often find they are not well prepared for the responsibility of caring for a relative (Anderson, 1983). Thus, family members need a variety of skills, information, as well as increased emotional support, to cope with the stress and emotional burden placed upon them.

Because mental health professionals (practitioners) are the first resource to which many families turn, when faced with such a burden, a number of studies have addressed such families' involvement with mental health professionals in relation to patient care. One consistent finding has been that families are dissatisfied with their contact with mental

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health professionals (Biegel, Li-yu & Milligan, 1995; Fisher, Benson & Tessler, 1990; Holden & Lewine, 1982; Thompson & Weisberg, 1990). Reasons for such widespread dissatisfaction include a deficiency on the part of practitioners to impart information about severe psychiatric disorders, treatment options, availability of services and practical coping and management techniques of families in need (Holden & Lewine, 1982; Hartfield & Lefley 1993; Thompson & Weisberg, 1990).

Furthermore, families often report problems in the quality of contact with the mental health system including communication difficulties and a lack of involvement in treatment decisions (Francell, Conn & Gray, 1988; Spaniol et al., 1984). Thus, there is a basic conflict between what families and patients want and what they actually receive from mental health care providers.

In response to families' need for information and emotional support, Greenberg et al. (1997) examined how the provision of mental health services to families is related to the psychological distress of family members. Results from their telephone survey indicate those levels of psychological distress experienced by family caregivers was lower when these individuals received information and advice from practitioners. Moreover, perceived psychological burden was significantly lower when families experienced a more collaborative relationship with practitioners throughout the treatment process. Thus, it appears that by sharing information with families and patients as part of practitioners' routine contact and by changing practitioners' attitudes about the role of families in the treatment process, mental health services can contribute to the well being of both the individual and the family.

Unfortunately, mental health professionals do not always integrate family members into a patient's treatment process, nor do they always provide direct emotional support or educational services to families (Tessler, Gamache, & Fisher 1994; Greenberg & Greenley, 1995). Mental health professionals tend to treat families as sources of intake information and disregard the families' needs for support and services (Lefley, 1996) on a continuing basis. Although mental health professionals may recognize the need for such services, a serious gap remains between meeting the needs of families with a mentally ill relative and the professionals who are trained to view these needs. One reason for this gap is the lack of preparation mental health practitioners and families receive in working with people with severe psychiatric disorders (Bowker & Rubin, 1982). Consequently, Psycho-educational interventions have been developed and implemented to train practitioners to be more sensitive to family experiences and needs when caring for their relative with a severe psychiatric disorder (Kuipers, McCarthy, Hurry & Harper, 1989; Lefley, 1988; Solomon, Draine, Mannion & Meisel, 1997, 1998). The results from these studies suggest that informational needs of family members can increase family self-efficacy and decrease the stress associated with caring for a mentally ill relative. Zipple et al. (1990) developed and tested Practitioner Training about Families (PTF) educational program on a sample of mental health professionals. Their program was designed to increase practitioners' knowledge of families caring for a mentally ill relative, improve the practitioners' attitudes about working with these families, and increase the frequency of contact that practitioners have with these families.

An evaluation of their program revealed that practitioners who received such training evidenced significant improvement in attitudes toward working with family members,

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and increase in knowledge about assisting such families. The purpose of the current study was to develop, implement, and evaluate a program directed at educating health practitioners and family members to gain knowledge and understanding of people presenting with mental health problems. As stated above, the goals of the educational program were to improve mental health professionals' attitudes and knowledge about working with people who have mental illness, and influence the removal of stigma towards mentally ill patients.

Relapse often presents a major problem for those providing treatment services (Mzimela 1995). High rate of relapse can be demoralizing to staff and have a negative impact on motivation. Psychiatric services and mental health service staff are particularly challenged to recognize and deal with reality of relapse behavior and to examine their attitude and perceptions of this problem. They also need to increase their knowledge and develop most effective skills in working with relapsers, their family members and those significant people immediately affected by the relapsing person's behavior.

This study focuses on aspects of developing a psychoeducational model for prevention and promoting programme against psychiatric patients' relapse. In this literature the researcher will focus on the factors that are thought to contribute to relapse, with a view towards prevention.

2.2 Contributing factors to relapse, with view of prevention

Like many diseases, mental illness has risk factors that can be prevented or reduced to provide a framework for strategies in mental health promotion and illness prevention.

2.2.1 Stigmatization

Stigma is the most critical burden suffered by person with mental illness (Hatfield & Lefley, 1993). Unlike those with physical illness, people with mental problems are generally subjected to stigma, prejudice and exclusion from access to social services and health care (WHO, 2001). Mental illness increases feelings of isolation and low self worth (Kendrick et.al 1996). Even though people can reach a desired level of functioning after treatment, often with enormously hard work on their own, they may yet find it difficult to get on with their lives because of societal restrictions (International council of nurses 1994). Stigma also poses difficulties in finding housing and employment. This causes suffering and diminished self-esteem.

WHO, (2001) & (1998) suggest, "Stigma is not the problem of the mentally ill but of society. The stigma is caused not by the illness but by ignorance of the medical cause of mental illness" (p30). It affects persons in every conceivable way: psychologically, economically and in terms of their quality of life, In a California well-being project, a survey of the experiences of 331 mental health clients, 41 % reported that "all" or "most" of the time they felt treated differently when people discovered they had received mental health services or had a psychiatric diagnosis. As a result, people with mental illness suffer doubly: from their illness and from the shame of social stigma.

This creates a challenge for nurses and other health professionals to foster understanding of mental illness, prevention and treatment. The main challenge is to remove the stigma of mental illness so that people will talk freely about their illness.

2.2.2 Non-compliance with medication

It is widely known and accepted that patients, who do not take their medication as prescribed, relapse in their illness. Research by Ventura, Neuchterelein, Hardesty and Gitlin (1992 : 615) on 23 recent- onset schizophrenia has shown that anti-psychiatric medications have a "protective factor which operates partially by raising the threshold for relapses in the face of environmental stressors such as life events and high levels of family expressed emotions".

Therefore, one-way of reducing the readmission or relapse of psychiatric patients is through the implementation of social skills programmes. The main aim is to help South African psychiatric patients to develop:

❑   skills for managing their own medication

❑   ability to exercise their rights

❑   ability to give and accept criticism

❑   ability to accept their needs and

❑   quality of life and function in the community to avoid relapse resulting in rehospitalization (Kaplan & Sadock 1998).

2.2.3 Inadequate mental health services

Madianos and Madinou (1992 : 40) state that " effective deinstitutionalisation of the chronic patient population depend on   the availability of adequate community based social support and rehabilitative services, compliance with after care, housing conditions, care with regard to clothing and nutrition, ability to be or live alone, social support, economic situation, family co-operation with after care daily activities, social relationships, interpersonal transactions, social roles leisure activities and coping with stressful situations".

The following programmes or services are important for managing and preventing relapse in South African psychiatric patients. Therefore they should be available in the community.

Psychiatric outpatient services- where patients can collect their medications and receive therapy within easy reach of their home. These services need to be adequately staffed by professionally trained personnel.

In-patient facilities- for relapse patients so that relatives feel at ease and not burdened.

Home visiting services- to check patient's relationship with family members, readjustment by the family, effectiveness of treatment and assisting families to deal, cope and understand the nature of mental health problems.

Psychoeducational programmes- to educate people about the nature, symptoms, causes, medication of mental illness and techniques to improve mental health.

Employment facilities- for the development of sheltered employment workshops for patients who cannot get employment in the open labor market.

Recreational facilities- for patients who are unemployed and have not fully regained their ability to fruitfully engaged themselves during the day.

Halfway houses- for gradual reintegration of the patient into the community after discharge from the mental hospital.

2.2.4 Life event stressors

The most important sources of stress for psychiatric patients come from the strain and tension within the family. Studies from several countries have documented a relationship between the emotional climate in the family home and the likelihood of relapse for in-patients with depression, schizophrenia, and mania (Ventura et al, 1992). Where such stressors are not occurring for the first time in the patient's history, his or her relapse is an indication of failure on the part of family members to obtain information and advise from mental health services (Liberman et.al 1989).

Therefore psychoeducational programs should be implemented for the relatives to recognize the existence of biomedical disorder in the patients, and not attempt to compensate for the patient's disability by overinvolvement, excessive nurturance and over protectiveness. It is assumed that excessive criticism and emotional overinvolvement are the main stress factors that lead to relapse. Therefore, one way of reducing the effects of family stress is to develop goals for the disabled psychiatric patients to pursue in social skills training, such as:

❏ developing social contacts outside home,

❏ learning to become more assertive with those relatives who are critical and overly involved, and

❏ teaching relatives and patients to positively reinforce each other's desired behavior.

2.2.5 Patients and staff perception on the causes of relapse

Realistic perception of events allows recognition of the relationship between events and the feeling of stress (Uys et.al, 1994). Felter and Lowery (1992; 301) used attribution theory to explain the perceptions of relapses by patients and staff. With internal attribution, patients saw themselves as failures, or factors responsible for their relapse such as treatment default. In external attribution patients saw the cause of relapse as being within their control. These researchers found that very few patients attributed their relapse to something uncontrollable by themselves. While many schizophrenics reported not taking their medications, they did not see this as the cause of their relapse.

Such distorted perceptions often prevent the recognition of the relationship between the events and the feelings of stress. Therefore efforts to prevent and manage mental problems have been unsuccessful and relapse not reduced.

2.3 Conclusion

Mental illness is nothing to be afraid of, like physical illness, because it is treatable. However, acceptance is needed within the family and amongst health practitioners to reduce the community attitude towards mental illness. Carson (2001) reported that, educating health practitioners and families has become an integral part of a comprehensive treatment plan for treating mental illnesses.

The psychiatric community is realizing that the more patients and families know about treatment and management of serious psychiatric disorders, the better will be the outcome for both the patient and his/her family. It is essential for the psychiatric nurse and other mental health professionals to be knowledgeable both about up-to-date information that patients and families need, as well as the teaching methods that can be used to impart that information (Carson 2001).

CHAPTER 3

3. Review of the program

3.1 Introduction

This research on relapse prevention among South African psychiatric patients was undertaken with the view of adding knowledge and understanding through a psychoeducational training model. The psychoeducational model was used to educate health professional staff and families about the nature of their loved one's disorders and the rationale for their clinical management. The participants were seen as a group. The program consisted of 18 hours of seminar talks to improve attitudes and knowledge about mental health. Basic principles such as causes of mental health problems, symptoms, treatment, management, attitudes, intervention and strategies of prevention were discussed. Mental health promotion was emphasized. The program was divided into six sessions, with each aspect was covered in one session.

This psychoeducation was helpful to the families and practitioners who had previously been "left in the dark" about the nature of the disorders from which their relatives suffer, and the sorts of responses that they could make to assist in their recovery (Falloon & Fadden 1995).

3.2 Population and sample

The population of the study were mental health professionals and relatives of people who experience mental health problems. A random sample of 70 participants was used. This included 37 practitioners and 33 relatives. These participants were systematically assigned to two conditions i.e experimental & control condition (Neuman 1997). A bigger sample of relatives was desired in order to complement patients' opinions, but relatives were not available at the time of collecting data. It was difficult to find the relatives of the patients that were interviewed because some of the subjects lived a distance away.

For both health professionals and relatives of people experiencing mental health problems, a questionnaire with both closed and open-ended questions was administered at the beginning and the end of the sessions. This established participants' pre and post intervention knowledge and was used as a measure of success of the course.

Coursey (1997), suggested that interviews are more effective when practitioners do not refer to medical or nursing notes. When using notes they tend to dwell on clinical details rather than on the sequence of events, the reasons for actions and the various external influences on the case. The interviewees, therefore, gave their experience through their observations. It was stressed that the researcher was not applying right or wrong answers, but simply trying to find out the causes, symptoms of mental illness and what could be done to prevent relapse of psychiatric patients. All the interviewees were willing to participate in the interview, particularly the relatives who were present. Some commented

before the interview that it was helpful to voice concerns that they sometimes found difficult to discuss with families or health professional

3.3 Permission and ethical consinderation

Permission to conduct the research was sought and obtained from the senior medical superintendent of Matikwane hospital. The right of self-respect was maintained as well as the right to refuse to participate in the research. Principles of informed consent were strictly applied. This means that the subjects had full knowledge and understanding about the research project. The volunteers were free to decide whether to participate or not after they were fully informed.

3.4 Scope and delimination

The study was conducted at Matikwane psychiatric unit, which admits and treat mentally ill patients. The program helped prepare families and mental health professionals to teach patients and families about mental illness through discussion of educational content and methods.

Content topics included the following.

> The needs of family members, professionals and patients

> Helping patients and families manage personal stress

> Helping patients manage prescribed medication

> Helping patients to gain understanding and knowledge about symptoms and causes of mental illness

> Practical suggestions for cooperative interventions.

3.5 Who attended

This educational event was of interest to advanced nursing staff & students, community members and patients particularly interested in psychiatric and mental health care. Other health and mental health care professionals, including psychiatric social workers, counselors, occupational therapists, and psychologists, also benefited from attending the seminar.

3.6 What was learned

At the end of this session, participants were able to:

> describe and understand mental illness.

> identify symptoms of mental illness and monitor relapse process.

➤ express knowledge about relapse prevention.

➤ express knowledge and understanding about prescribed medication.

➤ educate others about mental illness.

➤ identify specific techniques for teaching patients and families (Carson, 2001).

3.7 Strategies of prevention

Despite advances in health care, the development of community programs can be successful. Health professionals have a vital role in the promotion of mental health, illness prevention and improving access to care and services. Therefore the following activities should be available in order to combat stigma and fear of madness within the community.

➤ Promotion of mental health and prevention of illness by collaborating with other professions and sectors through:

- public education of risk factors

- life skills education

- referrals and treatment services

- positive parenting programmes

- early detection of symptoms.

➤ Improving access to mental health care services through:

- a support network of community based services

- increase of outreach and informal support groups

- improved quality of mental health services

- lobby for 24 hours crisis intervention

- de-institutionalize mental health services

➤ Stop exclusion and dare to care

- talking openly to the community about mental illness

- educate the public about risk factors of mental illness and ways to reduce them

- protects human rights and ensure legislation to improve care and reduce stigma

- publicize mental health issues through events such as the world mental health day, October 10 each year.

➢ Promote community participation

      - sensitize the community that mental health is the concern of the entire community

      - train health care providers to be partners and facilitators of care.

➢ Influence policy makers and the public about the importance of:

      - creating health environment and caring societies that reduce stress and enhance well being.

➢ Address educational needs of health personnel in mental health issues:

      - providing continuing education for health care providers

      - undertake research to determine effects of nursing interventions and health outcomes.

3.8 Conclusion

Questionnaires were used in evaluation to determine if there were changes in attitudes, knowledge and understanding of mental health problems. Questionnaires with closed and open-ended questions were administered at the beginning of the session and the end of the sessions. Mental health practitioners have a key role in promoting mental health, preventing mental illness and improving access to mental health services. They also have a role in educating the public about the nature, symptoms, medication and management of illness. Advances have been made regarding new treatment and care; on causation, associations, characteristics and prevention of mental problems. The benefits of this knowledge and understanding should reach all people with mental health problems, particularly in vulnerable societies.

CHAPTER 4

4. Data analysis

Participants were 70 in number from a small psychiatric unit in Mpumalanga Province. Participants were systematically assigned to either an experimental or control condition. By definition, a systematic sampling refers to a sample constructed by selecting every chosen element in the sampling frame. In the study every 3rd element in the sampling frame was included. This method is practical involves little work, provides enough information, is simple to perform, reduces error and retains the order of the sampling frame (Bailey 1982). Participants in the control condition were informed about the purpose of the program and were promised training at a later stage.

Of the original 70 participants, 9 participants dropped out of the experimental training group or failed to complete all measures and 11 participants from the control group did not complete the post-test questionnaire. The final sample consisted of 30 participants in the control condition (73 % women and 27% men) and 20 participants (55% women and 45% men) in the experimental group.

Instruction in each of the six sessions was shared by the researcher and the participants (with relatives and professionals) as co-trainers. The researcher was responsible for organizing the training, presenting the materials and educating participants about mental health problems. The participants were responsible for leading small discussion groups at the conclusion of each training session and when appropriate, sharing their personal experiences. Each session consisted of a presentation on aspects of mental illness.

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To test for differential attrition, a chi-square analysis was conducted using pre-test measures of participants' age, sex, education, marital status and home residence to predict group membership in either the experimental or control group conditions. The results yielded no significant predictors of group membership: participants who failed to complete either the training or the post-test questionnaires did not differ from those participants who did complete. Table 1 presents the characteristics of these participants. In the following table, certain alphabet are used as follows: total number (n), experimental condition (b), control condition (c) and chi-square analysis (d).

Table 1

1.1 Age

	A	B	C	D
25-35 YRS	14	5	9	
36-50YRS	23	10	13	
>50 YRS	12	5	7	
TOTAL	49	20	29	.79

Table 1.1 refers to the numbers of patients who fell into the age groups 25 to 35 years (29%), 36 to 50 years (47%) and over 50 years (24%), as systematically assigned into experimental and control conditions. A chi-square statistic of 0.79 revealed no significant pre-intervention difference between groups.

1.2 Sex

	A	B	C	D
MEN	17	9	8	
WOMEN	33	11	22	
TOTAL	50	20	30	1.79

The demographic data showed that there were more females (66%) than males (34%) in the study. The two by two chi-square table for patients as distributed for sex indicates an unequal but non-significant distribution.

1.3 Education

	A	B	C	D
DEGREES/ DIPLOMA'S	34	15	19	
HIGH SCHOOL	11	4	7	
OTHER	4	1	3	
TOTAL	49	20	29	.68

The majority of participants, (69%) had a tertiary education, then (22%) had high school education and (8%) had either primary education or no education at all.

1.4 Marital status

	A	B	C	D
Married	27	17	10	
Never married	6	2	4	
Divorced	14	5	9	
Total	47	24	23	.77

The majority of participants, 54% were married, 12% never married and 29% were divorced . The chi-square statistic of .77 revealed no significant differences.

1.5 RESIDENCE HOME

	A	B	C	D
RURAL	31	12	19	
URBAN	2	1	1	
URBAN-RURAL	9	5	4	
TOTAL	42	18	24	6.5

A chi-square statistic of 6.5 revealed significant differences between the experimental and control groups with regard to residence with more participants in rural (62%) than urban (4%) and urban-rural (18%).

4.1 Participants demographical data at pre-test and responses to questions.

4.1.1 Participants conception of the causes of patients illness and their relapse.

- Substance abuse and treatment defaults rank high in the participants conception of the cause of patient relapse.

4.2. Suggestion for preventing relapse.

- 50% of the participants wished for a place where psychiatric patients would work during the day so that they are taken away from drugs in the community.

- 32 % felt that more frequent contact between health professionals, patients and relatives would help patients take their treatment

- 18% problems of treatment default would be overcome by using injections rather than pills

A total of 20 participants participated in the experimental condition and completed the post- test measures. However, eight of the participants were unable to attend all six monthly training sessions. T- test computed to determine if differences existed in the post-test measure between those participants that completed six training sessions and those that did not, revealed no significant differences between the participants who completed all six sessions and those who did not. Therefore, analyses were conducted on all 20 participants from the experimental condition.

To determine whether there were significant differences between the experimental and control groups on the pre-test scores of attitudes, knowledge and understanding of mental health problems, t-tests were conducted. The results as presented in Table 2, indicate a significant mean difference at time of pre- test on knowledge about family needs between the experimental group and control group, ($t = 49$, $p < .0.05$). Those participants in the

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experimental group reported higher mean scores of knowledge about family needs (m=3.75) than did participants in the control group (m=3.5). However, no other significant differences were detected on the pre-test assessments.

Table 2 -- Mean comparison of pre-test scores between the control and experimental condition.

Legend for chart:

A - Control, m   B - Control, SD
C - Control, n   D - Experimental, M
E - Experimental, SD   F - Experimental, n
G - Experimental, df   H - Experimental, t

	A		C	D	E	F	G	H
ATTITUDES								
Information	3.60	.	30	3.74	.40	21	49	-1.23
Management Skills	3.83	.43	30	3.93	.52	21	49	.73
Emotional Support	3.43		30	3.59	.41	21	49	-1.37
KNOWLEDGE								
Medication	3.28	.27	30	3.30	.24	21	49	-.21
Family needs	3.58	.29	30	3.75	.27	21	49	-2.20

Behavior problems	3.51	.30	30	3.37	.46	21	49	1.43
Stress	3.58	.39	30	3.77	.37	21	49	-1.78
UNDERSTANDING								
Mental illness	3.33	.71	30	3.09	.86	20	48	1.12
Symptoms	46.62	.36	29	56.32	28.3	19	46	-1.06
Management	11.71	.12	24	11.26	8.94	19	41	.160

Because the participants were not randomly assigned to conditions and the difference in mean score on knowledge about family needs was significantly higher in the experimental condition at the time of pre- test, a decision was made to use analyses of covariance (ANOVA) with the pre-test score as covariates as a strategy for equalizing the groups.

Comparisons between experimental and control groups were conducted using ANOVA to test for changes in participant's knowledge, attitudes and understanding about mental health problems. The mean values, after adjusting for each covariate are presented in Table 3.

Table 3   Post-test scores between control and experimental conditions.

	CONTROL m	EXPERIMENTAL m	df	F
Attitudes				
Information	3.67	3.97	(1.48)	4.78
Management skills	3.84	4.12	(1.48)	3.48
Emotional support	3.51	3.75	(1.48)	1.32
Knowledge				
Medication	3.37	3.62	(1.48)	15.42
Family needs	3.32	3.25	(1.48)	1.15
Behavior problems	3.04	3.58	(1.48)	.52
Family stress	3.57	3.89	(1.48)	2.86
Understanding				
Mental illness	3.31	3.45	(1.47)	3.59

Symptoms	58.21	60.67	(1.45)	.35
Contact	10.33	15.42	(1.39)	2.16

4.3.1 Attitudes towards mental health problems

After controlling for pre-test attitude scores, the results of the analysis conducted on the post-test scores indicate significantly more positive attitudes toward providing information to participate in the experimental group than the control group (f 4.78, p < 0.05). Similarly, significantly more positive attitudes towards teaching skills to participants were found in experimental groups than in the control group (f = 3.48, P < .05). No significant difference was found between the groups on their attitudes towards providing support to mental health patients, (f = 1.32, p > .05). Thus participants in the experimental condition had significantly more positive attitudes toward providing information and teaching skills than did the participants from the control group.

4.3.2 Knowledge about mental health problems

After controlling for pre-test knowledge scores, the results of the analyses conducted on post-test scores indicate that participants in the experimental condition showed significantly greater knowledge about helping patients with medication than did the control group (f = 2.85, p < .05). However, no significant differences between the groups

were found on knowledge about mental health, (f = 1.15, P > 0.5),or on knowledge about managing symptoms and problem behavior, (f = 0.524, P > .05).

4..3.3 Patterns of contact with patients

After controlling for pre-test scores a significant mean difference was found for the post-test scores on the frequency of discussing topics such as managing medications and symptoms, emotional support and stress management with relatives and professionals who care for mentally ill clients, (f = 3.59, p < .05).

Specifically, participants in the experimental condition who made contact with patients, frequently with patients (m = 3.4) than did participants from the control condition (m 3.31). However, no significant differences between the experimental and control groups were found on the frequency of initiated or actual contact with patients, (f =1,45

4.4 Program evaluation

Participants that received the program responded favorably to the items assessing satisfaction of the psycho-education at the end of the sessions. The response indicated a moderate degree of satisfaction. Responses to the open-ended questions, however, revealed both positive and negative reactions. Regarding the benefits of participating in the program, 22% of the participants reported that their attitudes about working with mental health patients had improved as a consequence of the program, and over 35% of the participants reported learning new strategies for assigning these people, 33% of the participants indicated that preventing the disease was not feasible given their current

work-load, and 13% of the participants indicated that they did not have enough time to review the information provided during each session.

CHAPTER 5

5.1 Summary

This paper describes the implementation and evaluation of the participants (professionals & relatives) about relapse prevention in South African psychiatric patients. Results suggest that the participants' training programme significantly improved the attitudes and increased the knowledge mental health practitioners and relatives of mental health patients have about providing information and training to people with mental health problems. Results also suggest that when participant contacted mental health patients, they report an increase in the frequency of discussing topics related to the care of mental health individual. Thus, it appears that the psycho-educational model was effective in changing mental health professionals and relatives of those with mental health problems in terms of their attitudes, knowledge and understanding about mental health problems.

Recent research suggests that the organizational environment in mental health agencies can significantly influence the extent to which client's relatives and client themselves can cope and manage mental illness(Who, 1998). Another explanation is that labeling mentally ill people could be due to insufficient knowledge and understanding about mental illness. Attending six sessions covering a wide range of topics related to increasing participant's knowledge, attitudes and understanding may have been adequate but not strong enough to bring about changes in attitudes of people towards mentally ill people.

5.2 Limitations and implications

A primary limitation of this study was the small sample size and lack of power to detect significant program effects. Furthermore, the lack of random assignment of participants in both the experimental and control conditions threatens the validity of our conclusions.

Despite the methodological limitations to this study, the findings suggest that a psychoeducational model has potential as a method for training mental health practitioners and families to meet the needs of psychiatric patients. The change in the knowledge, attitudes and understanding of mental health problems suggest that the program was effective at changing participant's knowledge, attitudes and understanding. Consequently, the following list of recommendations for improving psychoeducational program was created.

5.2.1 Provide orientation and training for families and mental practitioners.

Additional programs could be developed to train family members to better utilize agency services and staff for information and emotional support. One consistent finding in the literature is that family satisfaction with agency services is highly dependent upon the occurrence of emotionally supportive interactions with practitioners (Tessler et al 1994).

5.2.2 Set policy.

The primary responsibility for initiating open communication between families, patients and practitioners should rest at the upper management level. Implementing policy that supports strong family consumer relationships as a high priority can set a standard for

fostering positive and constructive family relations. Mental health administrators and policy makers should give careful consideration to how the work environment encourages or limits mental health professional's abilities and willingness to interact with families and patients.

5.3   Conclusion

In summary, the results of this study suggest that the psycho-educational model was effective at improving participants' attitudes and increasing knowledge and understanding about working with clients with mental health problems. As practitioners and families become more involved in the welfare of their mentally ill members, the potential for advocating changes to mental health treatments increase. The value of developing and implementing training program similar to this psycho-education model cannot be overestimated. With improvement in program implementation, such participants training offers a potentially positive strategy for reducing some of the difficulties families face in caring for a loved one with serious mental illness.

Accepts and monitor prescribed medication

Community health services

Isolation of people with mental health problems

Lack of community health services

Psychiatric patients

Socio-economic status

Lack of social support

Psychoeducational model

Sheltered employment and workshops

Patient social support system

Unprepared families and health professionals

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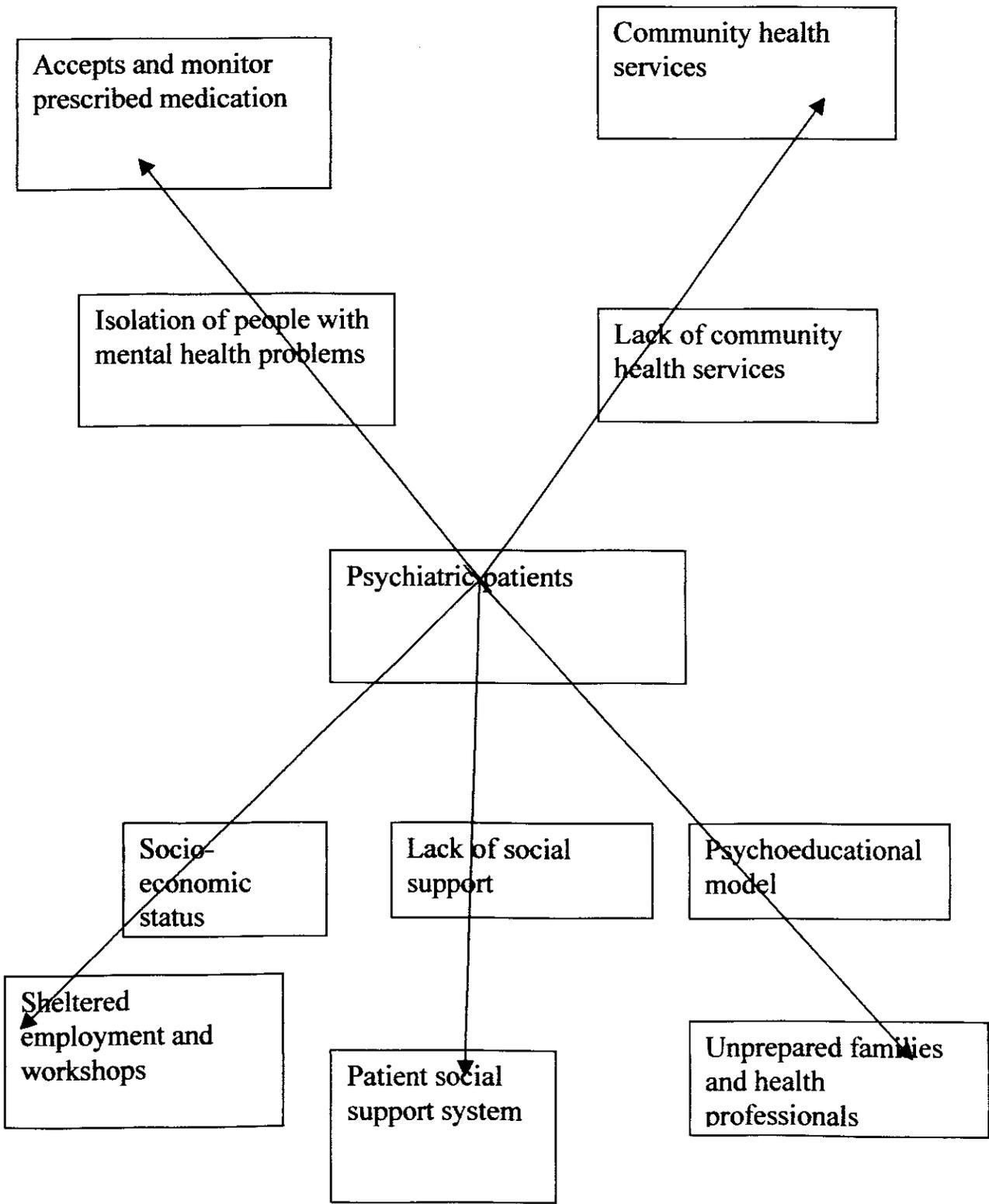
DEMOGRAPHICAL DATA AND QUESTIONS

FOR THE PARTICIPANTS

SECTION A

1. AGE

25-35 YEARS ☐

36-50 YEARS ☐

>50 YEARS ☐

2. SEX

FEMALE ☐

MALES ☐

3. EDUCATIONAL LEVEL

DEGREES/ DIPLOMA'S ☐

HIGH SCHOOL ☐

OTHER ☐

4. MARITAL STATUS

MARRIED ☐

NEVER MARRIED ☐

DIVORCED ☐

OTHER ☐

5. HOME RESIDENCE

RURAL ☐

URBAN ☐

URBAN-RURAL ☐

SECTION B

6. What do you understand by mental illness?-------------------------------------
----

----

7. What do you think are the causes?---

----

8. What can you do to make it worse?--

----

9. What can you do to make it better?--

----

10. What are the benefit of psychiatric medications?-----------------------------
----

----

11. What are the undesirable effects of medication?------------------------------
----
----

12. What are the main difficulties that are associated with this illness?-----------------
----

----

13. What can you actually do to cope with this difficulties?----------------------------
----
----

14. In your observation, what causes relapse to psychiatric patients?--------------------
----

----

15. What kind of people relapse?--

16. What do you think cause them to relapse?---
----

17. Do you have any health facilities in your place?

Yes------------- No-------------

18. If yes, what kind of health facilities do you have in your community?---------------
----
----

19. What do you understand by the following concepts?

19.1 In-patient services---

19.2 Out-patient services---
----

20. What problems did you have managing psychiatric patients?-----------------------
----

-

21. Were you taught how to manage the patient?

Yes-----------No-------------

If yes,

By whom?--

What were you taught?---

22. Generally, what is the attitude of the people towards psychiatric patients?-----------
_____
_____

23. How often do practitioners, families & patients engage in communication?---------
_____
_____

24. To your understanding what is wrong with psychiatric patients?--------------------
_____
_____

25. What suggestion would you make to prevent relapse?------------------------------
_____
_____
_____

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