

**RELAPSES IN PSYCHIATRIC  
PATIENTS IN THE KWAZULU-  
NATAL PROVINCE OF SOUTH  
AFRICA**

**By**

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KWAZULU-NATAL PROVINCE OF SOUTH AFRICA**

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## DEDICATION

This work is dedicated to:-

- (i) The psychiatric institutions and professionals of KwaZulu-Natal with the hope that it will help to improve the problem of relapses in psychiatric patients.
- (ii) Community health and psychiatric nursing students as a motivation for further research work.
- (iii) My beloved daughter Linda, my son Sanele and my late mother Miss A C Mzimela who laid in me the foundation of what I am today.

**DECLARATION**

I, Doreen Nelisiwe (Nicky) Mzimela do hereby declare that **“RELAPSES IN PSYCHIATRIC PATIENTS IN THE KWAZULU-NATAL PROVINCE OF SOUTH AFRICA”** is my own work in conception and creation. All sources that have been used or quoted have been indicated or acknowledged by means of complete references.

N D Mzimela  
**MISS N D MZIMELA**

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- the professional nurses of these institutions for completing the questionnaires, assisting with identifying patients and for helping me find the relatives of patients to be interviewed, as well as other information and other forms of help offered throughout the study;
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## ABSTRACT

This is a descriptive exploratory study which aimed at

- determining the extent of relapses in psychiatric patients in the KwaZulu-Natal province of South Africa;
- determining the factors that contribute to such relapses, and
- determining possible solutions to the problem.

Admission records of the three psychiatric institutions in this province were studied to determine the relapse/readmission rates during the year 1993. Questionnaires and interview schedules were used to determine the contributory factors and possible solutions from professional nurses, patients and their relatives respectively.

The major findings of the study confirmed the hypotheses made which were

- there is a dire shortage of psychiatric services for both inpatient and after care which makes patient care, rehabilitation, and keeping of the patients in the community ineffective.
- the knowledge, and attitude of patients' relatives towards the patients, are not conducive to patient rehabilitation and maintenance within the community;
- lack of aftercare services contribute to patients' substance abuse, treatment default and other problems and/or behaviours which cause patients to relapse.

Recommendations for solving this problem from professional nurses, patients and their relatives emphasised the importance of after care services as well as effective follow up by community psychiatric nurses. The researcher made recommendations based on the findings.

## OPSOMMING

Die studie is beskrywend sowel as ontledend en het ten doel om:

- die omvang van terugvalle van psigiatriese pasiënte in die KwaZulu-Natal provinsie van Suid-Afrika te bepaal;
- faktore wat bydra tot sulke terugvalle vas stel, en
- moontlike oplossings vir die probleem te vind.

Toelatingsverslae van drie psigiatriese institute in hierdie provinsie was bestudeerom vas te stel wat die tempo van terugvalle/heropnames gedurende die jaar 1993 was. Vraelyste en onderhoudskedules was gebruik om die bydraende faktore vas te stel en moontlike oplossings van respektiewelik professionele verpleegpersoneel, pasiënte en hulle families te verkry.

Die belangrikste bevindings van die studie het die aanvanklike hipoteses wat gemaak is, bevestig, naamlik:

- dat daar 'n erge tekort van psigiatriese dienste vir pasiënte in sorg en nasorg bestaan, wat pasiëntversorging, rehabilitasie en die behoud van die pasiënt in die gemeenskap oneffektief maak.
- familie se kennis van en houding teenoor die pasiënte, is nie bevorderlik vir die pasiënte se rehabilitasie en handhawing in die gemeenskap nie.
- 'n Gebrek aan nasorgdienste dra by tot die pasiënte se misbruik van dwelmmiddels, foutiewe behandeling en ander probleme en of gedrag wat pasiënte laat terugval.

Aanbevelings vir die oplos van hierdie probleem, verkry van professionele verpleegpersoneel, pasiënte en hulle familie, het die belangrikheid van nasorgdienste sowel as effektiewe opvolgwerk deur psigiatriese gemeenskap verpleegpersoneel beklemtoon.

Die navorser het aanbevelings op grond van die bevindings gemaak.

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## CHAPTER 1

### ORIENTATION TO THE STUDY

#### 1.1 INTRODUCTION

The modern approach to the treatment of diseases is that of community care, that is treating patients within the community as far as possible. This approach has important rationale and benefits for the patient, and much more for psychiatric patients. These benefits are:

- a) The removal of the stigma of mental illness on patients.
- b) The removal of the stigma of hospitalisation, especially to a mental institution.
- c) Involvement of the patient and his family in his treatment programme which ensures co-operation and longer lasting control of the condition.
- d) Treatment of causative and contributory factors to the patients' condition which are detected during home visits and home care of the patient.
- e) Prevention of family disorganisation as a result of separation with the patient during the period of hospitalisation.
- f) The relief of strain on the overcrowded hospitals and therefore affording the patients who still require acute care to get adequate care from the hospital staff.
- g) The prevention of dependence on the hospital which also contributes to overcrowding in the wards.

- h) Ensuring preventive and promotive mental health care e.g. through health education of the community about the primary, secondary and tertiary preventive and promotive health measures, and thus change their attitude towards mental illness and mentally ill patients (Brooker, 1990:115).

However, these benefits are frequently not realised, resulting in patients being admitted and readmitted to mental institutions or to psychiatric wings in general hospitals for acute attacks, thus creating the so called "revolving door syndrome".

## 1.2 MOTIVATION FOR THE STUDY

The researcher has been motivated to pursue this study after her observation of the recurrent readmission of psychiatric patients to mental institutions. As a community health nurse as well as a psychiatric nurse with interest in effective treatment as a secondary and tertiary preventive and promotive health measure, the researcher has been motivated to investigate the possible causes of patient relapses. Also, as a nurse educator for community health and psychiatric nursing students, the researcher wishes to investigate and provide up-to-date information to her students about the state, curability and management of mental illnesses.

## 1.3 STATEMENT OF THE PROBLEM

The mind is the master of the body. One cannot have a healthy body if the mind is unhealthy. It is a known fact that damage to the nervous tissue is irreparable. Some brain damage occurs when a person becomes mentally ill, and when a mental illness recurs the extent of brain damage increases. While some forms of mental illness are curable, if they recur repeatedly, they eventually become more ingrained and more difficult to treat. It is therefore important to prevent such recurrences through ensuring effective management of mental illness from the onset. While this is attempted, patients still relapse at a high rate, and this has to be prevented if we want to help our patients to become normal again.

#### 1.4 SIGNIFICANCE OF THE STUDY

It is hoped that the findings of this study will help:

- to provide up-to-date data on the state of relapses in psychiatric patients in the Natal-KwaZulu region
- to determine the possible causes or contributory factors to this problem
- to throw light about possible measures to reduce the rate of relapses and the resultant burden on psychiatric institutions' physical and financial resources
- to contribute to more effective community care of psychiatric patients and prevent relapses which are a problem to the health team, the patients themselves and their relatives.

#### 1.5 OBJECTIVES OF THE STUDY

The objectives of this study are

- a) to determine the extent of relapses in psychiatric patients in Natal and KwaZulu
- b) to determine the factors associated with these relapses
- c) to make recommendations for the reduction and prevention of these relapses.

## 1.6 THEORETICAL ASSUMPTIONS

The theoretical assumptions about such relapses are as follows:

- a) It is assumed that there are inadequate facilities for keeping mentally ill patients within the community, hence they relapse.
- b) There is inadequate community knowledge about the causes, effects and curability of mental illnesses even among the relatives of these patients.
- c) The attitude of the community and the handling of mentally ill patients by the community are not conducive to their recovery and retention within the community, hence the relapses.

## 1.7 DEFINITION OF TERMS

In this study, the following concepts will be used with the following meanings:

- **psychiatric patients** refers to patients who have been diagnosed and treated for conditions such as schizophrenia, alcohol and other substance abuse-induced psychoses, organic brain syndromes, neurotic and psychosomatic disorders, and excludes patients with chronic mental illnesses such as mental retardation
- **relapse** refers to recurrence of psychiatric symptoms for which the patient had been treated and recovered. Relapse in this study is determined by readmission of a patient to hospital when he had been treated and discharged as improved or recovered
- **revolving door syndrome** refers to "a pattern of short-term treatment and early discharge becoming repetitive" (Brooker, 1990). In this study, the term is used to

refer to patients who have been readmitted to hospital more than five (5) times since the onset of a basically acute and manageable mental illness.

## 1.8 CONCLUSION

This chapter guides the whole research study, thus it has become important for the researcher to relate to it in the literature review and the theoretical framework chapters which follow hereafter, and in the whole study.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

Relapses in psychiatric patients have been a subject of much research. A number of factors have been found to be related to patients' relapses.

Literature reviewed on this subject focuses on various aspects, namely the characteristics of patients who relapse, their diagnoses, their relatives, possible reasons or causes of relapse, and recommended solutions to overcome the problem. However, the researcher could not find any literature that indicates how extensive the problem of relapse is. There is an indication of frequency of relapses per individual patient, but no reference to the magnitude of the problem in both local and overseas literature. This study therefore focuses on this aspect of the problem in the Natal-KwaZulu province.

#### **2.2 FREQUENCY OF RELAPSES**

Most literature indicates that patients may relapse as often as five to ten times during their lifetime (Barbato, 1992; Curtis, 1992; Nakatani, 1992; Zubin, 1992). Geller (1992:p906) reports from his study of the "worst" state hospital recidivists in the United States that some patients have relapsed up to 121 times with the mean of 31 relapses.

#### **2.3 CHARACTERISTICS OF RELAPSING PATIENTS, THEIR ILLNESSES AND THEIR RELATIVES**

Special features in patients and their relatives as well as special psychiatric conditions make some patients more prone to relapse than others.

- 2.3.1 Schizophrenics, bipolar disorders and personality disorders have been identified by J. L. Geller (1992): pp904-908).
- 2.3.2 Schizophrenics and substance abusers are the most prone in Japan according to a study by Nakatani, Ohki, Yamada, Iwanani & Fujimon (1992:p1032).
- 2.3.3 Snowden and Holschuh (1992:p282 & 288) further identified the following types of relapsing patients:
- patients who are unemployed, and therefore dependent upon siblings, children or parents for financial support
  - patients with fewer people available to substitute for them on their tasks or social roles when they fail to perform them themselves
  - unmarried clients, for lack of someone intimate to support and assist the client
  - patients with low socio-economic status, for lack of means to enhance the quality of life by providing for his needs which are vocational, social, clinical, medical as well as need for food, shelter and clothing
  - women more than men;
  - Blacks more than whites. In their study of ethnic differences in emergency psychiatric care and hospitalisation in a program for the severely mentally ill, Snowden and Holschuh(1992:p283) report that Blacks were found to make fewer visits than whites for case management and individual therapy, whereas Hispanics were found to make more visits than whites for case management and assessment, but fewer visits for medication and individual therapy.

2.3.4 Davis, Dinitz and Pasamanick (1974:p121) explained that poor and sporadic users of clinic facilities cause clinic staff to react unenthusiastically towards them, and hence fail to get the essential support from health service personnel. They become discouraged from attending clinic for follow-up care and medication, and then relapse.

2.3.5 Studies have also shown that patients from families with high expressed emotions (HEE) relatives relapse more than patients from low expressed emotions (LEE) families (Vaughn & Leff, 1976; Brown, Burley and Wing, 1972; Neuchterlein, Snyder and Mintz, 1986). High expressed emotions refers to critical remarks based on content and tone of voice, hostility and emotional over- involvement among the significant others of psychiatric patients (Keith 1992:p35; Goldstein 1981:p30).

Since almost all the above factors are beyond the psychiatric patients' means of control, relaps would be expected to be inevitable unless health professionals help patients to overcome those factors that can be overcome e.g. substance abuse, and to cope with those that cannot be changed eg the diagnosis and their gender.

## 2.4 FACTORS CONTRIBUTING TO RELAPSES

Some degree of disagreement exists among writers about the causes or reasons for relapses, but, on the whole, the following factors are advanced by most authors:

2.4.1 **Non compliance with medication.** It is widely known and accepted that patients who do not take their medications as prescribed (defaulters) relapse in their illnesses. Research by Ventura, Neuchterlein, Hardesty and Gitlin (1992:p615) on 23 recent-onset schizophrenics has shown that antipsychiatric 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 familial expressed emotions".

A significantly higher frequency of independent life events was found in the month prior to a relapse for ten patients on medication as compared to the analogous month for 13 drug-free patients. These findings suggest that neuroleptic medication may produce prophylactic effects raising a patient's threshold of vulnerability to relapse.

According to Mawker, Stanislav, Lacombe, Pierco, Hornstra and Sommi (1992:p201), medication non-compliance in 64% of a sample of 155 patients with manic symptoms was responsible for their relapse. Post, Leverich, Altshuler and Mikalauskas (1992:p1727) found in a study on lithium-discontinuation-induced refractoriness that once the drug was reinstated, even at higher doses, it was no longer effective. A similar process exists in general medicine where micro-organisms become resistant to antibiotics administered for an incomplete course of treatment.

2.4.2 **Life event stressors:** The occurrence of life event stresses such as interpersonal problems, economic stresses, death in the family, job losses and physical problems have been suggested to be associated with schizophrenic relapses (Davis, Dinitz & Pasamanick, 1974:p121; Tarrier, 1992; Marken, 1992; Ventura, 1992). It is largely the patient's failure to deal or to cope with such stresses due to defective ego defense/coping mechanisms that differentiates him from other people who are also faced with similar events but do not break down into mental illnesses. Where such stressors are occurring not for the first time in the patient's history, his relapse is an indicator of failure on the part of the health service personnel (self-care agents according to Dorothy Orem) to equip the patient with such skills during previous attacks.

2.4.3 **Physiologic homeostasis disruption** - Zubin, Steinhauer and Condray (1992:p14) state that relapse occurs because of a disruption of physiological homeostasis,

manifesting for example as mood swings. Premenstrual tension, for example, may precipitate an attack of depression in the patient.

2.4.4 Relapses also occur when the individual's coping ability (with or without assistance of therapeutic intervention) no longer serves to screen out the impinging stressors, which formerly could be contained (Zubin, Steinhauer and Condray, 1992:p14).

2.4.5 **Expressed emotions:** Patients discharged to live with high expressed emotions relatives have been found to have significantly higher relapse rates than those returning to live with low expressed emotions relatives. Living with relatives who are critical, hostile or emotionally overinvolved results in exposure to an overstimulating environment (Tarrier and Turpin 1992:p3). Mozny and Votypkova, (1992) following their study in Czechoslovakia state that expressed emotions was the best single predictor of relapse, and patients from high expressed emotions families spent thrice as long in hospital as patients from low expressed emotions families. In contrast, Montero, Gomez - Benetyo, Ruiz, Puche and Adam (1992:p220) report from their two-year follow-up study in Spain that no association was found between expressed emotions and relapse. This may be explained by Freeman and Simontz's finding that certain families move to readmit the patient even though he may exhibit less bizarre behaviour than would elicit this response in other families (Freeman & Simmons 1963:p199).

2.4.6 **Inadequate community psychiatric health services** to support the patients and their relatives in Dorothy Orem's three stages of self care is another well-documented cause of relapse (Snowden and Holschuh, 1992; Madianos and Madianou, 1992; Uys, 1992; Wits University study, 1991).

The services essential for effective community psychiatric patient management are:

- **psychiatric wings in general hospitals** so that patients do not get admitted to psychiatric institutions and come out with the stigma or label of mental illness which grossly hampers their reacceptance in the community
- **psychiatric outpatient services** in general hospitals and clinic centres where patients can collect their medications and receive other forms of therapy within easy reach. These services should be adequately staffed by psychiatric trained personnel, that is doctors, nurses, social workers, psychologists etc.
- **inpatient facilities** for relapsed patients so that relatives feel at ease and not burdened with a patient whom they often refer to as “thrown out” or “dismissed” from hospital
- **24 hour emergency services** to help relatives cope with crisis situations e.g. suicide, aggression, hyperkinesis
- **day hospitals** for the admission of patients during the day while relatives are at work. The patient then returns home in the afternoon and on weekends when the relatives are home
- **night hospitals** where patients like the manics and hyperkinetic children (who are a burden to the family during the night) are admitted, to give the family peaceful sleep. The patient is then collected every morning to be with the family
- **home visiting services** to
  - \* check the patient's readjustment and acceptance by the family

- \* check the effectiveness of the treatment the patient is on, and to make adjustments where necessary
- \* assist the family in dealing with the patient and his residual problems
- **halfway houses** for gradual reintegration of the patient into the community after discharge from hospital
- **employment facilities** and sheltered employment workshops where patients cannot be reemployed in the open labour market. It is essential to orientate employers and patients' work colleagues about the patients' condition and functional abilities so that they are accepted and treated properly at work
- **recreational facilities** especially for patients who are unemployed and have not fully regained their ability to fruitfully engage themselves during the day to prevent boredom
- **rehabilitative services** e.g. Alcoholics Anonymous or the South African National Council for Alcoholics and Drug Dependents, to help the patients to overcome these problems
- **psychopharmacotherapeutics**, especially the long-acting phenothiazides like mofegate, an injection which helps to reduce the rate of relapse by overcoming the problem of patients failing to take their pills/tablets everyday
- **community orientation** on the causes, effects, curability of mental illnesses, and the handling of mentally ill persons. Failure of the community to accept the patient as cured, capable and normal again disturbs the efforts that patients make towards recovery. (Community Psychiatric Nursing Lecture notes; Madadeni Hospital, Newcastle 1977).

Madianos and Madianou (1992:p40 & p47) state that “.... effective deinstitutionalisation of the chronic patient population will depend on the availability of adequate community-based social support and rehabilitative services, ..... compliance with aftercare, housing conditions, care with regard to clothing and nutrition, ability to be or live alone, social support, economic situation, family co-operation with aftercare daily activities, social relationships, interpersonal transactions, social roles, leisure activities and coping with stressful situations”. Snowden and Holschuh (1992:p282), quoting Goldfinger, Hopkins and Surber (1984) state that “programs that aim to provide an enhanced quality of life must address a broad spectrum of needs: vocational, social, clinical, medical, as well as the need for food, shelter and clothing”. Medication and ensuring that this is taken properly are therefore not the answer to the problem of relapse, but it is essential to ensure that all the basic needs of the patient are met.

In developing countries like South Africa (or parts thereof), there is a serious shortage of the above essential services (Uys, 1992:p38; Beigel, 1983:p149; Witwatersrand University study, 1991:p35-36), hence the higher relapse rates.

#### 2.4.7. **The patients' and staff perspectives/perceptions of the causes of relapse**

Fetter and Lowery (1992:p301) used the attribution theory to explain the perceptions of relapses by patients and staff. In **internal attribution**, patients saw themselves as failures, or factors responsible for their relapse were thought to be with or within them e.g. failure to take treatment as prescribed. In **external attribution** patients saw the cause of relapse as being not under 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 perception makes a patient feel that he is not responsible for his relapse and so can do nothing to prevent it.

Davis et al (1974:p121) found that the failures in their study were attributable to internal, intrapsychic problems with no viable external precipitants. Hence Zubin, Steinhauer and Condray (1992:p14) say that relapse is an indigenous characteristic of a subtype of schizophrenia which occurs in some patients regardless of treatment, that is these patients possess a special vulnerability which is not present in nonrelapsers.

Davis et al (1974:p111) summarised this section of causes of relapses by emphasizing that the course taken by any patient depends upon the following variables:

- the intensity and extent of the patients' illness
- the degree of health or disorganisation in the patient's family
- the availability of appropriate medication, and
- the provision of adequate services such as social service help or supportive counselling, depending upon the needs of the patient and his family

## 2.5 CONCLUSION

The foregoing discussion, especially that relating to the causes of relapses is in keeping with Dorothy Orem's environmental conditions essential for development on which this study is based. These conditions are deficient in the communities caring for psychiatric patients, hence they relapse. These conditions are:

- opportunities to be helped by being with other persons or groups where care is offered, as in day care centres, social clubs and halfway houses
- available opportunities for solitude and companionship

- provision of help for personal and group concerns without limiting individual decisions and personal pursuits
- shared respect, belief and trust
- recognition and fostering of developmental potential
- each person strives to have respect and trust as he/she assumes or attempts to assume responsibility for development (Orem 1985).

## **CHAPTER 3**

### **CONCEPTUAL MODEL USED IN THE STUDY: DOROTHY OREM'S SELFCARE MODEL**

#### **3.1 INTRODUCTION**

When psychiatric patients are discharged from hospital, they are expected to care for themselves with the help of the family members and community psychiatric support services where and when necessary. However, they are often confronted with situations, attitudes and reactions from the community which are not conducive to healthy recuperation and readjustment to society.

As indicated in Chapter 2, patients need shelter, clothing, food, acceptance by the family and friends, employment, financial security and relief from the stresses that they can no longer tolerate. (Madianos & Madianou 1992:40; Snowden and Holschuh 1992:282). Usually they are not accepted as the same people that they were or into the same roles that they used to play before illness. As a result they are frequently unemployed and so have financial problems. They lack facilities for constructive use of leisure time and so they become bored and then relapse into withdrawal, depression, hallucinations, aggression and so on.

The effectiveness of the care given to patients in the community and outside hospitals depends mostly on the efficiency of the patient in caring for himself, and whoever is assisting him in such care. Dorothy Orem calls this "self care".

#### **3.2 DOROTHY OREM'S SELF CARE MODEL**

Dorothy Orem's selfcare model centres around the ability of the individual to help himself in maintaining the normal daily life activities. Underwood, in Reynolds and Cormarck

(1990:175) says: "We must change the way we look at patients and nursing practice by shifting our focus from the individual's psychological problem, condition and symptoms to the individual's ability to meet selfcare requisites". Nursing intervention therefore should focus on assisting the client towards selfcare and in overcoming his self care deficits. We should look at what the patient is able to do more than at his disability; at his strengths more than at his weaknesses because it is the strengths and abilities that we should build on.

Like other nurse theorists, Orem uses the four major concepts found in other nursing theories, that is, man, health, environment and nursing. She sees **man** as an integrated whole, a unit inseparable in the physical, psychological and interpersonal aspects, functioning biologically, symbolically and socially (Fitzpatrick and Whall 1983:138). The psychiatric patient is no different - he is not merely a psychiatric deviant requiring psychiatric care only. He requires a holistic approach to his care to ensure that he recovers completely and continues in that state.

Orem defines **health** as a state of wholeness or integrity of the individual human being, his parts and his mode of functioning. As with the definition of man, the psychiatric patient requires physical, social, psychological and spiritual care to ensure his integrity.

The **environment** and **man** are described by Orem as an integrated system related to self care. The patient does not live in a vacuum. Therefore environmental problems like social pressures and the socioeconomic climate affect him as much as, if not more than they affect any other person. The psychiatric patient needs employment, like everybody, when he has adequately improved, but if there is a high rate of unemployment his chances of getting a job are even smaller than those of a normal person.

According to Orem's theory as stated by Leddy and Pepper (1985:142), **nursing** is defined as actions to overcome or prevent the development of selfcare limitations and to

provide therapeutic selfcare for all individuals who are unable to do so. Orem's selfcare deficit theory is labelled as a general theory which is composed of three related theories.

These are:

- the theory of selfcare or the selfcare construct
- the selfcare deficit construct, and
- the nursing system's construct (George 1985:125).

### 3.2.1 The selfcare construct

Selfcare is the practice of activities that the individuals initiate and perform on their own behalf in maintaining life, health and wellbeing (Marriner, 1986:119). Those who provide selfcare are referred to as selfcare agents, and those who provide care to infants, children or dependent adults are called dependent care agents. The ability of the human being to engage in selfcare is referred to as selfcare agency (George 1985:125).

In community care of psychiatric patients, this construct refers to the patient's ability to continue taking medication and to control those stressors that cause him to relapse.

Orem presents three categories of selfcare requisites. Selfcare requisites are the purposes to be attained through the kinds of action called selfcare. They are

- universal selfcare requisites
- developmental self care requisites and
- health deviation selfcare requisites.

- a) **Universal selfcare requisites** are associated with life processes and maintenance of integrity of human structures and functioning e.g. air, food, water, care associated with elimination processes, activity and rest; social interaction, prevention of hazards to human life functioning and wellbeing. At the higher level of Maslow's hierarchy of needs are the needs for companionship, self actualisation, achievement, recognition, mastery etc. While the lower basic needs may be met, the discharged psychiatric patient may have a problem meeting the higher order needs, hence the relapses.
- b) **Developmental selfcare requisites** comprise maintenance of conditions to support life processes and human development needs, and preventive care for adverse conditions affecting the developmental processes for instance coping with stress, decision making and others. Life event stressors like interpersonal problems or conflicts, economic stresses, death and loss of a job are a common occurrence in life (Davis, Dinitz and Pasamanick 1974:p121). Unless a patient develops adequate coping skills, he will find it hard to "keep his head above water" and avoid relapsing.
- c) **Health care deviation selfcare** is required in conditions of illness, injury or disease or a medical intervention done for corrective surgery for example the colostomy that will require the patient to adjust to new selfcare techniques for elimination. Seeing that compliance with medication is important for its protective effect (Ventura, Neuchterlein, Hardesty and Gitlin 1992:615), it is essential for a psychiatric patient to realise that his health deviates from the normal unless he takes medication regularly.

### 3.2.2 The selfcare deficit construct

Selfcare deficit refers to a state where the self care agency is not adequate to meet the known therapeutic selfcare demands, or is unable to care of himself (Marinner 1985:120).

The selfcare deficit construct delineates when nursing is needed as well as identifying the one who needs nursing care in cases of selfcare deficit which is health - related. Nursing will be required in the absence or limitation of an adult or parent or guardian in the case of a child, to meet continuous selfcare requirements (George 1985:127). The domain of nursing practice refers to activities in which nurses engage when they provide nursing. These areas include entering into and maintaining nurse-patient relationships, determining how patients will be helped through nursing, responding to patients' needs, desires and requests, presenting, providing and regulating direct help to patients and their relatives, and finally coordinating and integrating nursing with daily living, including other services needed. As discussed in Chapter 2, while there is a deficit in the psychiatric patient and his relatives' selfcare system, there is also a marked deficiency of psychiatric health care or health agency services to assist the patient and his relatives, hence patients relapse (Uys 1992:38; Beiger, 1983:1491; Wits University Study 1991:35-36).

### 3.2.3 The nursing systems construct

Nursing systems are actions performed by nurses using their abilities to prescribe, design and provide nursing to patients. They aim at regulating the individual's capability to selfcare and to meet selfcare requisites (Marinner 1986:120).

Orem has further developed three nursing systems to meet the selfcare requisites of patients. These are based on the identification of

- the specific role and responsibilities of the patient
- the specific helping method to be utilised by the nurse to attain selfcare goals
- classification of patient care.

a) **The wholly compensatory nursing system**

This is indicated where the patient has no active role in the performance of care. It is characterised by the patient's role incapacitation mentally or physically. The patient may be in a state of physical incapacitation but conscious. The patient's psychomotor aspect may be impaired for effective human functioning, for example a patient who is not responsive to stimulation. In psychiatric nursing, as in general hospitals, these patients are chronics, and are frequently discharged to the community to free the hospital beds for acute cases who will be treated and leave room for others. Because they are a burden even to the family, they are often readmitted to relieve the family of the burden even though they do not exhibit acute symptoms (Freeman and Simmons, 1963:199).

b) **Partly compensatory nursing system**

Here both the patient and the nurse are engaged in activities involving manipulation tasks or ambulation. Both have a role to play, for example in post operative patients (George 1985:129). At this level, the patient should participate in decision making about selfcare and is assisted by the nurse in so doing (Orem 1985:153). To be able to do this, the nurse should know the patient well to determine whether the patient's decisions are realistic or not. In the situation described by Uys (1992), Beigel (1983) and the Witwatersrand University Study (1991) where there is about one psychiatrist to 133 patients compared to 1:12 in the United States, and one psychiatric nurse to fifty patients, this is not always possible. Nurses then resort to the wholly compensatory or the supportive educative systems which are inappropriate for the patients' rehabilitation.

c) **The supportive educative system**

Here the patient is able, or can and should learn to perform the required care measures but is unable to do so without assistance. Nursing activities included are guidance, support, teaching or provision of a therapeutic environment (George 1985:129). Some of these services are rendered by clinical psychologists, of which there are 200 serving the

predominantly white population of Johannesburg/Randburg, or about 33 psychologists per 100000 people (Witwatersrand University Study : 1991:p35). These services should commence while the patient is still in hospital, during his rehabilitation and preparation for discharge and continue in the real community setting with the help of community psychiatric services. As a result of the shortage of these services, the patients then do not get adequate guidance, support, teaching or provision of a therapeutic environment in the family or the community, and then they relapse.

Orem (1985) also identifies certain conditions that are essential for the effective attainment of selfcare, especially the maximum level of selfcare where there is little help from the family or health service personnel. These conditions are:

- awareness, perception and decision making as related to self and environment
- a state of motivation and interest necessary to learning and applying knowledge
- opportunities to be helped by being with other persons or groups who care
- availability of opportunities for solitude and companionship
- provision of help for personal and group concerns without limiting individual decisions and personal pursuits
- shared respect, belief and trust
- recognition and fostering of developmental potential

While most discharged psychiatric patients are capable of selfcare, they are not provided with the above conditions, hence they relapse.

- sometimes they are not given an opportunity to be helped, but they are forgotten or counted out of the family circle
- individual decisions and personal pursuits are criticised or ridiculed
- they no longer receive the respect and trust that they deserve or used to get before illness
- their developmental potential is no longer recognised

### **3.3 APPLICATION OF DOROTHY OREM'S SELF CARE MODEL TO THE STUDY**

Psychiatric nursing has traditionally used theories developed by other disciplines and, as a result, has focused on the same clinical problems and developed the same or similar interventions. The selfcare model provides us with an opportunity to develop an independent practice of nursing that is grounded in and reflective of nursing rather than medicine or psychotherapy.

The deliberate action of selfcare is essential for health and wellbeing and when, due to health - related selfcare limitations, individuals are unable to meet therapeutic selfcare demands and experience selfcare deficits, nurses are needed to assist persons to accomplish selfcare. The nurse and patient meet in the helping situation where nurses design, manage and maintain systems of care. These nursing systems include the social, interpersonal and technological subsystems and are designed to assist persons to meet selfcare demands and thus to meet selfcare requisites in day-to-day life. The selfcare model guides the nurse to focus on the individual and his selfcare behaviour in day-to-day living rather than on any specific psychological problem, symptom or condition.

The concept of selfcare indicates that the patient is capable of caring for himself. But, as indicated in the discussion of the selfcare model, there are varying degrees of selfcare and so varying degrees of support or assistance that the patient requires to be able to care for himself. The nurse therefore begins by assessing basic conditioning factors. This gives an idea who the person is, and what may have and will continue to influence his ability to meet the selfcare demands. Then, for each universal selfcare requisite, the nurse will or should ask the following questions:

- what are all the behaviours usually necessary to meet this selfcare requisite (therapeutic selfcare demands)? The patient should then be assessed for presence (or absence) of these behaviours, e.g. for the psychiatric patient to be able to take medication properly, he should be able to identify the medications and tell the times for taking the medications. His memory must also be reliable. If patients are discharged on medication without establishing these behaviours, or establishing the presence of selfcare agents (relatives) who will help to remind the patient to take his treatment, then the patient will relapse
- was this person able to engage in all the behaviours in the past? If the patient was for example, able to cope with loss, there is hope that he can be helped to strengthen his coping mechanisms, but a person who was generally incapable is difficult to teach new tricks after mental illness. He is thus a good candidate for relapse when similar stresses appear after discharge
- does he have the potential to engage in the behaviours in the future? This means that patients must be assessed for their extent of capabilities to lead a normal or near normal life after discharge, and not merely discharged because it is time for that. Having the potential means that the patient should be rehabilitated and helped to strengthen these behaviours and so prevent relapses
- what prevents him from engaging in the behaviours (selfcare limitations)?

- what specific behaviour is the patient unable to do (selfcare deficit)? To what extent will such deficit affect the patient's aftercare? The presence of selfcare deficits initiates the development of nursing intervention.

Although not uniform with all patients - hence the need for individual patient assessment - the most common selfcare requisites of psychiatric patients that would help to prevent relapses may be

- maintaining balance of solitude and social interaction
- prevention, mitigation and/or overcoming the effects of situational (environmentally - related) crises across the lifespan
- health deviation: associated with management of the effects of the illness and injury and diagnostic, therapeutic and rehabilitation measures e.g.
  - seeking appropriate health care
  - being aware of and attending to effects and results of pathological conditions
  - carrying out prescribed diagnostic therapeutic and rehabilitative measures
- being aware of and attending to enduring social relations
- fostering bonds of affection, love and friendship
- effectively managing impulses to the others for selfish purposes, disregarding their individuality, integrity and rights

- promoting individual autonomy as well as group membership.

The above selfcare requisites, limitations and deficits relate well to the causes of relapse as outlined in the literature review, namely

- a) non compliance with medication
- b) life event stressors, coupled with
- c) ineffective coping mechanisms/abilities
- d) physiologic homeostasis disruption
- e) high expressed emotion relatives
- f) inadequate community psychiatric health services, and
- g) patients' external attribution of the causes of their relapse.

### 3.4 CONCLUSION

From the foregoing discussion, then, it is clear that the discharged psychiatric patient needs assistance, either wholly or partially, to help him refind his place in the community that may no longer accept him as normal and completely cured, or if not completely cured, that at least still has capabilities.

When nurses focus on assisting the patient to be self-reliant and responsible in meeting selfcare requisites, we offer him the opportunity to enhance health and wellbeing, especially his wellbeing. In so doing we make a meaningful and unique contribution to patient care and treatment, and so help to keep the patient in the community by preventing relapses.

## **CHAPTER 4**

### **METHODOLOGY**

#### **4.1 INTRODUCTION**

In order to meet the objectives of this study on relapses in psychiatric patients, which were

- to determine the extent of relapses,
- to determine the contributory factors, and
- to make recommendations for improving the situation,

an extensive data collection approach had to be adopted. The approach was then divided into three:

Firstly, a quantitative research approach was used to determine the extent of relapses in the subjects under study.

Secondly, an exploratory descriptive type of approach was used to explore and describe the extent and possible causes of the problem.

Thirdly, a historical study of admission and readmission records was conducted to collect factual data on the extent of relapses.

According to Seaman (1987:188), "the descriptive-exploratory design proposes to observe, describe, explore and assemble new knowledge and the primary objective of descriptive or exploratory research is not to generalise but to provide new information".

#### **4.2 SCOPE AND DELIMITATION**

The study was conducted at the three institutions which admit and treat mentally ill patients in Natal and KwaZulu.

These are

- Madadeni Hospital which is located in Northern Natal, 17 km from the town of Newcastle, +- 350 km northwest of Durban and +- 250 km south east of Johannesburg (see map Annexure 1).
- Fort Napier and Townhill hospitals which are located at Pietermaritzburg in the Natal Midlands, +- 100 km Northwest of Durban.

The study was confined to patients treated at these three institutions only.

#### **4.3 METHODS/INSTRUMENTS FOR DATA COLLECTION**

To be able to collect data relevant to the objectives of the study the researcher had to use more than one instrument.

- 4.3.1 A checklist was used to collect information on admission and readmission rates for 1993 from the admission ward registers of the three institutions under study;
- 4.3.2 Questionnaires were used to obtain information from the hospital management about the size, catchment area, services and staff establishment of the institutions.
- 4.3.3 Questionnaires were also used to collect information from the professional nurses on their opinions and observation of causes of relapses and possible solutions.
- 4.3.4 Interviews were held with patients and their relatives also to elicit their side of the story.

#### **4.4 POPULATION AND SAMPLE**

- 4.4.1 The population for the study was relapsed patients readmitted to Madadeni, Fort Napier and Townhill Hospitals.

Admission and readmission rates for 1993 were studied as this was the most current and complete calendar year

A random sample of 89 readmitted patients present at the institutions at the time of the field study was interviewed. From these, a sample of 75 patients with coherent information was selected.

The population was drawn from a list of readmitted patients as indicated in the admission records, and the convenience sample of patients who were adequately improved to communicate coherently was drawn, with the help of the ward personnel.

Patients with the "revolving door syndrome" were given first preference as they display a more serious problem with being retained within the community.

4.4.2 The professional nurses in the admission wards, longterm wards where patients are transferred from the admission wards, and community services personnel were given questionnaires for professional information. The person in charge of each of these units was given the questionnaire, and the unit professional nurses filled in the questionnaire as a ward team. Out of twelve questionnaires given out ten were returned from the 3 institutions.

4.4.3 A sample of twenty five (25) relatives were interviewed as they became available for their input on the problems encountered with the patients and suggestions for help were elicited. A bigger sample of relatives was desired in order to complement the patients' opinions, but relatives were not available at the time of collecting data. Firstly it was difficult to find the relatives of the patients that were interviewed because some of the subjects were from as far afield as Kokstad and Ngwavuma.

An attempt to visit the homes of some of the patients was also not helpful as there was either no one at home, or the addresses given on the patients' records were incorrect.

A helpful strategy was to visit mobile clinic points with the community services' staff and see relatives who were escorting patients to clinic.

Eventually, a sample of twenty five (25) relatives were interviewed, eight (8) at Madadeni and Fort Napier hospitals, five (5) during home visits and twelve (12) at mobile clinic points. It was not possible for the researcher to get in contact with relatives of relapsed patients of Townhill hospital at Pietermaritzburg.

#### **4.5 PILOT STUDY**

The research instruments were tested on three (3) professional nurses, ten (10) patients and three (3) relatives at the Ngwelezane hospital psychiatric unit. The unit is a wing which admits psychiatric patients from the general wards and from the community served by the hospital.

Necessary corrections and modifications were made on the original instruments after pilot testing.

#### **4.6 PERMISSION AND ETHICAL CONSIDERATIONS**

Permission to conduct the study was sought and obtained from the Senior Nursing Service Manager, Madadeni Hospital and from the Senior Medical Superintendent for Fort Napier and Townhill Hospitals (see Annexure 7). The patients were also asked for their consent, and they were assured that no harm was going to ensue from their participation in the study. Patients who refused to participate were not included or coaxed in any way.

Patients were further assured that privacy and anonymity would be ensured.

#### 4.7 CONCLUSION

- The methodology adopted for the study was found to be very helpful in collecting data
- The admission records at the 3 institutions clearly indicated which patients were first admissions and which were readmissions
- The administrative personnel had no reservations to the use of the records, their ward staff and other facilities to collect data
- Administering questionnaires to the ward personnel while conducting interviews with patients ensured an 89% return rate (ten out of twelve questionnaires were returned)
- using interviews with patients and relatives ensured that questions were well explained and appropriately responded to.

## CHAPTER 5

### ANALYSIS AND DISCUSSION OF FINDINGS

#### 5.1 INTRODUCTION

This chapter discusses the findings of the study, the historical data and information from questionnaires and interviews obtained during the study.

Data is presented by means of graphs and figures and then interpreted simultaneously for coherence and continuity.

#### 5.2 ANALYSIS AND DISCUSSION OF FINDINGS

The study was done at the three psychiatric institutions in Natal/KwaZulu, namely Madadeni, Townhill and Fort Napier hospitals.

The objectives of the study were to determine the rate of relapses in psychiatric patients, the contributory factors, and to make recommendations for relieving this problem.

Information pertaining to each institution is presented in relation to historical data as these differ, but information pertaining to staff, patients and their relatives' opinion is only referred to according to institutions where there are remarkable differences in responses of these participants.

## ITEMS A.2, A.3, A.4 AND A.5

### SIZE OF PSYCHIATRIC INSTITUTIONS, SERVICES RENDERED AND STAFF ESTABLISHMENT OF EACH

The researcher was interested in determining these factors as they reflect the quality of care rendered to psychiatric patients. An ideal institution is expected to have an adequate staff establishment for its patient bed state, and also render most of the comprehensive health services essential for efficient and effective patient care.

5.2.1.1 **Madadeni Hospital** is a 810 bed hospital serving the Black community North of the Tugela River. Its catchment area extends into the Transvaal and includes such areas as Amersvold and Wakerstroom, into the Orange Free State and includes such areas as Harrismith, Vrede and Memel, and in the North East of Natal it receives patients from such areas as Pongola, Manguzi, Mahlabathini and Ezakheni District (see map, Annexure 1).

The hospital and community services that it renders are presented in the table below:

**TABLE 5.1: MADADENI HOSPITAL PSYCHIATRIC SERVICES**

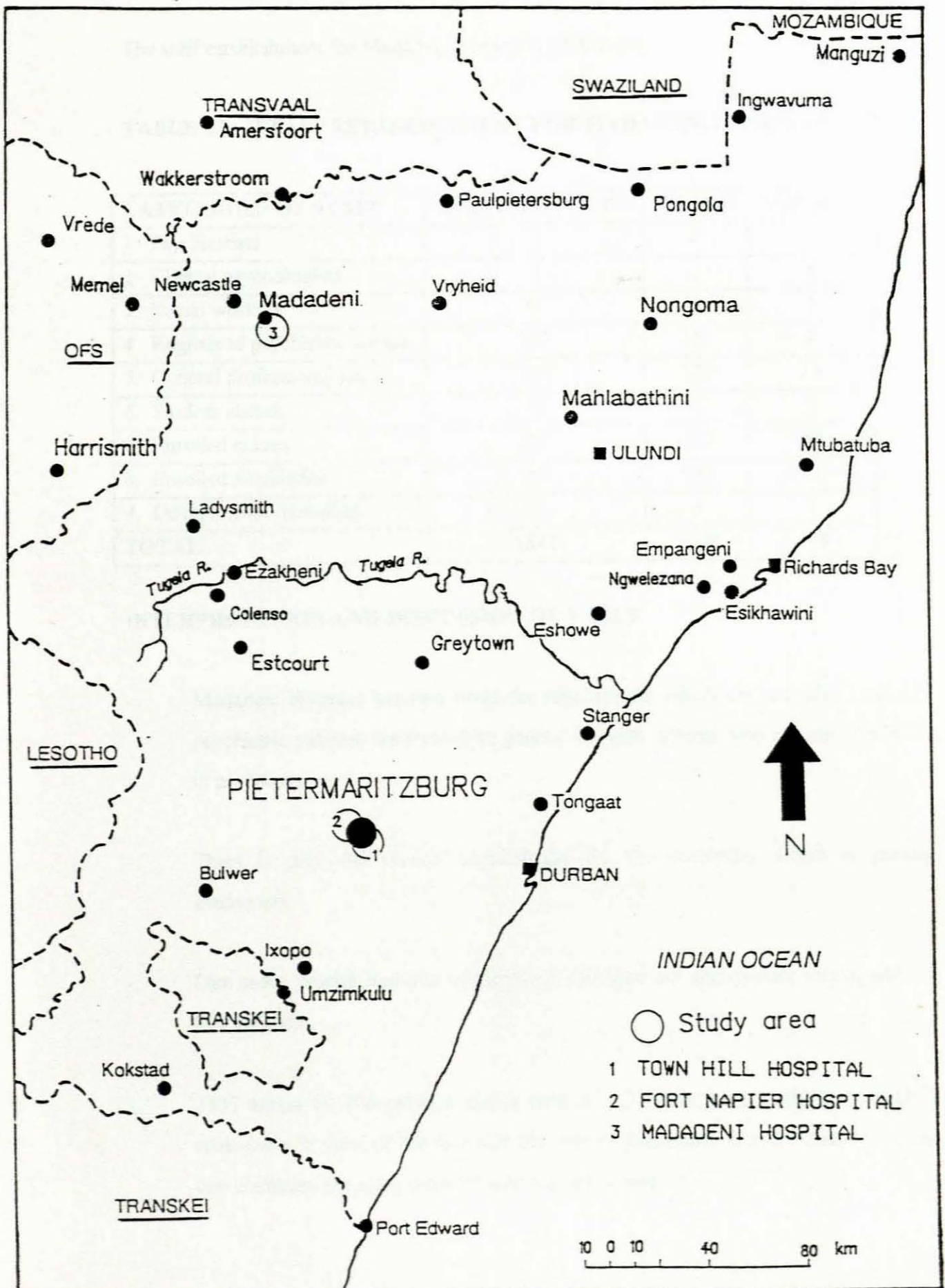
<b>WARD</b>	<b>TYPE OF WARD</b>	<b>BEDSTATE</b>
Ward E2	Male admission	32
Ward E3	Female admission	32
Ward E4	Sick bay - integrated	34
Ward E5	Female geriatric	34
Ward C1	Male retardates	72
Ward C2	Female retardates	46
Ward C3	Female convalescents	48
Ward C4	Female long term	56
Ward C5	Male geriatrics	72
Ward C6	Male long term	96
Ward C7	Male long term	96
Ward C8	Male convalescent	96
Ward C9	Male convalescent	96
Community psychiatric services		-
<b>TOTAL</b>		<b>810</b>

The community psychiatric services have a staff of 15 professional nurses and 5 enrolled auxiliaries, which run a comprehensive community service divided into outpatients, admissions, discharges and outreach services.

- the outpatients service consults patients most of whom report to collect medications and to receive care and advice in case of problems
- the admissions section attends to patients and relatives on admission, with the aim of making contact with the patient's family and counsel it while the patient is in hospital, and prepare the family for the patient's discharge
- the discharges subsection ensures that the patient is well accepted on discharge, at home, in the community in general, and that the patient readjusts well to community life
- the outreach subsection visits homes of patients who no longer report for medication, as well as helping patients and families who need help with patient care at home, in the community in general and at work
- There are (8) satellite clinics, 3 at Madadeni, two at Osizweni, one at Blaaubosch, one at Nyanyadu and one at Naasform.

The mobile clinic service from the hospital has twelve (12) clinic points at Philisiwe, Phunguphunu, Osizweni Crafts Centre, Indoni, Phathakahle, Mbabane, Dicks Halt, Kilkeel, Masondeza, Stanford Hill, Annandale and Ntendeka (see map Figures 5.2 & 5.3) with a total of about 700 patients.

FIGURE 5.1: MAP OF NATAL



(Source: Shuter's Magister Atlas for Secondary Schools, 1984, p. 47.)

The staff establishment for Madadeni hospital is as follows:

**TABLE 5.2: STAFF ESTABLISHMENT FOR MADADENI HOSPITAL 1993**

<b>CATEGORIES OF STAFF</b>	<b>CREATED POSTS</b>	<b>FILLED</b>	<b>VACANT</b>
1. Psychiatrists	2	0	2
2. Clinical psychologists	2	1	1
3. Social workers	2	1	1
4. Registered psychiatric nurses	335	333	2
5. General professional nurses	143	130	13
6. Student nurses	0	0	0
7. Enrolled nurses	581	530	51
8. Enrolled auxiliaries	581	544	37
9. Occupational therapists	2	1	1
<b>TOTAL</b>	<b>1648</b>	<b>1540</b>	<b>108</b>

#### **INTERPRETATION AND DISCUSSION OF TABLE**

- Madadeni Hospital has two posts for psychiatrists which are not filled, and 810 psychiatric patients are treated by general medical officers who are not specialists in psychiatry
- There is only one clinical psychologist for the institution, which is grossly inadequate
- One social worker and one occupational therapist are also grossly inadequate for 810 patients
- 1537 nurses for 810 patients give a ratio of  $\pm 2$  nurses per patient (2:1) which is reasonable in view of the fact that the patient population is more than 810 when one considers the many patients who are outpatients

The staff establishment for Fort Napier hospital is as follows:

**TABLE 5.4: STAFF ESTABLISHMENT FOR FORT NAPIER HOSPITAL**

<b>CATEGORIES OF STAFF</b>	<b>CREATED POSTS</b>	<b>FILLED</b>	<b>VACANT</b>
1. Psychiatrists	5 F/T, 3P/T*	2F/T, 3P/T	3
2. Clinical psychologists	4 F/T, 5 P/T	1F/T, 3 P/T	5
3. Social workers	5	3	2
4. Professional nurses	137	128	9
5. Student nurses	0	0	0
6. Enrolled nurses	30	30	0
7. Enrolled auxiliaries	132	130	2
8. Occupational therapists	3	3	0
9. Medical officers	12	12	0
10. Specialists	8	7	1
11. Specialised auxiliary doctors	5	5	0
12. Pharmacists	4	4	0
<b>TOTAL</b>	<b>353</b>	<b>331</b>	<b>22</b>

\*KEY: F/T = Full time

P/T = Part time

**INTERPRETATION AND DISCUSSION OF TABLE**

- Except for nursing personnel, Fort Napier shares its medical and paramedical staff with Townhill hospital

- Although there are adequate posts for psychiatrists and clinical psychologists, eight (8) of these are vacant, and filled by consultants, interns and other specialist doctors
- There were also 2 vacant posts for social workers
- There were 288 nurses for 525 patients which gives a ratio of  $\pm 1$  nurse for 2 (1:2) patients which is a reasonable ratio

5.2.1.3 **Townhill hospital** is a 584 bed institution serving white, coloured and Indian communities of the whole of Natal and KwaZulu. Its services are represented in the table below:

**TABLE 5.5: TOWNHILL HOSPITAL PSYCHIATRIC SERVICES**

<b>WARD</b>	<b>TYPE OF WARD</b>	<b>BEDSTATE</b>
1. Peacehaven	Female admission	30
2. - Libertas and Moregloed	Male admission	60
3. Jacaranda	Female acute	30
4. Impala	Male security	52
5. North Park	Psychotherapy	26
6. Ward O	Male geriatric	20
7. Hillside B	Assessment and sickbay	28
8. Hillside C, D & E	Psychogeriatric	90
9. Uitsig A,B,C,D,E,F,G, & H	Long term	208
10. Ward 3	Longterm & geriatric	40
<b>TOTAL</b>		<b>584</b>

\* The patients of Townhill hospital mostly have medical aids and therefore use private doctors for outpatient care. Therefore Townhill hospital does not have community outreach services

\* Because of the large number of male patients admitted, there are double the admission facilities for males than for females

The staff establishment for Townhill hospital is as follows:

**TABLE 5.6: STAFF ESTABLISHMENT FOR TOWNHILL HOSPITAL**

<b>CATEGORIES OF STAFF</b>	<b>POSTS CREATED</b>	<b>POSTS FILLED</b>	<b>POSTS VACANT</b>
1. Psychiatrists	5 F/T, 3PT*	2 F/T, 3P/T	3
2. Clinical psychologists	4 P/T, SA	1 F/T, 3P/T	5
3. Social workers	5	3	2
4. Professional nurses	130	129	1
5. Student nurses	0	0	0
6. Enrolled nurses	24	24	0
7. Enrolled auxiliaries	123	123	0
8. Occupational therapists	3	3	0
9. Medical officers	12	12	0
10. Specialists	8	7	1
11. Specialised auxiliary doctors	5	5	0
12. Pharmacists	4	4	0
<b>TOTAL</b>	<b>363</b>	<b>351</b>	<b>12</b>

\* F/T F Full time P/T = Part time

## **INTERPRETATION AND DISCUSSION OF ABOVE TABLE**

- As indicated in 5.2.1.2, Townhill hospital shares medical and paramedical services with Fort Napier hospital
- The nurse: patient ratio for Townhill hospital is 280 nurses: 584 patients, which is  $\pm$  1 nurse to 2 patients (1:2). This is a fair and reasonable ratio, and especially in view of the fact that Townhill hospital provides inpatient services only

### **5.2.1.4 Comparative discussion related to the three institutions**

- \* Although Townhill hospital serves different population groups and the whole of Natal and KwaZulu, it is not as big as the other two institutions. It was established that most of the patients from Townhill use private practitioners more than hospital services, as opposed to black patients
- \* Research findings indicate that Madadeni hospital does not have even one psychiatrist, but only one clinical psychologist, one social worker and one occupational therapist for a 810 bed hospital and hundreds of outpatients. Fort Napier and Townhill hospitals also have an inadequate supply of psychiatrists and clinical psychologists, most of whom are either part-time or doing only sessions at the two institutions
- \* It was also noted that the three hospitals still serve patients according to their racial groups even though the Minister of Health, the then Dr Rina Venter announced in 1991 that all hospitals would be opened to all race groups, meaning that hospitals would have no colour boundaries.

## 5.2.2 Admission and Relapse (Readmission) Rates (Item A.6)

The admission and readmission rates for the three institutions were analysed separately and then jointly in order to provide full information on the extent of the problem under study.

### 5.2.2.1 Admission and readmission rates for Madadeni Hospital 1993

The monthly admission and readmission figures and tables appear in Annexure 2, page 99. The annual totals and rates are as follows:

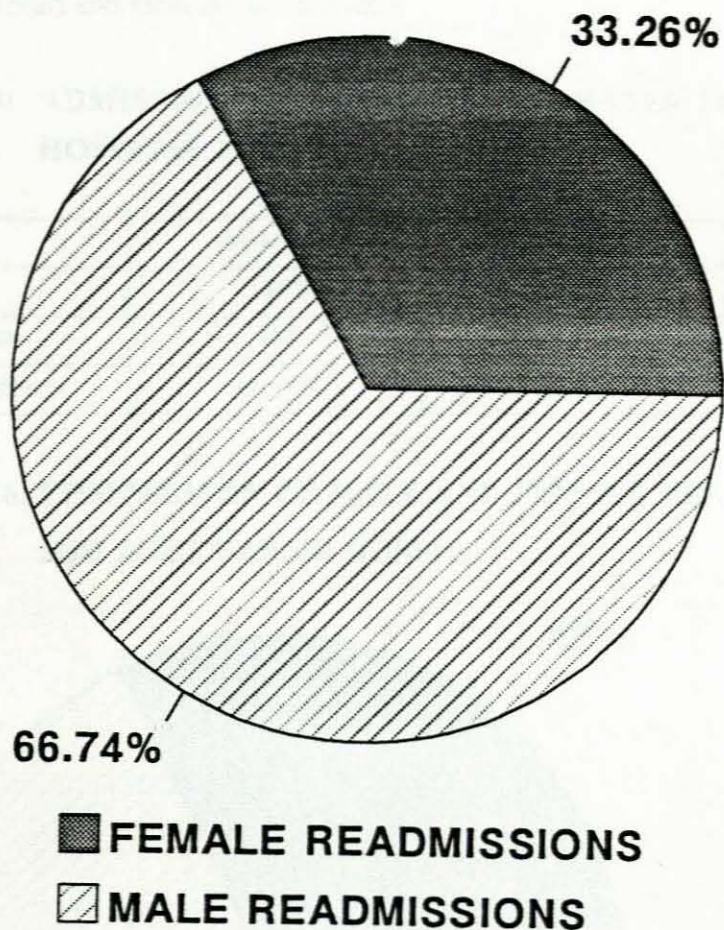
**TABLE 5.7: TOTAL ADMISSION AND READMISSION FIGURES AND RATES FOR MADADENI HOSPITAL 1993**

	<b>MALES</b>	<b>FEMALES</b>	<b>N</b>
Admissions	746	364	1110
Readmissions	339	169	508
%-Readmission rates	45.14%	46.4%	45.76%

### COMPARISON OF MALE AND FEMALE ADMISSION RATES

Male readmissions at Madadeni Hospital are 66.73% of the total readmissions (339 out of 508), and the female readmissions are 33.26% which is 169 out of 508. This can be presented on the following figure 5.5.

**FIGURE 5.5: COMPARISON OF MALE AND FEMALE READMISSION RATES  
AT MADADENI HOSPITAL**



**Discussion**

- \* At Madadeni Hospital it was noted that although the admission and readmission figures for males were double those of females, readmission rates were not that different (45.4% for males and 46.4% for females). This is in keeping with the literature review (Snowden and Holschuh, 1992) that females relapse more frequently than males.

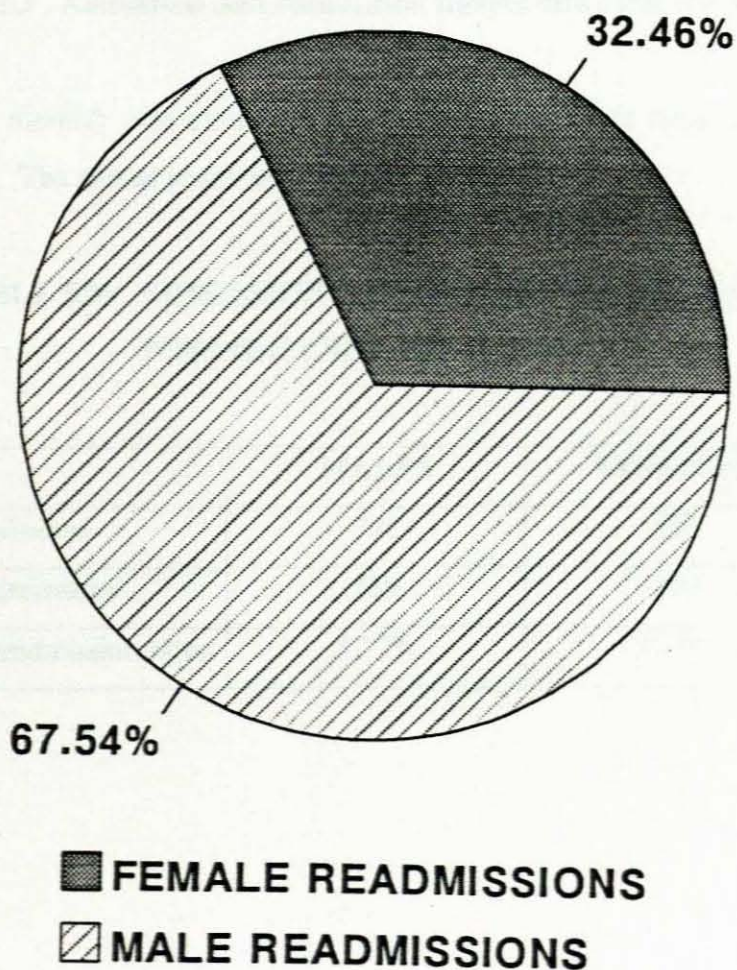
### 5.2.2.2 Admission and readmission rates for Fort Napier Hospital 1993

Monthly admission and readmission figures and tables appear in Annexure 3, page 100. The annual totals and rates are as follows:

**TABLE 5.8: ADMISSION AND READMISSION RATES FOR FORT NAPIER HOSPITAL 1993**

	<b>MALES</b>	<b>FEMALES</b>	<b>N</b>
Admissions	1808	553	2361
Readmissions	343	165	508
% Readmissions	18.97%	29.8%	21.51%

**FIGURE 5.6: COMPARISON OF MALE AND FEMALE READMISSION RATES FOR FORT NAPIER HOSPITAL**



## Discussion

As may be expected from the wide and densely populated geographical area served by this institution (South of the Tugela River), the admission figures are much higher than those of Madadeni Hospital (males 1806 vs 746 and females 553 vs 364). However, the readmission figures are nearly similar (males 343 at Fort Napier and 339 for Madadeni; females 165 at Fort Napier and 169 at Madadeni). This means that more patients are readmitted at Madadeni Hospital than at Fort Napier Hospital (18.97% males and 29.8% females vs 45.4% males and 46.4 females).

As with Madadeni Hospital, female readmission rates are higher than male readmission rates.

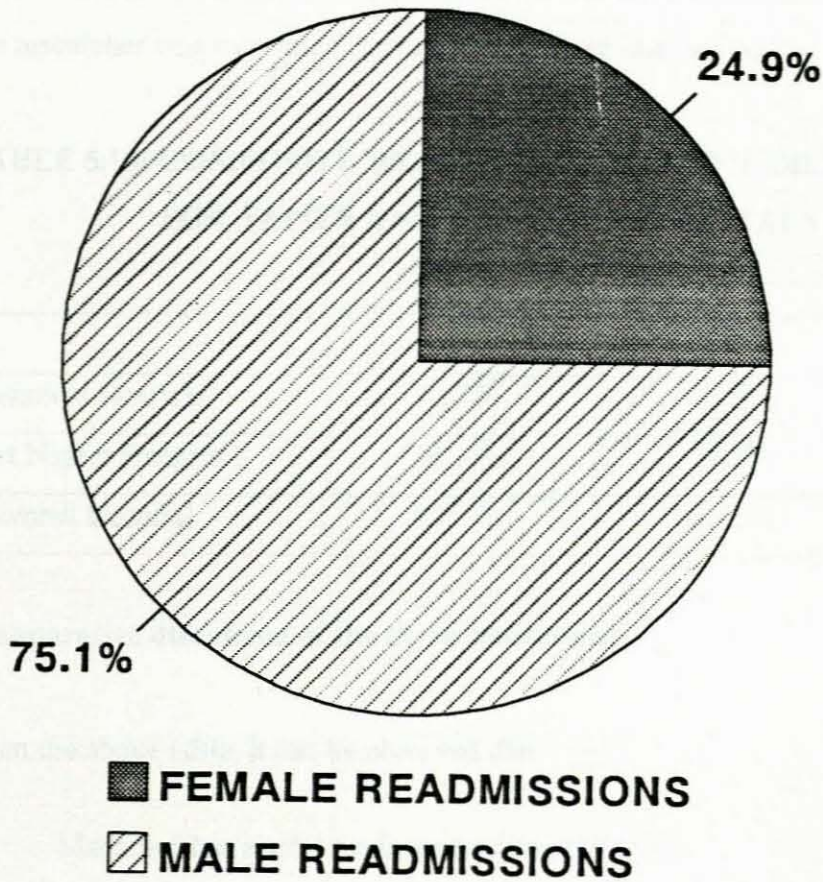
### 5.2.2.3 Admission and readmission figures and rates for Townhill Hospital 1993

The monthly admission and readmission figures and tables appear in Annexure 4, page 101. The annual totals and rates are as follows:

**TABLE 5.9: ADMISSION AND READMISSION FIGURES AND RATES FOR TOWNHILL HOSPITAL 1993**

	<b>MALES</b>	<b>FEMALES</b>	<b>N</b>
Admissions	795	350	1334
Readmissions	539	179	718
% Readmission rates	67.7%	51.1%	53.8%

**FIGURE 5.7: COMPARISON BETWEEN MALE AND FEMALE READMISSION RATES**



**Discussion**

- 67.7% of male admissions are readmissions, and 51.1% of female admissions are readmissions. The male readmission rates are higher than female readmissions here, as opposed to literature and to the other two institutions in this study
- 75.1% of readmissions are males and 24.9% are females, which is a third of the males.

#### 5.2.2.4 The composite/comprehensive readmission rates table for the three institutions

As a result of the differences in the rates for the three institutions obtained in the study, the researcher was motivated to compare the three institutions.

**TABLE 5.10: COMPOSITE READMISSION RATES TABLE FOR MADADENI, FOR NAPIER AND TOWNHILL HOSPITALS 1993**

	M	F	TOTAL
Madadeni Hospital	45.4%	46.4%	45.76%
Fort Napier Hospital	18.97%	29.8%	21.51%
Townhill Hospital	67.7%	51.1%	53.8%

#### Comparative discussion of the three institutions

From the above table, it can be observed that

- Madadeni has a total readmission rate of 45.76%
- Fort Napier has a total readmission rate of 21.51%, the lowest of the three institutions, and
- Townhill hospital has a total readmission rate of 53.8% which is the highest of the three institutions

From the above findings, it may be summarised that

- While Fort Napier does not have as extensive a hospital service as Townhill hospital with whom it shares medical and paramedical services, its extensive community outreach service is responsible for the lowest readmission rates.

- Madadeni hospital, (having neither the hospital facilities like Townhill hospital, nor a psychiatrist, and only one clinical psychologist), also has lower relapse rates than Townhill. As with Fort Napier Hospital, Madadeni has a well established community psychiatric service which may be accountable for its low readmission rates. However, it has higher readmission rates than Fort Napier Hospital because of the shortage of patient care services i.e. psychiatrists, psychotherapy etc.
- Townhill hospital has the highest readmission rates for both males and females. Male readmissions are almost triple those of Fort Napier, (Townhill equals 67.7%: Fort Napier 18.97%), and female readmissions almost double, despite its facilities for patient care and rehabilitation e.g. psychotherapy, industrial and occupational therapy units.
- In percentage, of the total of 4616 patients admitted to the three institutions in 1993, 1734 were readmissions, which is 37.56% as total readmission rate.

### 5.3 STAFF/PROFESSIONAL NURSES' RESPONSES TO THE QUESTION ON

#### 5.3.1 Causes of Patient Relapse (Item A.7)

The professional psychiatric nurses' opinion of the possible causes of relapse in psychiatric patients can be represented as follows:

**TABLE 5.11: PROFESSIONAL NURSES' OPINION OF THE CAUSES OF RELAPSE**

	<b>f</b>	<b>%</b>
1. Treatment default	10	100
2. Poverty and financial problems	6	60
3. Substance abuse	5	50
4. Unemployment	5	50
5. Lack of support	4	40
6. Poor facilities of after care	4	40

**(Respondents could identify more than 1 item)**

## Interpretation and discussion of findings

Out of the 10 questionnaires returned, 100% (ten) of the nursing personnel feel that treatment default contributes greatly to relapses in psychiatric patients. 60% (6) feel that patients have financial problems: 50% (5) feel substance abuse and unemployment are the problems. Another 40% (4) feel that patients lack support from family and community members, and that there are inadequate facilities for after care.

These findings are compared with those of patients' and relatives' opinions later on in the study.

### 5.3.2 Professional Nurses' Opinion of the Attitudes of Family Members Towards Patients (Item A.8)

The professional nurses' opinion of the attitudes of family members towards psychiatric patients were elicited. The professional nurses basically feel that patients' relatives are largely negative towards the patients. This can be seen in the following table:

**TABLE 5.12: PROFESSIONAL NURSES' OPINION OF THE ATTITUDES OF FAMILY MEMBERS TOWARDS PATIENTS**

	f	%
1. Do not take responsibility/cooperate	4	40
2. Rejecting	3	30
3. Negative	2	20
4. Afraid of patients	2	20
5. Sometimes intolerant	1	10
6. Sometimes overprotective	1	10
7. Some caring	1	10
8. Some positive	1	10

Only 20% (2) of staff feel that the relatives are caring or positive towards patients. The negative and rejecting attitude is reflected in the relatives' failure to visit patients in hospital. Some patients are not even brought/escorted to hospital by their relatives on admission.

The attitude of relatives towards the patients is important because the patient will not be well received, accepted and supported on discharge if the family's attitude is negative, and then the patient will relapse.

### 5.3.3 Community Attitude Towards Psychiatric Patients (Item A.9)

The professional nurses' opinion of the community's attitude towards psychiatric patients was also elicited. Their opinion is reflected in the following table:

**TABLE 5.13: COMMUNITY ATTITUDE TOWARDS PSYCHIATRIC PATIENTS**

	f	%
1. Rejecting	3	30
2. Punitive	3	30
3. Non-supportive	2	20
4. Afraid	2	20
5. Still stigmatised	2	20
6. Intolerant	1	10
7. Positive (some)	1	10

The community's attitude is also seen as largely rejecting (3=30%), punitive (3=30%), non-supportive (2=20%), afraid (2=20%), still stigmatised (2=20%) and intolerant (1=10%). Only one respondent (10%) stated that some community members are positive towards psychiatric patients.

This attitude is also important because if the patients feel unaccepted in the community they would be either depressed or aggressive, and by such behaviour the community unjustifiably recertifies them as relapsed.

#### 5.3.4 Preparation of Patients for Discharge (Item A.10)

It is very important to teach the patient to readjust himself to community life, and to prepare him to cope with the stresses that he is likely to encounter on discharge.

The professional nurses of the three institutions reported that the patients were prepared for discharge in the following ways:

**TABLE 5.14: PREPARATION OF PATIENTS FOR DISCHARGE**

	<b>f</b>	<b>%</b>
1. Education re-treatment	6	60
2. Education re-drugs & substance abuse	3	30
3.. Education re-self help	3	30
4. Pre-discharge interviews re-financial upkeep, accommodation	2	20
5. Given leave of absence (LOA)	1	10
6. Education re-stress management	1	10

The preparation of patients for discharge was reported to be largely related to teaching the patient about his follow-up medication, 60% (6), education of patients about drugs and substance abuse 30% (3), and self-help. Self help relates to personal care as well as preparation for financial self help through teaching handcraft skills in occupational and industrial therapy.

Patients were also interviewed to determine if they had some source of income and accommodation. They reported that they are often given leave-of-absence (LOA) to see if they adjust well in the community.

However, the staff in all three institutions felt that patient preparation for discharge was inadequate as the means of investigating each patient's problems and taking active steps to attend to these were insufficient.

### 5.3.5 Preparation of Patient's Relatives for Discharge (Item A.11)

While the patient is in hospital, an effort should be made to prepare his/her relatives for his/her return. The relatives should know how to interact with the patient, to avoid inferiority complex in the patient, and to support and help him with his treatment and in his limitations.

The hospital staff gave the following responses to their contribution towards this:

**TABLE 5.15: PREPARATION OF PATIENTS' RELATIVES FOR DISCHARGE**

	f	%
1. Health education about		
- clinic attendance	4	40
- medication	4	40
- mental illness	4	40
- to assist the patient	3	30
- to accept the patient	1	10
2. home visits	1	10
3. disability grants to meet financial needs	1	10

(Respondents could identify more than one item)

The preparation of relatives is mainly through health education on the condition and on the importance of clinic attendance and taking medication. Inadequate contact with relatives who do not visit the patients often enough, and are not home when home visits by community psychiatric nurses are made is the main cause of the inadequate preparation of relatives.

### 5.3.6 Community Preparation for the Patients' Discharge (Item A.12)

It is important to prepare the community to which the patient returns for his/her discharge. The community should be accepting, understanding, and treat the patient as they do any other person in the community. The patient should be made not to feel that he is different from other people in the community. The following means of community preparation were indicated by respondents:

**TABLE 5.16: COMMUNITY PREPARATION FOR PATIENTS' DISCHARGE**

	f	%
Health talks to the community at		
- health awareness symposia/days	4	40
- schools	3	30
- churches	2	20
- radios, television and newspapers	2	20
- places of work/employment	1	10

**(Respondents could identify more than one item)**

Community psychiatric nurses are trying hard to educate the community through regular health awareness days 40% (4), at schools 30% (3), at churches 20% (2), through mass media 20% (2), and at places of work. However, some respondents 30% (3) felt that community health nurses spend too much time at clinics and not home visiting.

### 5.3.7 Suggestions for Prevention of Relapses (Item A.13)

The professional nurses suggested that the following strategies be employed to try and prevent or reduce the rate of relapses in psychiatric patients:

**TABLE 5.17: SUGGESTIONS FOR PREVENTION OF RELAPSES**

	<b>f</b>	<b>%</b>
1. Provide facilities and services for quality patient care and aftercare	7	70
2. Extensive follow up	4	40
3. Employment opportunities	3	30
4. Health education on substance abuse	2	20
5. Employers not to retrench people who become mentally ill	1	10
6. Team approach - community health workers, family and community	1	10
7. Community and family education	1	10

There is marked consensus (70% (7)) that facilities and services for quality patient care and aftercare are essential for the prevention of relapses. Services such as sheltered employment workshops, (30% (3)) homecare, accommodation, halfway houses and night hospitals are very essential. Extensive follow up care, (40% (4)) coupled with means for improving identified problems should also be stepped up.

### 5.3.8 Professional Nurses Opinion of Psychiatric Wings in General Hospitals (Item A.15)

Psychiatric wings in general hospitals were introduced in order to ensure that patients are treated close to their homes, so that relatives can visit them easily. They are expected to relieve the stigma of mental illness as patients would then be treated at general hospitals and not in "assylums". The community's frequent contact with the mentally ill would also help to disillusion people about mental illness and so help to change the community's attitude towards mental illness and mentally ill patients for the better. However, it is observed that such wings are not well accepted and therefore not well utilised by patients and their relatives. The following tables indicate the professional nurses' observation of such attitudes:

**TABLE 5.18: ACCEPTANCE OF PSYCHIATRIC WINGS BY GENERAL HOSPITAL PERSONNEL**

	<b>f</b>	<b>%</b>
1.. Very well	3	30
2. Well	2	20
3. Poorly	5	50
4. Not at all	0	0
<b>TOTAL</b>	<b>10</b>	<b>100</b>

50% (5) of the respondents indicated that psychiatric wings are not well accepted by general hospital personnel while 50% (5) indicate that they are well accepted therefore there is balance in opinions. However they are abused for admission of patients with acute delirious symptoms of organic and transient nature e.g. acute alcoholic intoxication.

**TABLE 5.19: UTILISATION OF PSYCHIATRIC WINGS BY COMMUNITY**

	<b>f</b>	<b>%</b>
1. Very well	3	30
2. Well	2	20
3. Poorly	5	50
4. Not at all	0	0
<b>TOTAL</b>	<b>10</b>	<b>100</b>

50% (5) of the staff feel that the community utilises this services well, and 50% (5) feel it is poorly utilised.

**TABLE 5.20: REDUCING RELAPSES BY UTILISATION OF PSYCHIATRIC WINGS**

Their opinion about the role of the psychiatric wings in reducing relapses is as follows:

	<b>f</b>	<b>%</b>
1. Very helpful	3	30
2. Helpful	2	20
3. Not very helpful	4	40
4. Not at all helpful	1	10
<b>TOTAL</b>	<b>10</b>	<b>100</b>

The majority of psychiatric nurses, 50% (5) felt that psychiatric wings in general hospitals are helpful in reducing relapses. 50% (5) felt that they are not helpful.

### 5.3.9 Services available for Community Psychiatric Patient Care (A.16)

As indicated in item A.13, relapses in psychiatric patients would be relieved by improvement in variety and quantity of services essential for patient care. The following table indicates the availability (or scarcity) of such services:

**TABLE 5.21: SERVICES AVAILABLE FOR COMMUNITY**

	<b>f</b>	<b>%</b>
1. Medical depots	9	90
2. Psychiatric nurses	10	100
3. Psychiatrists	3	30
4. Clinical psychologists	4	40
5. Follow up services	8	80
6. Social welfare	8	80
7. Sheltered employment	3	30
8. Day care centres	0	0
9. Night hospitals	0	0
10. Group therapy	1	10
11. Family therapy	3	30
12. Occupational therapy	4	40
13. Psychiatric wings in general hospitals	10	100
14. Crisis intervention services	2	20
15. Halfway houses	2	20
16. Social clubs for mental patients	1	10

(Respondents could choose more than one item.)

According to table 5.21, there are enough psychiatric nurses, (100% (10), and psychiatric wings in general hospitals, 100% (10). Medical depots are not available to all patients 90% (9) in urban areas, but scarce in rural areas. Patients in rural areas have to travel long distances to collect their treatment. Social welfare and follow-up services are reported to be next to adequate 80% (8), and psychiatrists 30% (3), psychologists 40% (4), and occupational therapy 40% (4) are available but inadequate. Family therapy and sheltered employment rated 30% (3); crisis intervention and halfway houses 20% (2), group therapy and social clubs 10% (1).

### 5.3.10 Attitude of Professional Nurses Towards Informal Support Systems (Item A.17)

In view of the shortage of patient support systems, some authors e.g. Uys (1992) recommend the use of non-formal support systems like community health workers. The attitude of the professional nurses towards this approach is as follows:

**TABLE 5.22: ATTITUDE OF PROFESSIONAL**

	POSITIVE		NEUTRAL		NEGATIVE
	N	%	N	%	N/%
1. Church	10	100	0	0	0
2. Self help groups	9	90	1	10	0
3. Community health workers	7	70	3	30	0
4. School psychologists	9	90	1	10	0
5. Traditional healers	9	90	1	10	0

- 100% (10) of the professional nurses have no objection to the involvement of church groups in community care of psychiatric patients

- 90% (9) have no objections to the use of self help groups like Women's Clubs, school psychologists and traditional healers, and 10% (1) of the respondents are neutral to all these groups
- 70% (7) of respondents are positively disposed towards community health workers, and 30% (3) are neutral
- all in all, none of the respondents were negative towards these groups

#### **5.3.11 Comments (Item A.18)**

In general comments, every respondent was pleading for one service or another, in keeping with item A.13 - suggestions for the prevention of relapses. This means that professional nurses generally feel that inadequate services are a cause of high relapse rates in psychiatric patients.

### **5.4 SECTION B: RESPONSES FROM PATIENT INTERVIEWS**

Items B2 to B18 are responses from interviews with relapsed patients. 89 patients were interviewed at the three institutions, and 75 interviews were used for the study as the other 14 had incoherent information in some items and therefore were declared invalid.

#### **5.4.1 Diagnosis of Patients (Item B.2)**

According to Geller (1992) and other authors, patients with schizophrenias, bipolar disorders, personality disorders and substance abusers relapse more frequently than other categories of patients. In this study the relapse rates were as follows:

**TABLE 5.23: DIAGNOSES OF RELAPSED PATIENTS**

<b>DSM III-R NO</b>	<b>CONDITION</b>	<b>f</b>	<b>%</b>
290	Primary degenerative dementia	8	10.6
291	Alcohol abuse	9	12
292	Organic brain syndrome	10	13.3
293	Schizophrenia due to dagga	11	14.6
294	Epilepsy	9	12
295	Schizophrenia	10	13.3
296	Schizophrenia/bipolar disorder	18	24
	<b>TOTAL</b>	<b>75</b>	<b>99.8</b>

In this study, 24% (18), which is the majority of patients, had schizo affective or bipolar disorders. The majority (53%) (40) of these patients were from Townhill hospital, and this was in keeping with the patients' responses to the question on relationships with family, friends, co-workers and neighbours. More patients had poor interpersonal relations with people, and even during interviews had higher expressed emotions than their counterparts at Madadeni and Fort Napier hospitals.

Psychosis due to substance abuse has been reported to be on the increase by the professional nurses in this study. 40% (30) of patients in this study had this diagnosis. During interviews with the patients, substance abuse was identified by  $\pm 25\%$  of them as the cause of their relapse. They accepted that the solution to the problem of their relapse would be to stop these habits, but  $\pm 80\%$  of them had difficulty of abstaining. This problem calls for more intensive efforts in the primary prevention of this problem, as well as means to help patients who are already motivated to abstain.

#### 5.4.2 Ages of Patients Readmitted (Item B3)

The age range of patients who were readmitted were as follows:

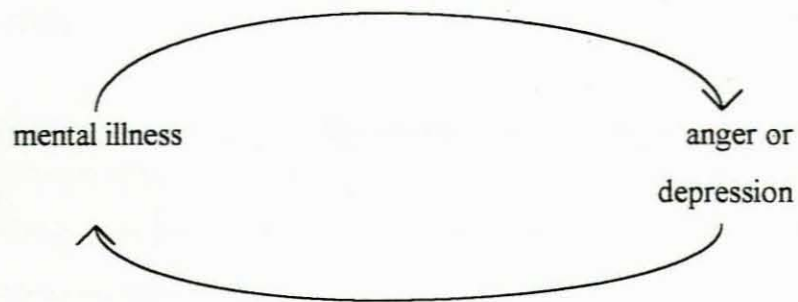
**TABLE 5.24: AGES OF PATIENTS READMITTED**

<b>AGE</b>	<b>f</b>	<b>%</b>
15 - 20 years	3	4
21 - 25 years	17	22
26 - 30 years	11	15
31 - 35 years	16	21
36 - 40 years	14	19
41 - 50 years	11	15
51 - 55 years	2	3
56 - 60 years	1	1
61 - 65 years	-	-
65 years +	-	-
<b>TOTAL</b>	<b>75</b>	<b>100</b>

Out of the 75 patients interviewed, 40% (30) (mean) is in the age group of 31-40 years and 38% (29) in the 21-30 age group. The lowest relapse percentages are in the 15-20, 4% (3) and over 50 age groups, 4% (3). The 15-20 age group is at the adolescent stage with adolescent problems. The 21-40 age group is early adulthood and middle age with problems of starting a family and family responsibilities. Relapses at these age groups are not unexpected due to life crises at these age groups, but they have a bad negative on the person and his/her life.

According to Erik Erikson's Psychosocial theory of personality development, an adolescent reacts to illness by anger over the dependency caused by illness and in young adulthood by depression over the interruption of one's plans (Ellis and Nowlis, 1989:p321). These reactions are characteristic of mental illness and so a vicious cycle is created.

**FIGURE 5.8: VICIOUS CYCLE OF MENTAL ILLNESS AND REACTIONS TO IT**



#### 5.4.3 The Sex of Respondents (Item B4)

Although the admission records showed that there are more male than female patients in the hospitals, a balance was ensured in sampling for the study. There were 37 males and 38 female subjects interviewed.

The relapse rates according to gender was determined from the records and analysed in item A.6 (5.2.2).

#### 5.4.4 Home Residence of Respondents (Item B.5)

An attempt was made to determine whether relapsing patients are mostly from rural, semi urban or urban areas. One would expect patients from urban and semi urban areas to relapse more frequently because of financial stresses suffered by people in these areas. Also, substance abuse is higher than in rural areas.

The rural areas, on the other hand, have fewer resources and facilities for patient aftercare than urban and semi urban areas. Commodities like transport to distant health services as well as food at shops are more expensive, adding to the patients' financial problems.

According to this study, the relapses were distributed as follows:

**TABLE 5.25: HOME RESIDENCE OF RESPONDENT PATIENTS**

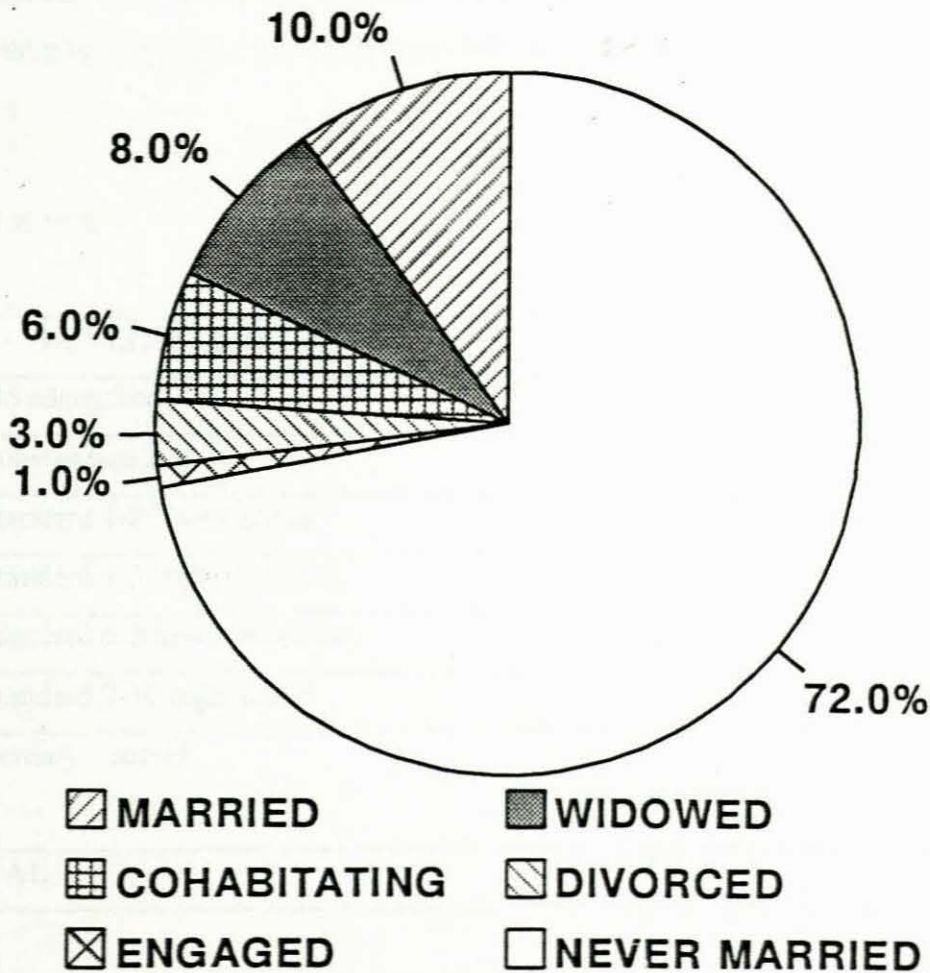
<b>HOME</b>	<b>f</b>	<b>%</b>
Rural	31	41
Urban	15	20
Semi urban	29	39
<b>TOTAL</b>	<b>75</b>	<b>100</b>

There is a balance in relapses in patients from rural and semi urban areas, 41% (31) and 39% (29) respectively and a low incidence of relapses in patients from urban areas, 20% (15). This supports the assumption that availability of health services is important for reducing relapses.

#### 5.4.5 Marital Status of Respondents (Item B.6)

The marital status of the subjects of this study was as follows:

**FIGURE 5.9: MARITAL STATUS OF RESPONDENT PATIENTS**



Seventy two percent (55) of the respondents were single (never married); 10% (6) married; 8% (5) widowed; 6% (4) cohabiting; 3% (3) divorced and 1% (2) engaged. Of the married patients, 80% (5) had poor interpersonal relations with their spouses and were hence separated or living apart. This is also in keeping with Snowden and Holschuh's marital status of psychiatric patients (single = 66,8%, married = 4.8%, divorced = 26.3%, widowed 1.6%) (Snowden & Holschuh 1992:p.285).

#### 5.4.6 Respondents' Educational Standard (Item B.7)

Although mental illness is found in all classes of people, people with a higher educational standard are expected to have better life coping skills, and should understand enough about taking medications regularly. They are people with professional and semi professional occupations and therefore have fewer financial and occupational stresses. According to this study, the relationship between relapses and educational standard is as follows:

**TABLE 5.26**

<b>LEVEL OF EDUCATION</b>	<b>f</b>	<b>%</b>
1. No education	6	8
2. Substandard A & b	3	4
3. Standard 1-2 lower primary	8	10
4. Standard 3-5 higher primary	27	36
5. Standard 6-8 junior secondary	15	20
6. Standard 9-10 high school	13	17
7. Tertiary - nurses	2	3
- B.A.	1	1
<b>TOTAL</b>	<b>75</b>	<b>99</b>

The majority of patients 36% (27) have a higher primary education, then junior secondary 20% (15) and then high school education 17% (3). 8% (6) of respondents had no education at all, and 4% (3) had tertiary education.

#### 5.4.7 With Whom the Patient Stays at Home (Item B8)

The patient's place of residence and the people that the patient stays with are of importance in the patient's rehabilitation programme.

In this study, the respondents gave the following responses to this item:

**TABLE 5.27**

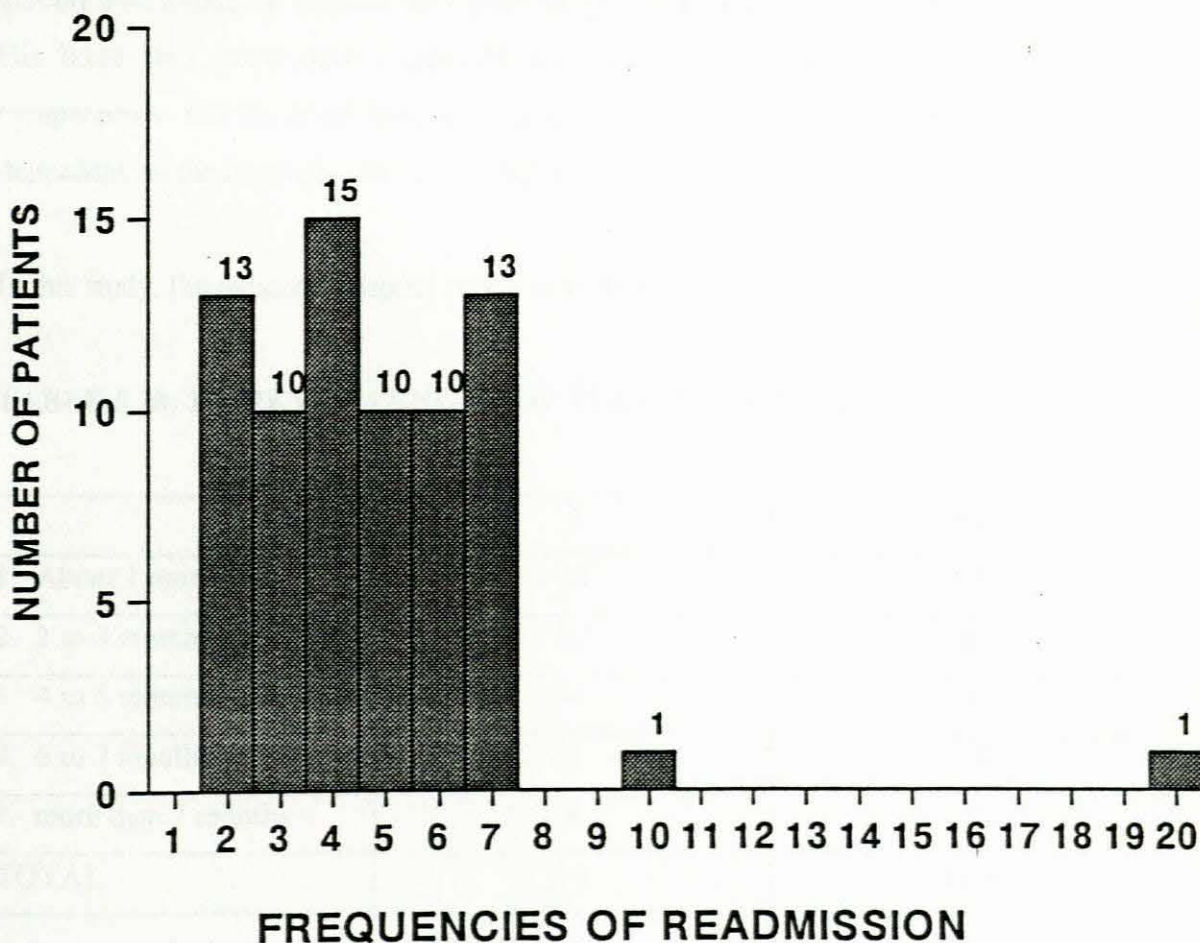
<b>WITH WHOM THE PATIENT STAYS</b>	<b>N</b>	<b>%</b>
1. Both parents	11	15
2. Mother	14	19
3. Father	4	5
4. Grandparents	4	5
5. Brother	10	13
6. Sister	8	10
7. Children	14	19
8. Uncle	2	3
9. Aunt	1	1
10. Other-foster care	2	3
11. Alone	3	4
12. No home	2	3
<b>TOTAL</b>	<b>75</b>	<b>100</b>

While 83% of patients stayed with their families or relatives, 4% (3) of the respondents lived alone, and 3% (2) said they had no homes. This is a good formula for relapse.

The interpersonal relations with the people that patients stay with in most instances were said not to be good. Some patient 7% (5) reported that they were misunderstood and “recertified by their relatives for normal reactions e.g. justifiable loss of temper or anger”. This was confirmed by some professional nurses.

#### 5.4.8 Frequency of Readmissions (Item B.9)

FIGURE 5.10: FREQUENCIES OF READMISSION



Out of the sample of seventy five (75) patients, twenty percent (20) (N=15) of patients had been readmitted four times since the onset of the mental illness. 13 patients (19%) had been readmitted twice, and another 13 (17%) had been readmitted seven times. 10 patients (13%) had been readmitted thrice, another 13% had been readmitted five times, and another 13% had been readmitted six times. One patient stated that he had been readmitted several times, and another one estimated his readmissions to twenty. In line

with the literature reviewed, the highest rates of readmissions are during the first two years of onset of mental illness (Hogarty et al, 1983:633; Sullinger, 1988:21; Geller 1992).

#### 5.4.9 Length of Stay in Hospital (Item B.10)

The period that the patient spends in hospital has implications on effectiveness of his rehabilitation as well as on the dependency that the patient may develop. If the patient is quickly discharged, he may not have been adequately rehabilitated and ready for discharge. His home and community conditions may also not be changed and ready for his recuperation. On the other hand, if the patient stays in hospital too long he may become dependant on the hospital, and fail to readjust to community life, demands and stresses.

In this study, the patients' hospital stay was as follows:

**TABLE 5.28: PATIENTS' LENGTH OF STAY IN HOSPITAL**

	<b>f</b>	<b>%</b>
1. About 1 month	36	48
2. 2 to 3 months	27	8
3. 4 to 5 months	6	8
4. 6 to 7 months	2	2.6
7. more than 7 months	4	5.3
<b>TOTAL</b>	<b>75</b>	<b>99.9</b>

Forty eight (48) percent (36) of the patients stayed in hospital for less than a month, and 36% (27) for two to three months. Due to overcrowding in hospitals, it is observed that patients do not stay long enough to be adequately assessed, stabilised and the home conditions improved for their return. This was also an expressed concern of the hospital staff that the researcher had discussions with.

#### 5.4.10 Relapse Precipitating Factors (Item B.11)

The respondents identified the following factors as having precipitated their relapse:

**TABLE 5.29: PATIENTS' VIEW/OPINION OF RELAPSE PRECIPITATING FACTORS**

<b>RESPONSES</b>	<b>f</b>	<b>%</b>
1. Substance abuse	16	21.3
2. The relatives' attitude	15	20
3. Treatment default	11	14.6
4. Financial problems	9	12
5. Bereavement	9	12
6. Witchcraft	7	8.3
7. Unemployment	5	6.6
8. Nurses	1	1.3
9. Don't know	6	8

**(Respondents could give more than one answer.)**

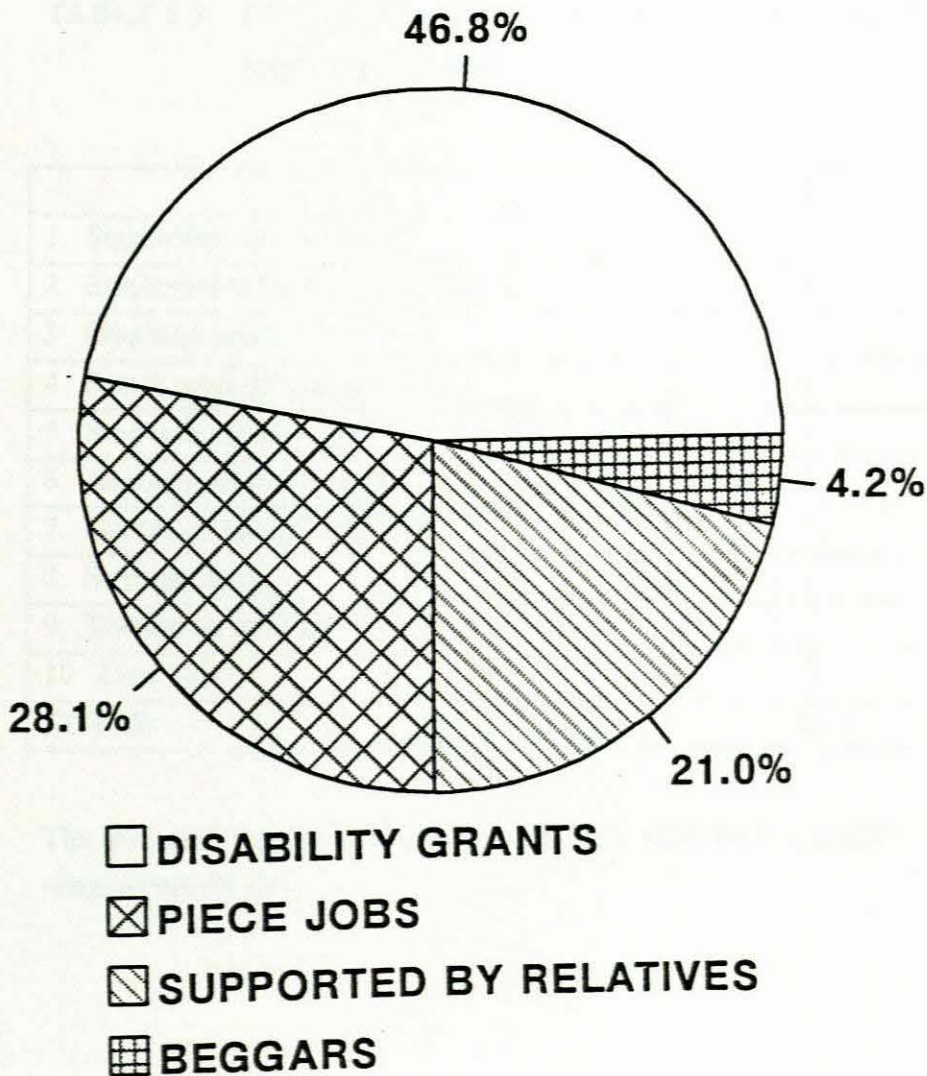
According to Fetter and Lowery's theory of attribution, patients and staff may express causes of relapse in terms of being external or internal to the patient, as stable or unstable, and as controllable or uncontrollable. If patients see the causes as internal to themselves, then they are using internal attribution, and the vice versa for external attribution. If problems are seen as stable and uncontrollable, then the patient feels he has no control over his relapse (Fetter & Lowery, 1992:303).

well accepted at work. The absence of "labelling" of people is important for their rehabilitation and readjustment to society, thus prevents relapses.

#### 5.4.15 Financial Support for the Unemployed Patients (Item B.16)

Out of the 43 patients that had not been working prior to the present episode of illness, it was determined that 46.5% (20) lived on disability grants 27.9% (12) did piece jobs; 20,9% (9) were supported by their relatives, and 4.6% (2) were beggars.

**FIGURE 5.11: FINANCIAL SUPPORT FOR THE UNEMPLOYED PSYCHIATRIC PATIENTS**



The large number of patients living on disability grants again support “the sick role” and the need for sheltered employment workshops in order to reduce taxation of taxpayers.

It is appreciated that 27.9% of patients do make an effort to be self supporting through doing piece work for neighbours while ± 20.90% depend on their relatives for support.

**5.4.16 Patients’ Opinion of the Possible Solutions to their Relapses (Item B.17)**

The patients’ opinion of the possible solutions to their relapses may be presented as follows:

**TABLE 5.31: PATIENTS’ OPINIONS OF THE POSSIBLE SOLUTIONS TO THEIR RELAPSE**

	<b>f</b>	<b>%</b>
1. Supervision of treatment	10	13.3
2. Employment for source of income	9	12
3. Disability grant	9	12
4. Better medical supplies	8	10.7
5. Stop substance abuse	8	10.7
6. Accommodation facilities	7	9.3
7. Nurses to educate relatives	5	8
8. Stronger pills	3	4
9. Traditional healing	3	4
10. Don’t know	12	16
<b>TOTAL</b>	<b>75</b>	<b>100</b>

The patients’ responses are very congruent with their concept of the causes of their relapse (item B.11).

- For treatment default, 13.3% (10) of the patient suggest better supervision of their treatment, better medical supplies 10.6% (8) and stronger pills 4% (3).
- For financial problems, 24% (18) of patients suggest employment opportunities and disability grants. It is interesting to note that there are as many patients who want to work as those who want to receive disability grant (12% (9) each).
- For the bad attitudes of relatives, (8% (5) they suggest that nurses should educate them.
- 10.6% (8) request help to stop substance abuse.
- 16% (12) of the patients, however, do not know or have no suggestions for how they can be helped. This is also in keeping with the fact that 8% (6) did not know what causes their relapse, although there are more patients who do not have a solution than those who do not know the cause of relapse 16% (12).

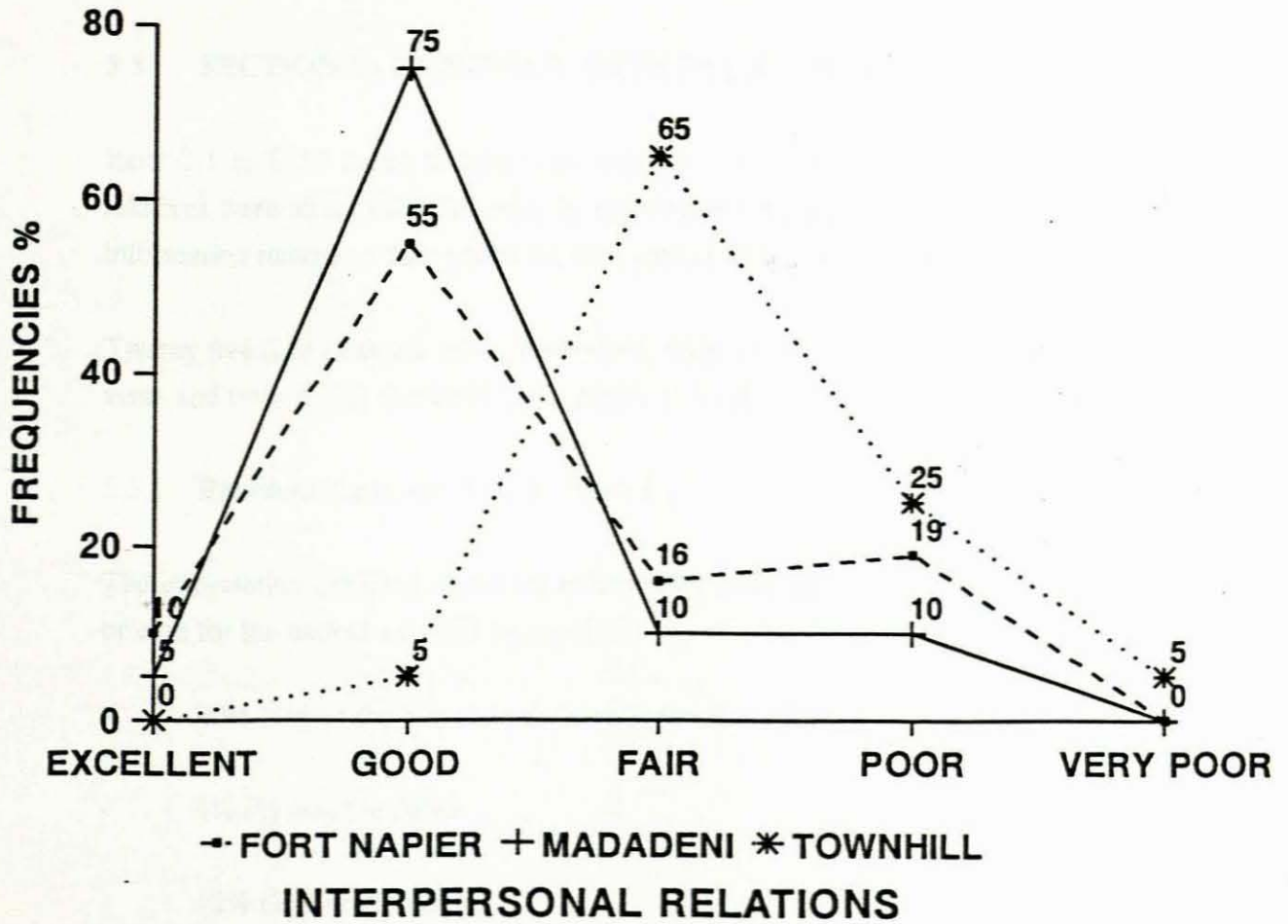
#### 5.4.17 Interpersonal Relations with Relatives (Item B.18)

The patients expressed their interpersonal relationships with their relatives as ranging from excellent to very poor. There was a marked variation between the responses of patients at the different institutions.

**TABLE 5:32 INTERPERSONAL RELATIONS WITH RELATIVES**

	N	EXCELLENT	GOOD	FAIR	POOR	VERY POOR	TOTAL
		%	%	%	%	%	%
Madadeni	25	5	75	10	10	0	100
Fort Napier	25	10	55	16	19	0	100
Town Hill	25	0	5	65	25	5	100
<b>TOTALS</b>	<b>75</b>	<b>3</b>	<b>46</b>	<b>31</b>	<b>18</b>	<b>2</b>	<b>100</b>

**FIGURE 5.12: INTERPERSONAL RELATIONS WITH RELATIVES**



- Seventy five 75% (14) (mean) of the patients at Madadeni and 55% (14) (mean) at Fort Napier had good interpersonal relations with relatives; where as
- Fifty five 55% (18) (mean) of the patients at Townhill had fair and 25% (9) poor interpersonal relations.

The negatively skewed graph for Townhill Hospital shows that these patients have poorer interpersonal relations with their relatives than do patients at Madadeni and Fort Napier hospitals. These findings are in keeping with the diagnoses of schizoaffective disorders which formed the mean 24% (18) as reflected in Item B.2. p. 60.

- On the whole, the patients felt that their interpersonal relations with relatives were good to fair.

## 5.5 SECTION C: INTERVIEW WITH PATIENTS' RELATIVES

Item C.1 to C.12 relate to responses from the interviews with patients' relatives. The relatives were interviewed in order to complement the patients' responses, and to obtain information related to their problems with patient care in the community.

Twenty five (25) relatives were interviewed, eight (8) at the hospital, five (5) during home visits and twelve (12) at mobile clinic points of Madadeni and Fort Napier hospitals.

### 5.5.1 Relationship to the Patient (Item C1)

The information obtained about the patient was obtained from the person who stays with or care for the patient as much as possible.

- 40% (10) of the respondents were patients' mothers
- 4% (1) was the father
- 12% (3) were brothers
- 20% (5) were patients' sisters
- 4% (1) were uncles, husband, wife or son, and 8% (2) were aunts.

These findings indicate that mothers play the most role in caring for the patients. Only one patient (4%) was looked after by his wife, and another one (4%) by her husband. This is in keeping with the patients' marital status which is 72% single and only 10% married (Item B.6 p. 65 ; Snowden & Holschuh 1992:p.285), and the findings of this study that most married patients had poor interpersonal relations with their spouses and so were separated or living apart.

### 5.5.2 Knowledge of the Patients' Diagnoses (Item C2)

Although most relatives did not know the medical terms for the patients' diagnoses, 76% (19) of them knew what was wrong with the patient.

### 5.5.3 Knowledge of the Cause of the Patient's Condition and his Relapse (Item C3)

The relatives' conception of the causes of the patients illness and their relapse were found to be as follows:

**TABLE 5.33: RELATIVES CONCEPTION OF CAUSES OF PATIENTS' ILLNESS AND THEIR RELAPSE**

	f	%
1. Substance abuse	9	36
2. Treatment default	7	28
3. Bereavement	2	8
4. Witchcraft	2	8
5. Stress	2	8
6. Love disappointments	3	12
<b>TOTAL</b>	<b>25</b>	<b>100</b>

- In keeping with the opinions of professional nurses and the patients themselves, substance abuse and treatment default rank high in the relatives' conception of the cause of the patients' relapse 36% (9)
- The fact that 8% (2) of the relatives and 8.3% (2) of the patients (Item B.11) see witchcraft as a cause of the patient's illness and his relapse partly explains why patients stop taking hospital treatment as they would not see it as effective against witchcraft

- 36% (9) of the relatives see the cause of the patients' relapse as external and uncontrollable, according to Fetter & Lowery's attribution theory. Factors such as bereavement, witchcraft, stress and love disappointment are external to the patients and uncontrollable by them.

#### 5.5.4 Problems Encountered with Patient Care at Home (Item C4)

The following table shows the problems that relatives experience with the management of their patients at home:

**TABLE 5.34**

	f	%
1. Patient refusing to take treatment	10	40
2. Patient vegetative and doing nothing	8	32
3. Friends mislead patient to take drugs	6	24
4. Oversleeping due to treatment	6	24
5. Hallucinations and fighting	6	24
6. Short temper	5	20
7. Insomnia	5	20

(Respondents could identify more than one item.)

- 40% (10) of respondents reported that patients are uncooperative and refuse to take treatment. These relatives expressed great anger with this behaviour, and indicated that the relatives' attitude towards psychiatric patients seem to be negative because they (relatives) feel that the patients' relapse is self imposed by their refusal to take treatment as advised.

### 5.5.5 Patients' Employment Status (Item C9)

This question was asked to check on the validity of the information given by patients about their employment. The relatives gave the following responses:

**TABLE 5.35**

	YES		NO	
	f	%	f	%
Employment - before illness	7	28	13	52
- after illness	4	16	16	64

According to this table,

28% (7) of patients had been employed before illness, as opposed to 95.8% (69) given by patients (Item B.12);

16% (4) were employed after illness, which means that fewer mentally ill patients are employed.

The relatives probably did not regard the patients' piece jobs as employment whereas patients do. This diversity of opinion has implications in that the relatives will describe the patient as "useless" when he sees himself as being "useful", and so destroy his self esteem.

### 5.5.6 How Relatives Got Along with the Patient (Item C10)

56% (14) of the relatives stated that they got on well with the patients, and 44% (11) said they got on poorly. Bearing in mind that the respondents for this section were solely for Madadeni and Fort Napier hospitals, where patients had positively skewed responses, there is discrepancy between the patients and the relatives opinion (see Item B.18 p. 75).

### 5.5.7 Availability of Services for Patient Care (Item C.11)

- 96% (24) of the respondents had never heard of services like sheltered employment workshops and halfway homes
- 100% (25) of the respondents said there are enough nurses, clinics and medical depots
- 28% (7) of the respondents complained that at the clinics they are made to wait in the sun for long hours or turned back if it is not the day for them to come for treatment.

### 5.5.8 Suggestions for Prevention of Relapses (Item C.12)

The relatives suggested the following steps for helping them to cope with the psychiatric patients at home successfully:

**TABLE 5.36**

	<b>f</b>	<b>%</b>
1. Sheltered employment workshops	7	28
2. More visits by nurses	5	20
3. Injections better than pills	2	8
4. Secure source of income	2	8
5. Disability grants	2	8
6. Special schools for children	1	4
7. Education on masturbation	1	4

- 28% (7) of the relatives wished for a place where the psychiatric patients would work during the day so that they are taken away from the drugs in the community
- 20% (5) felt that more frequent visits by nurses would help patients take their treatment
- 8% (2) felt that the problem of default with treatment would be overcome by using injections rather than pills
- 16% (4) saw the solution to the patients' financial problems as employment or disability grants for a secure source of income
- 4% (1) needed a special school for the mentally disturbed scholars, and
- 4% (1) felt that disappointment in love advances should be overcome by teaching patients to masturbate.

## 5.6 CONCLUSION

The foregoing data has provided information which was essential to meet the objectives of the study and to confirm the assumptions made, namely

- to determine the extent of the problem of relapses in psychiatric patients in the Natal/KwaZulu region
- to establish the possible causes of such relapses;
- that there are inadequate facilities for efficient and effective treatment of psychiatric patients, and
- that there is inadequate preparation of patients' relatives for the patients' discharge.

## CHAPTER 6

### SUMMARY, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

#### 6.1 INTRODUCTION

In this chapter, the summary, conclusions, limitations and recommendations of the study will be discussed.

#### 6.2 SUMMARY OF THE STUDY

The study aimed at investigating the extent of relapses in psychiatric patients in the KwaZulu - Natal province of South Africa, the contributing factors and possible solutions to this problem.

Literature reviewed showed that relapses are a serious problem in other countries as well, and with poor facilities reported in South Africa, the situation was expected to be worse. However, the literature reviewed expressed relapse rates in terms of individual patients and not in magnitude of the problem. Therefore it was not possible to say whether the problem is better or worse in Natal/KwaZulu than in other countries.

An exploratory research approach was used to collect data on the extent of the problem and to determine the possible causes and solutions. Three institutions that admit and treat psychiatric patients in Natal/KwaZulu were investigated, that is Madadeni, Fort Napier and Townhill hospitals.

A historical approach was used to determine the readmission rates from the hospital records.

A sample of seventy-five (75) patients and twenty-five (25) relatives were interviewed, and questionnaires were given out to ten (10) professional nurses of the admission, long-term and community service units of the above institutions to establish the possible causes and solutions to the problem. Data concerning the available facilities like psychiatrists, psychiatric nurses, clinical psychologists, social workers, sheltered employment workshops, halfway homes etc was also collected.

### 6.3 CONCLUSIONS

The objectives of the study were

- to determine the extent of relapses in psychiatric patients in Natal/KwaZulu province
- to determine the contributory factors to such relapses
- to determine possible solutions to the problem.

The assumptions held were that

- there are inadequate facilities for effective community psychiatric care
- there is inadequate community knowledge about the causes, effects and curability of mental illnesses, even among the patients' relatives
- the attitude of the community and the handling of the mentally ill patients by the community are not conducive to their recovery and retention within the community, hence the relapses.

Conclusions based on data collected indicate the following;

### **Objective 1: Extent of relapse:**

- 37,56% (1734) of patients admitted to the institutions are readmissions (1993 statistics: 1734 out of 4616 patients were readmissions)
- some patients had been readmitted so many times they could not remember how many times they had been readmitted
- in some instances readmissions exceed total admissions. In Townhill Hospital, for example, male readmissions exceed female new and readmitted patients put together (539 vs 529).

### **Objective 2: Contributory factors.**

The assumptions made which were related to this objective were proved to be true. According to the literature reviewed in relation to the study, relapsing patients have special features. In this study, it was found that these features were in keeping with those suggested by other studies/authors.

- the majority 25% (19) of readmitted patients were patients with schizo affective disorders
- 72% (54) of patient respondents were single/never married, and of the married, 80% (17) had poor interpersonal relations with their spouses. Mental illness and recurrent relapses are either a cause or a result of such marital status.
- Patients are admitted for too short a period each time to make an appreciable change in their personal problems and improve the home and community conditions to which they return
- There is inadequate preparation of patients, their relatives and the community for the patient's discharge

- There is such shortage of essential patient care services that most of the patients and their relatives had never even heard of them. Such services as sheltered employment workshops, halfway houses, crisis intervention, family therapy were unknown to most patients. Even within the health services, there is a serious shortage of professional health team members. One 810 bedded hospital, for example, operates without a psychiatrist and with only one clinical psychologist and one social worker.
- Services that would be used to provide care like satellite clinics and nearby hospitals are not well accepted and therefore poorly utilised by patients and their relatives as a result of poor service and unwelcoming attitudes of the staff of such services. Patients then either have to travel long distances to psychiatric hospitals or the hospital travels to them. If patients do not have the money to travel, and there is no mobile service from the hospital then the patients stay without treatment, and then they relapse.
- Community outreach programmes seem to play a very important role in reducing relapses as evidenced by low readmission rates for Fort Napier 24.38% (508 out of 2361) and Madadeni Hospitals 45.9% (508 out of 1110) as opposed to Townhill Hospital 59.4% (718 out of 1334) which, in spite of good inpatient services, does not have an outreach programme for discharged patients
- Lack of employment opportunities for psychiatric patients makes them a burden to their relatives both physically and financially as they vegetate and eventually reengage in substance abuse
- There is general acceptance of the informal support systems e.g. community health care workers for community care of psychiatric patients but it seems that people do not yet know how to utilise these services effectively.

- Patients attribute their relapse partly to factors external to and uncontrollable by them (e.g. poor relatives' attitudes) and partly to factors internal to them (e.g. substance abuse) but uncontrollable.

#### 6.4 LIMITATIONS OF THE STUDY

Because of time and financial constraints, as well as shortage of the other members of the psychiatric team i.e. the psychiatrists, clinical psychologists, social workers etc, the researcher was unable to explore their opinions of the problem at hand.

The researcher had limitations in relation to contacting patients relatives.

#### 6.5 RECOMMENDATIONS

The researcher recommends that;

- 6.5.1 The Department of Health investigates the shortage of psychiatrists and clinical psychologists in the institutions under study. An effort should be made to recruit such personnel because they are a very essential part of the patient care team. Many patients with neurotic problems like relapses due to bereavement and interpersonal problems need the services of clinical psychologists, much as are psychiatrists and social workers.
- 6.5.2 An effort should be made to establish placement services like halfway homes in order to reduce the hospital load and to make room and time for the hospital staff to give better quality care to the acute cases, and to allow patients to stay longer and be better rehabilitated before discharge.
- 6.5.3 Sheltered employment workshops be established in order to provide employment for the discharged psychiatric patients who cannot be reemployed into the open labour market. A full motivation and the rationale for such a service areas follows:

- 95% patients had been working prior to first episode
- 43% patients had been working prior to present episode
- patients are taught occupational skills in or
- relatives report that the patients' unemployment causes them to engage in substance abuse
- to solve the financial problems
- to reduce taxation on taxpayers
- ex mental patients less successful in job hunting than normal persons

6.5.4 More intensive strategies be employed for fighting substance abuse at the primary level and hence nip in the bud this increasing menace which is identified even by the patients themselves as a serious problem.

6.5.5 More intensive education of the community, and specifically the family members about the handling of and interaction with psychiatric patients, to solve the problem of relatives who recertify patients for justifiable emotional reactions.

6.5.6 Satellite clinics should have special psychiatric clinics everyday. If such clinics are not busy, and the clinic needs the staff to help with other clinic duties, they should however relinquish such duties as and when a psychiatric patient pitches up. These patients and their relatives feel it very strongly if they are told to wait in the sun or go back home because "today is antenatal clinic or well baby clinic day".

6.5.7 A protocol for working with informal support systems like the community health care workers (oNompilo) should be established. Such services have been very successful and effectively used for community development work, primary health care, for the control of infantile problems like gastro-enteritis and for supervision of patients on ambulatory anti TB treatment, and so can be used just as effectively to control psychiatric relapses.

It is also essential to establish a protocol for liaison between the psychiatric institutions and satellite clinics personnel who should be providing aftercare for

discharged patients to ensure that such care is satisfactorily rendered. Psychiatric community services of the hospitals should not have to travel miles and miles to provide the service to patients where there are local services that can be economically and effectively utilised.

Based on the above findings and recommendations, the following modified self-care model for effective community care of psychiatric patients is suggested:

In this model, the psychiatric patient is imprisoned by problems such as

- inadequate preparation for discharge
- lack of community service essential for his aftercare
- unprepared families
- lack of support systems in the community
- socio economic problems

To set him free, and reduce the rate of relapses, there should be

- effective inpatient care
- adequate community health aftercare services
- family therapy
- patient support systems e.g. through community health care workers
- services to improve his socio economic status without making him dependent, e.g. sheltered employment workshops

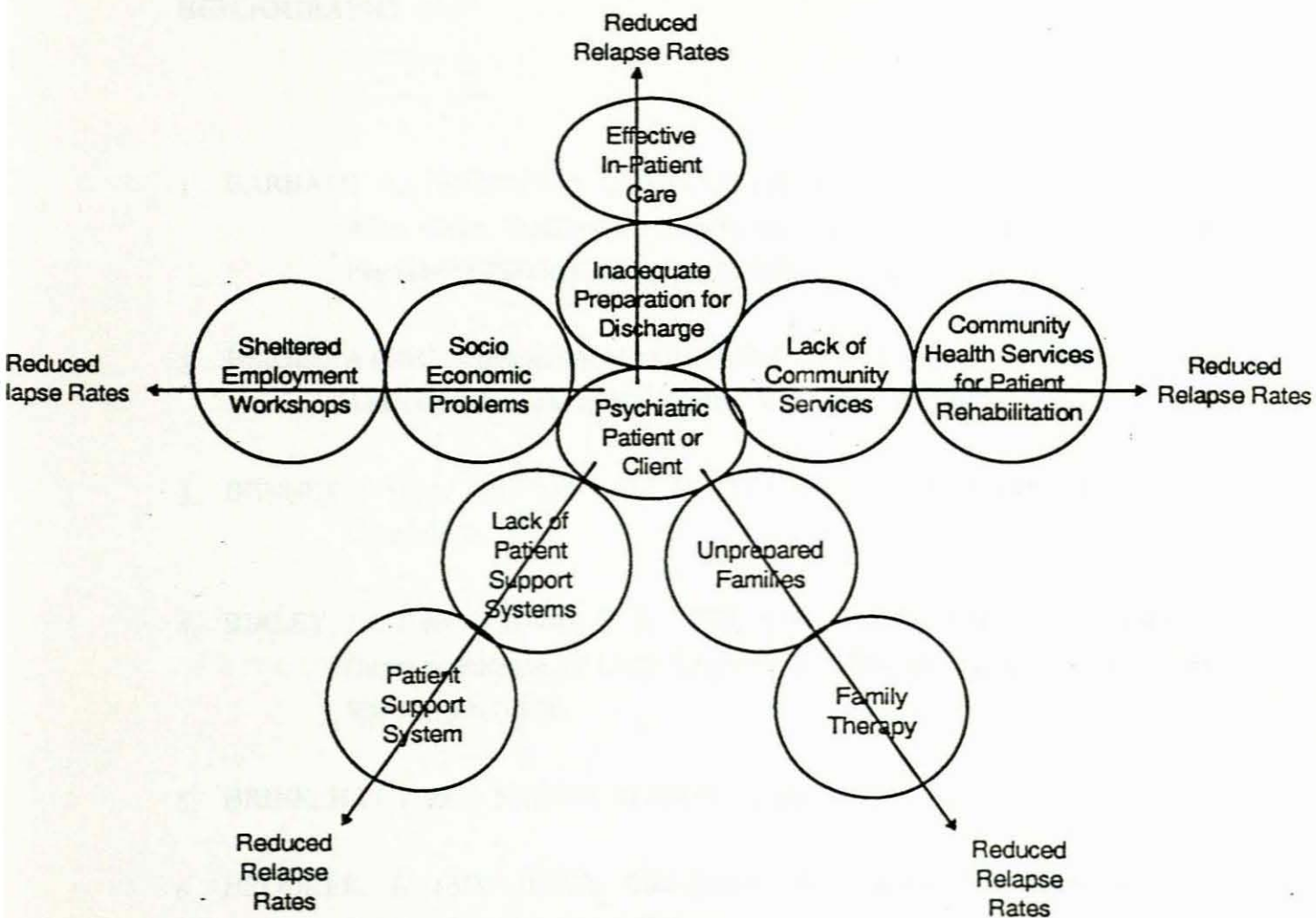
## 6.6 RECOMMENDATIONS FOR FURTHER RESEARCH

For further study, the researcher would like to recommend an investigation into

- the opinions of other members of the psychiatric team about the causes and possible solution to this problem

- the situations in other provinces of South Africa, to compare that with the situation in the KwaZulu - Natal region, and if lower, to determine how other regions cope with the problem
- the situation in other countries, especially those with better facilities than South Africa. Available literature discusses relapse rates per individual patient, but the magnitude of the problem is not documented.

FIGURE 6.1: UNREGISTERED HIV/AIDS PATIENTS  
RELAPSES BY PROVINCE 2011-2012



**FIGURE 6.1: SUGGESTED MODEL FOR PREVENTION OF RELAPSES IN PSYCHIATRIC PATIENTS**

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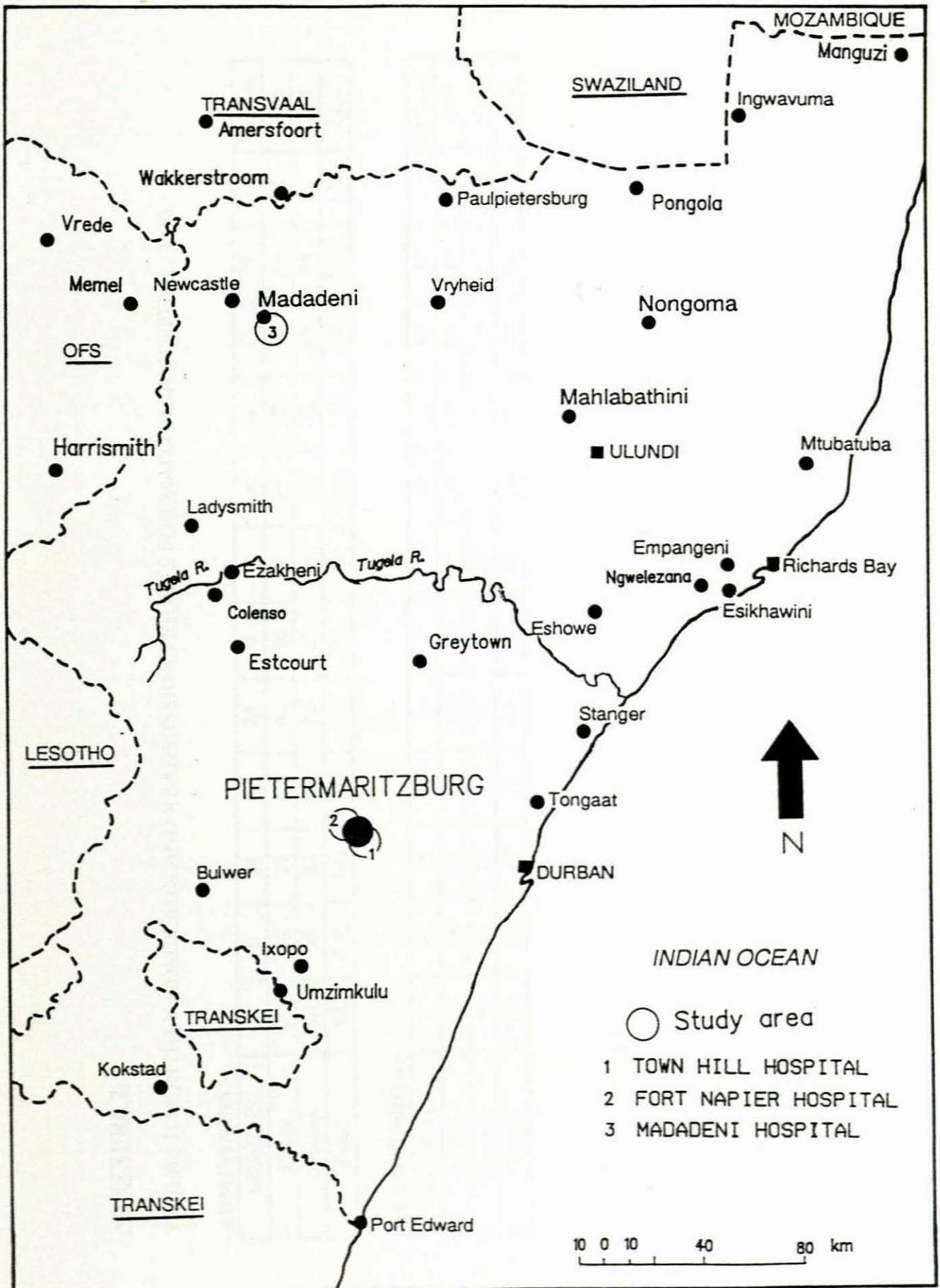
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# ANNEXURE 1: MAP OF NATAL



(Source: Shuter's Magister Atlas for Secondary Schools, 1984, p. 47.)

**ANNEXURE 2:**

TABLE 11: MONTHLY ADMISSION AND READMISSION FIGURES FOR MADADENI HOSPITAL, 1993.

**ADMISSIONS**

MONTHS	J	F	M	A	M	J	J	A	S	O	N	D	TOTAL
Males	70	65	77	47	45	50	85	62	78	59	67	71	746
Females	24	36	34	27	27	21	37	26	33	35	34	32	364
Total	94	101	101	74	71	71	132	88	111	94	111	103	1110

**READMISSIONS**

MONTHS	J	F	M	A	M	J	J	A	S	O	N	D	TOTAL
Males	19	38	37	28	26	23	11	19	46	26	34	32	339
Females	9	14	11	14	7	8	24	15	16	19	13	19	169
Total	28	52	48	42	33	31	35	34	62	45	47	51	508

**ANNEXURE 3:**

TABLE 12: MONTHLY ADMISSIONS AND READMISSION FIGURES FOR FORT NAPIER HOSPITAL, 1993

**ADMISSIONS**

MONTHS	J	F	M	A	M	J	J	A	S	O	N	D	TOTAL
Males	120	160	87	79	96	170	188	230	201	136	169	172	1808
Females	46	50	30	38	28	59	52	42	35	76	63	34	553
Total	166	210	117	117	124	229	240	272	236	212	232	206	2361

**READMISSIONS**

MONTHS	J	F	M	A	M	J	J	A	S	O	N	D	TOTAL
Males	39	54	12	10	39	35	30	62	27	11	12	24	343
Females	8	21	7	6	9	15	9	11	7	44	21	7	165
Total	47	75	19	16	48	50	39	73	34	55	33	31	508

**ANNEXURE 4:**

TABLE 13: MONTHLY ADMISSION AND READMISSION FIGURES FOR TOWNHILL HOSPITAL, 1993.

**ADMISSIONS**

MONTHS	J	F	M	A	M	J	J	A	S	O	N	D	TOTAL
Males	87	66	54	64	50	60	64	63	65	78	78	66	795
Females	34	32	28	32	28	29	34	26	35	23	27	22	350
Total	121	98	82	96	78	89	98	89	100	101	105	88	1145

**READMISSIONS**

MONTHS	J	F	M	A	M	J	J	A	S	O	N	D	TOTAL
Males	65	47	43	44	39	37	45	32	46	43	54	44	539
Females	18	17	15	15	13	17	20	16	11	11	16	10	179
Total	83	64	58	59	52	54	65	48	57	54	70	54	718

101

**ANNEXURE 5:**

TABLE 14: TOTAL ADMISSION AND READMISSION FIGURES FOR THE THREE PSYCHIATRIC INSTITUTIONS, 1993

	Admissions		Readmissions	
	Males	Females	Males	Females
1. Madadeni	746	364	339	169
2. Fort Napier	1808	553	343	165
3. Townhill	795	350	539	179
Totals	3349	1267	1221	513

**ANNEXURE 6:**

TABLE 15: ADMISSION AND READMISSION FIGURES AND RATES FOR MADADENI, FORT NAPIER AND TOWNHILL HOSPITALS, 1993.

**A. ADMISSIONS****A1 MALES**

MONTHS	J	F	M	A	M	J	J	A	S	O	N	D	TOTAL
a) MADADENI	70	65	77	47	45	50	85	62	78	59	67	61	746
b) FORT NAPIER	120	160	87	79	96	170	188	230	201	136	169	172	1808
c) TOWNHILL	87	66	54	64	50	60	64	63	65	78	78	66	795
SUBTOTAL	277	291	218	190	191	280	337	335	344	273	314	299	3349

**A2 FEMALES**

MONTHS	J	F	M	A	M	J	J	A	S	O	N	D	TOTAL
a) MADADENI	24	36	34	27	27	21	37	26	33	35	34	32	364
b) FORT NAPIER	46	50	30	38	28	59	52	42	35	76	63	34	553
c) TOWNHILL	34	32	28	32	28	29	34	26	35	23	27	22	350
SUBTOTAL	104	118	92	97	83	109	123	94	103	134	124	88	1267
GRANDTOTAL	381	409	310	287	274	389	460	449	447	407	438	387	4616

**B. READMISSIONS .....P.T.O.**

## **B. READMISSIONS**

### **B1 MALES**

MONTHS	J	F	M	A	M	J	J	A	S	O	N	D	TOTAL
a) MADADENI	19	38	37	28	26	23	11	19	46	26	34	32	339
b) FORT NAPIER	39	54	12	10	39	35	30	62	27	11	12	24	343
c) TOWNHILL	65	47	43	44	39	37	45	32	46	43	54	44	539
SUBTOTAL	123	139	92	82	104	95	86	113	119	80	100	100	1221

### **B2 FEMALES**

MONTHS	J	F	M	A	M	J	J	A	S	O	N	D	TOTAL
a) MADADENI	9	14	11	14	7	8	24	15	16	19	13	19	169
b) FORT NAPIER	8	21	7	6	9	15	9	11	7	44	21	7	165
c) TOWNHILL	18	17	15	15	13	17	20	16	11	11	16	10	179
SUBTOTAL	35	52	33	35	29	30	53	42	34	74	50	36	513
GRANDTOTAL	158	191	125	117	133	125	139	155	153	154	150	136	1734

NATALSE PROVINSIALE  
ADMINISTRASIE

DEPARTEMENT VAN HOSPITAALDIENSTE



NATAL PROVINCIAL  
ADMINISTRATION

DEPARTMENT OF HOSPITAL SERVICES

Enquiries: Dr J N G Ross/mn  
Navrae:

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3886

Midlands Hospital  
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Box 370  
PIETERMARITZBURG  
3200

454221 EXT.  
FAX:455730 BYLYN

Reference No.  
Verwysing No. S7/5/1

Your Reference No.  
U Verwysing No.

16 September 1993

PERMISSION TO DO RESEARCH AT FORT NAPIER HOSPITAL

Your letter dated 4 August 1993 refers.

Permission to do research at Fort Napier is granted with the following provisions:

1. Your interviews with patients must include a consent form signed by them.
2. The hospital ward and community staff will not be involved with interviews. You will have to arrange to do this yourself.

SENIOR MEDICAL SUPERINTENDENT

**UMNYANGO WEZEMPILO  
NEZENHLALAKAHLE**



**DEPARTMENT OF HEALTH  
AND WELFARE**

**OFFICE OF:— Senior Medical Superintendent Madadeni Hospital**

<b>Ikheli Locingo :</b> <b>IMPILO</b>	<b>Isikhwama Seposi:</b> <b>P.O. Box :</b> X6642 <b>Private Bag :</b> NEWCASTLE	<b>Ucingo :</b> <b>Telephone:</b> 49221
<b>Telegraphic Address:</b>		
<b>Imibuzo :</b> <b>Enquiries:</b> Mrs M.G. Buthelezi	<b>Usuku:</b> <b>Date :</b> 29/10/1993	<b>Inkomba :</b> Research <b>Reference:</b>

Mrs N.D. Mzimela  
University of Zululand  
P/Bag 1001  
Kwa-DLANGEZWA

Dear Madam

**REQUEST FOR PERMISSION TO DO RESEARCH AT MADADENI HOSPITAL-PSYCHIATRIC DEPARTMENT.**

Your letter dated 14.10.93 on above proposal refers.

We are grateful to notify you that the Senior Medical Superintendent has granted you the permission to conduct the proposed research programme as request.

Application forms for research proposal and the proposal are attached hereto.

We hope the service will benefit from your research on Mental Health

**NURSING SERVICE MANAGER  
For CHIEF MEDICAL SUPERINTENDENT**

RELAPSES IN PSYCHIATRIC PATIENTS

RESEARCH INSTRUMENT

A. HISTORICAL DATA AND QUESTIONS FOR THE COMMUNITY PSYCHIATRIC NURSES

- 1. Name of the institution: .....
- 2. Size of the institution: ..... beds
- 3. Community served:
  - 3.1 Geographically: .....
  - 3.2 Racially: .....
- 4. Services rendered:
  - 4.1 Acute care: .....
  - 4.2 Long term care: .....
  - 4.3 Rehabilitation: .....
  - 4.4 Community services: .....

COMMUNITY

HOSPITAL

5. STAFF ESTABLISHMENT

7. In your opinion, what makes patients relapse?

.....

.....

.....

8. In your opinion, what is the attitude of the patients' families in general towards psychiatric patients?

.....

Substantiate:-

.....

.....

9. In your opinion, what is the attitude of the community towards discharged psychiatric patients?

.....

.....

Substantiate:-

.....

.....

10. How are your patients prepared for discharge?

.....

.....

.....

11. How are patients' relatives prepared for the patients' discharge?

.....  
.....  
.....

12. How is the community prepared for the acceptance of psychiatric patients?

.....  
.....  
.....

13. How do you think relapses in psychiatric patients can be prevented?

.....  
.....  
.....

14. What category of patients do psychiatric wings in general hospitals cater for?

- acute
- chronic
- new cases
- readmissions
- others (specify)

15. To what extent have these wings been:-

a) accepted by the general hospital staff and management?

Very well	
Well	
Poorly	
Not at all	

**B. INTERVIEW SCHEDULE AND HISTORICAL DATA CONCERNING THE RELAPSED PATIENTS**

1. Patient's Hospital Number .....

2. Diagnosis: .....

3. Age: .....

4. Sex

M		F	
---	--	---	--

5. Home address:-

RURAL	
-------	--

URBAN	
-------	--

SEMI-URBAN	
------------	--

6. Marital Status: .....

7. Educational Standard: .....

8. With whom do you stay at home? .....

9. How many times have you been readmitted to mental hospital?  
.....

10. How long did you stay in hospital each time?  
.....

11. What in your opinion precipitates your relapses?  
.....

12. Were you employed prior to the first episode of mental illness?  
.....

13. If yes to Number 12,

a) Where were you employed? .....

b) What did your work entail? .....

c) Did you re-apply for work with your previous employer after discharge?

.....

d) Were you re-employed? .....

14. Were you employed prior to the present episode of illness?

.....

15. If yes to number 14,

a) Where were you employed? .....

b) What did your work entail? .....

c) In your opinion, were you accepted

by your employer? .....

by your co-workers? .....

16. If you were not employed?

a) Did you look for a job? .....

b) What problems did you encounter with getting a job?

- there were no jobs generally .....

- the fact that you had been mentally ill affected your choices of employment  
.....

- you were not completely cured and fit for work  
.....

c) How were you supported financially?  
.....

17. What do you think would help ensure that you are successfully discharged and that you do not relapse/get re-admitted?

.....

.....

18. How is your relationship with the following people?

	<b>EXCELLENT</b>	<b>GOOD</b>	<b>FAIR</b>	<b>POOR</b>
Mother				
Father				
Brothers				
Sisters				
Spouse				
Children				
In-laws				
Boss				
Co-workers				
Friends				
Neighbours				

**C. INTERVIEW SCHEDULE/QUESTIONNAIRE FOR RELAPSED PATIENTS' RELATIVES**

1. Patients' Hospital Number: .....

2. Sex		3. Age	
--------	--	--------	--

4. Diagnosis		5. Number of relapses	
--------------	--	-----------------------	--

6. How are you related to the patient?

- a) Father .....
- b) Mother .....
- c) Brother .....
- d) Sister .....
- e) Spouse .....
- f) Son/Daughter .....
- g) Friend .....
- h) Neighbour .....
- i) Other: Specify

7. To your understanding, what is wrong with the patient (diagnosis)

- schizophrenic .....
- neurotic .....
- mentally retarded .....
- other (specify) .....

8. What causes it?

.....

9. What treatment was the patient on after discharge from hospital?

10. What problems did you have managing the patient at home?

- a) medication - supplies?
  - patient refusal to take Rx
  - health services too far

- personality change due to medication
- b) patient unacceptance by the community
- c) lack of facilities for patient care
- d) lack of community support
- e) others (specify)

11. Were you taught how to manage the patient at home?

Yes ..... No .....

If yes,

by whom? .....

what were you taught? .....

12. During the period while he/she was out of hospital, how did you get along with him/her?

very well	
--------------	--

well	
------	--

fair	
------	--

poorly	
--------	--

13. Did your relative experience any of the following problems when he was discharged from hospital the last time?

- a) finding or holding a job .....
- b) avoidance by some of his/her friends .....
- c) some of his/her relatives looking upon him/her .....
- d) some of his/her neighbours making remarks? .....

14. Are the following services available in your area for the after care of psychiatric patients?

	YES	NO
Medication depots or clinics within easy reach		
Psychiatric nurses at satellite clinics		
Psychiatrists		
Psychologists		
Psychiatric follow-up services		
Social Welfare Services		
Sheltered employment		
Day Care Centre		
Night Hospitals		
Group Therapy		
Social clubs for psychiatric patients		
Family therapy		
Occupational therapy		
Psychiatric wings in general hospitals		
Crisis intervention/emergency services		
Halfway houses		

15. What suggestions would you make to improve the after care of psychiatric patients?

.....

.....

.....

Thank you for your co-operation.

14. Are the following services available in your area for the after care of psychiatric patients?

	YES	NO
Medication depots or clinics within easy reach		
Psychiatric nurses at satellite clinics		
Psychiatrists		
Psychologists		
Psychiatric follow-up services		
Social Welfare Services		
Sheltered employment		
Day Care Centre		
Night Hospitals		
Group Therapy		
Social clubs for psychiatric patients		
Family therapy		
Occupational therapy		
Psychiatric wings in general hospitals		
Crisis intervention/emergency services		
Halfway houses		

15. What suggestions would you make to improve the after care of psychiatric patients?

.....

.....

.....

Thank you for your co-operation.