

**Factors leading to re-admission of mental health care users in Thabamoopo Hospital of  
the Capricorn District,**

**Limpopo Province**

by

**Lina Sebolaisi Takalo**

MINI-DISSERTATION submitted in partial fulfilment of the requirements for the degree of

**Master of Curationis**

in the

**FACULTY OF HEALTH SCIENCES**

**(School of Health Sciences)**

at the

**UNIVERSITY OF LIMPOPO**

Supervisor: Prof J. C. Kgole

Co-Supervisor: Prof M. E. Lekhuleni

2015

## DECLARATION

I declare that the “**Factors leading to re-admission of mental health care users in the Thabamoopo Hospital of the Capricorn District, Limpopo Province**” (mini-dissertation) hereby submitted to the University of Limpopo, for the degree of Masters Curationis (MCur) has not been previously been submitted by me for a degree at this or any other University, that it is my work in design and in execution, and that all materials contained herein have been duly acknowledged.

---

**Takalo , LS (Ms)**

---

**Date**

## **DEDICATION**

The study is dedicated to my parents, Makau Alfred and Sina Rangoato Takalo; my siblings, Katlego Takalo, Moloto Takalo, Mathabo Takalo - Ranamane, Mothabela Takalo, Makgafela Takalo and Mahlogonolo Takalo. They are a wonderful family to have.

This is also dedicated to the mental health care users and the mental health care practitioners at the Thabamooopo Hospital.

## ACKNOWLEDGEMENTS

I thank God almighty for His blessings in my life and grace in this study. My sincerest gratitude also goes to:

- My supervisor, Prof J. C. Kgole for her guidance, support, and encouragement;
- My co-supervisor, Prof M. E. Lekhuleni for her guidance, support, and encouragement;
- The University Of Limpopo (Turfloup Campus) for allowing me to register as masters student
- The University of Limpopo Medunsa Research and Ethics Committee (MREC) for approval of the study;
- The Department of Health and the Thabamoo Hospital management, for the permission granted to conduct the study;
- All nurses at the Thabamoo Hospital, who offered courage and support when I needed it the most;
- Sister G. Raphadu for the continuous support she provided and for helping me in identifying relevant participants in this study
- Silas Hlahla for the support he provided throughout the study.
- All mental health care users and the relatives who took part in this study.
- Prof. MN Jali for agreeing to be my independent coder;
- Revd, Dr. Lutz Ackermann for agreeing to be my English editor.

## **ABSTRACT**

**Background:** Re-admission is a common problem encountered in psychiatric care. Re-admissions are often, but not always, related to a problem inadequately resolved in the prior hospitalization. A better understanding of factors leading multiple psychiatric admissions is needed. Such knowledge can help planners to set priorities and to make appropriate services and resources available to mental health care users and their families after hospital discharge.

**Objective:** The purpose of this study was to explore the factors leading to re-admission of mental health care users at the Thabamopo Psychiatric Hospital, Limpopo Province.

**Methodology:** A qualitative phenomenological research approach was used to explore the factors leading to readmission of mental health care users. Purposive sampling was used to select participants of the study at the Thabamopo Hospital. Twelve one-on-one semi-structured interviews were conducted. Ethical clearance was granted by the Medunsa Research Ethics Committee and permission to collect data was granted by the Limpopo Department of Health. The data were analysed through Tesch's method of analysis.

**Results:** The research findings indicate that the use of substances, non-adherence to psychiatric medication, the nature of the illness and social problems contributes to readmission of mental health care users.

**Conclusion and recommendations:** In order to deal with factors related to re-admission of mental health care users, the mental health care practitioners, mental health care users and their families must be involved and work together.

**Keywords:** Readmission, mental health care user, factors, psychiatric Hospital.

## **DEFINITION OF CONCEPTS**

### **Factors**

The circumstances that contributes to the result (Concise Oxford Dictionary, 2009). For the purpose of this study factors will mean circumstances that contribute to re-admission of mental health care users.

### **Mental health care user**

A person receiving care, treatment and rehabilitation services at a mental health institution (Mental Health Care Act no 17 of 2002). For the purpose of this study it will mean a person receiving care, treatment and rehabilitation in Thabamoopo hospital.

### **Psychiatric hospital**

A health care facility providing in-patient and out-patient therapeutic services to clients with behavioural or emotional illness (Mosby's dictionary of medicine, nursing and health professions, 2007). For the purpose of this study psychiatric hospital will mean the Thabamoopo hospital.

### **Readmission**

A re-admission is defined as a hospitalization that occurs shortly after a discharge (Silow-Carroll, Edwards, & Lashbrook, 2011). For the purpose of this study re-admission will mean the act of mental health care users admitted in Thabamoopo hospital more than twice during the course of the study.

## **ABBREVIATIONS**

MREC            Medunsa Research and Ethics Committee

WHO            World Health Organisation

MHCU          Mental Health Care User

## TABLE OF CONTENTS

	Page
Declaration	(i)
Dedication	(ii)
Acknowledgements	(iii)
Abstract	(iv)
Definition of concepts	(v)
Abbreviations	(vi)
<b>1. CHAPTER 1 : OVERVIEW OF THE STUDY</b>	<b>1</b>
1.1. INTRODUCTION AND BACKGROUND	1
1.2. PROBLEM STATEMENT	3
1.3. AIM OF THE STUDY	3
1.4. RESEARCH QUESTIONS	3
1.5. OBJECTIVES OF THE STUDY	4
1.6. METHODOLOGY	4
1.7. SIGNIFICANCE OF THE STUDY	4
1.8. CONCLUSION	5
<b>2. CHAPTER 2 : LITERATURE REVIEW</b>	<b>6</b>
2.1. INTRODUCTION	6
2.2. FACTORS RELATED READMISSION	6
2.2.1. Hospital factors	7
2.2.2. Type of illness	8
2.2.3. Type of treatment given to the user	10
2.2.4. Non-adherence to psychiatric treatment	10
2.2.5. Substance abuse	13
2.2.6. Occupational status	14
2.2.7. Missing appointments	15
2.2.8. Stigma and discrimination	16
2.2.9. Social factors	16
2.2.10. Other factors	17
2.3. CONCLUSION	18
<b>3. CHAPTER 3: RESEARCH METHODOLOGY</b>	<b>19</b>
3.1. INTRODUCTION	19

3.2.	STUDY SITE	19
3.3.	RESEARCH METHODOLOGY	19
3.4.	RESEARCH DESIGN	20
3.5.	POPULATION AND SAMPLING	21
3.6.	DATA COLLECTION	23
3.7.	DATA ANALYSIS	27
3.8.	MEASURES TO ENSURE TRUSTWORTHINESS	28
3.9.	ETHICAL CONSIDERATIONS	30
3.10.	CONCLUSION	31
4.	<b>CHAPTER 4: DISCUSSION OF RESULTS AND LITERATURE CONTROL</b>	32
4.1.	INTRODUCTION	32
4.2.	THE PARTICIPANTS OF THE STUDY	32
4.3.	DISCUSSION OF THE FINDINGS	34
4.3.1.	Theme 1: Substance abuse	34
4.3.1.1.	Sub-theme 1.1: Abuse of dagga	35
4.3.1.2.	Sub-theme 1.2: Abuse of alcohol	37
4.3.2.	Theme 2: Non-adherence to psychiatric medication	38
4.3.2.1.	Sub-theme 2.1: Side effects	38
4.3.2.2.	Sub-theme 2.2: Lack of insight	40
4.3.3.	Theme 3: Nature of illness	42
4.3.3.1.	Sub-theme 3.1: Schizophrenia	42
4.3.4.	Theme 4: Social problems	44
4.3.4.1.	Sub-theme 4.1: Lack of family support	44
4.3.4.2.	Sub-theme 4.2: Family disorganisation	46
4.3.4.3.	Sub-theme 4.3: Psychological distress	47
4.4.	CONCLUSION	48
5.	<b>CHAPTER 5: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS</b>	49
5.1.	INTRODUCTION	49
5.2.	SUMMARIES ABOUT THE STUDY	49
5.3.	FINDINGS OF THE STUDY	50
5.4.	GUIDELINES TO PREVENT RE-ADMISSION	50
5.5.	RECOMMENDATIONS	57

5.6. LIMITATIONS OF THE STUDY	58
5.7. CONCLUSION	58
REFERENCES	60
APPENDICES	
Appendix 1: Interview guide	71
Appendix 2: Letter for permission from the Department of Health	74
Appendix 3: Ethical clearance certificate	75
Appendix 4: Independent coder's certificate	76
Appendix 5: English editor's certificate	77
Appendix 6: Semi-structured interview taken from twelve interviews conducted for the main study	78

## CHAPTER 1

### OVERVIEW OF THE STUDY

#### 1.1. INTRODUCTION AND BACKGROUND

Re-admission is a common problem encountered in psychiatric care. Since the initiation of deinstitutionalization, the locus of care has shifted from the mental institutions to the community (AmerSiddiq, Aida, Zuraida & Abdul Kadir, 2010). This resulted in an increase in re-admissions into hospitals or institution on discharge. This phenomenon is due to many reasons and among them are poor patient compliance, aggression, inability to cope in the community due to poor social skills and also severity of disease (AmerSiddiq et al., 2010).

Re-admissions are often, but not always, related to a problem inadequately resolved in the prior hospitalization. It also can be caused by deterioration in a patient's health after discharge due to inadequate management of their condition, misunderstanding of how to manage it, or lack of access to appropriate services or medications (Silow-Carroll, Edwards & Lashbrook, 2011). Therefore, interventions to reduce re-admissions target both inpatient care, through efforts to improve the quality and safety of care, and the transition to outpatient care, through efforts to ensure continuity and coordination between providers and timely access to needed follow-up services. At a time when health care leaders are driven to reduce waste and inefficiency, eliminating unnecessary re-admissions has been identified as a desirable and achievable goal by practitioners (Silow-Carroll et al., 2011).

In countries such as Malaysia the rate of re-admissions has been used as a performance indicator and for this reason it has gathered much attention (AmerSiddiq et al., 2010). Globally the 6 monthly re-admission rates has been said to be between 15% and 38%. In some countries re-admission rate is calculated as the number of readmitting patients over total number of admissions for the given period. However, lately the trend has shifted to number of readmitting patients over the number of discharge for a given period. The latter appeared to be a better way to truly reflect the re-admission rate (AmerSiddiq et al., 2010).

Hospital efforts to reduce re-admissions have become more visible and important because the financial stakes. Preventing re-admissions is very challenging because so many community and

patient factors contribute to the problem and many of those factors are outside of the direct control of the hospital (Metzger, 2010). Re-admission of a patient is a problem both to the patient and the ward staff. Frequent re-admissions lead to reduction of the productivity and working capacity of both the patient and his family and also increase the expenditure for treatments. It would also disturb their day to day life, mental and social well-being. These factors ultimately contribute to the reduction in productivity of the whole country (Chamika, 2005).

Increased number of re-admissions leads to overcrowding and makes the ward noisy, busy and also an unpleasant place to stay. Due to overcrowding the patients tend to get discharged from the wards early, before optimal recovery, which may in turn increase the relapse rate and the need to be re-admitted (Chamika, 2005).

A high re-admission rate among persons discharged from inpatient psychiatric treatment may reflect the fact that the community lacks adequate accommodation for such patients and can be used as an indicator of inadequacy or inappropriateness of community-based aftercare (Ovsiew & Munich, 2008). A wide range of psychiatric re-admission rates has been reported, mainly because studies use various time intervals. Reported rates have ranged from 10% re-admission within one month after hospital discharge to as high as 47% within one year (Wall, Sorensen & Batki, 2003).

The Mental Health Care Act no 17 of 2002 of South Africa makes provision for involuntary admission to designated health establishments of persons who are assessed as mentally ill and a danger to themselves or others. Therefore, psychiatric hospitals cannot refuse patients admission or put them on a waiting list in order to retain patients who are inadequately stabilised on treatment (Uys & Middleton, 2004).

A better understanding of factors that reduce the likelihood of multiple psychiatric admissions is needed. Such knowledge can help planners to set priorities and to make appropriate services and resources available to patients and their families after hospital discharge (Silva, Bassani & Palazzo 2009). Given the gap in knowledge, this study seeks to explore the factors leading to re-admission of psychiatric patients in Thabamooopo hospital.

## **1.2. PROBLEM STATEMENT**

Minnot (2008) found that 37% of mentally ill patients discharged from a psychiatric hospital required re-admission within 1 year, compared with 27.3% of the general patient population. For most patients, who leave the hospital, the last thing they want is to return anytime soon. Yet, many patients discharged from psychiatric hospital find themselves back in the hospital after discharge.

The researcher has observed that the mental health care users admitted in Thabamoopo Hospital were re-admissions. According to Lin & Li (2008) approximately 50% of all patients admitted in the psychiatric hospital are re-admitted. These re-admissions made the researcher engage in this study to find out why mental health care users were being re-admitted.

According to Omranifard, Yazdani, Yaghoubi and Namdari (2008) the reasons behind these high numbers of re-admissions have not been closely studied previously, that is re-admissions that occur soon after the last discharge leave us wondering whether anything important has been missed; something that perhaps should have delayed discharge.

## **1.3. AIM OF THE STUDY**

The aim of this study was to explore the factors leading to re-admission of mental health care users in Thabamoopo Psychiatric Hospital, Limpopo Province.

## **1.4. RESEARCH QUESTION**

What are the factors leading to re-admission of mental health care users at Thabamoopo Psychiatric Hospital, Limpopo Province?

## **1.5. OBJECTIVES OF THE STUDY**

- To identify factors leading to re-admission of mental health care users in Thabamooop Psychiatric Hospital, Limpopo Province.
- To determine the guidelines for prevention of re-admissions of mental health care users in Thabamooop Psychiatric Hospital, Limpopo Province.

## **1.6. METHODOLOGY**

A qualitative research method was used in this study to explore factors leading to re-admission of mental health care users in Thabamooop Hospital of the Capricorn District, Limpopo Province. The research design used in this study was phenomenological to get insight into the factors leading to re-admission of mental health care users. The population of the study comprises all mental health care users who were discharged and re-admitted in Thabamooop Hospital and the relatives taking care of the mental health care users. Purposive sampling was used and twelve participants were selected for this study. Data collection was done through semi-structured interviews. Tech's open-coding was used for data analysis. The researcher made a summary of the themes and sub-themes identified before sending the data to an independent coder. The details of methodology will be discussed in Chapter 3.

## **1.7. SIGNIFICANCE OF THE STUDY**

The study might contribute to reducing the factors that lead to re-admission of mental health care users by finding out the causes of re-admission and making recommendations to the relevant stakeholders to reduce re-admission of mental health care users. The study might also benefit the department of health in saving funds that are used on readmitted patients.

## **1.8. CONCLUSION**

In this chapter, the researcher has highlighted what the research is all about, introduced the study, explained its background and the problem statement, and the research methodology have been summarized. Chapter 2 will deal with literature review.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1. INTRODUCTION**

The purpose of the literature review is to check what other researchers have found regarding the problem being studied. The literature review was conducted using journal articles, books and online media reports. Many researchers came up with some of the factors that could lead to re-admission of mental health care users in the psychiatric institution.

#### **2.2. FACTORS RELATED TO RE-ADMISSION**

Hospital re-admissions are a leading topic of healthcare policy and practice reform because they are common, costly, and potentially avoidable events. Hospitals face the prospect of reduced or eliminated reimbursement for an increasing number of preventable re-admissions under nationwide cost savings and quality improvement efforts. To meet the current changes and future expectations, organizations are looking for potential strategies to reduce re-admissions. It is thus important that a systematic review of the literature is undertaken to determine what factors are associated with preventable readmissions (Vest, Gamm, Oxford, Gonzalez & Slawson, 2010).

Understanding the risk factors for re-admissions in psychiatric patients is a key factor in developing targeted interventions to improve the quality of care. According to the medical literature, certain patient characteristics and diagnoses of psychiatric patients are risk factors for re-admission. For example, a diagnosis (or a history of diagnoses) such as depression, schizophrenia and affective disorders, and patient characteristics such as low socioeconomic status and substance abuse have been shown to be associated with higher rates of re-admission (Karth, 2007).

The re-admission rate has been found to be associated with severe mental disorder, longer duration of illness, earlier onset of mental illness, worse condition at discharge, co-morbid alcohol or drug problems, present heavy use of inpatient psychiatric resources or frequent previous hospitalization and poor adherence to medication. Social and demographic factors, such

as being unmarried, unemployed, inadequately housed, poorly integrated in the community, involved in the criminal justice system, involuntarily hospitalized at first admission and being unable to gain access to adequate aftercare resources have also been identified as being associated with frequent use of inpatient psychiatric services (Bobo, Hoge, Messina, Pavlovic, Levandowski & Grieger, 2004).

Frequent re-admissions increase the cost of health care and this is a very serious issue for developing countries, thus it is very important to prevent or else at least reduce re-admissions. To do that the reasons for re-admissions should be known to all medical professionals including the workers in the primary health care system. Reducing the number of re-admissions may reduce the cost of health care, increase the productivity of the country and improve the quality of health care services. Reducing the number of re-admissions will reduce the disease burden due to psychiatric illnesses improving the economical state of the country (Chamika, 2005).

### **2.2.1. Hospital factors**

Persistent demand of acute psychiatric hospitalization is of great concern to the health care providers and often causes a strain on patients, clinicians and caregivers. High rates of bed turnover and bed occupancy are commonly closely associated with high rates of re-admission which may be seen as counterproductive to the optimal use of psychiatric health care resources (Ovsiew & Munich, 2008).

The lack of resources and funds in mental health probably could influence the dropout and re-hospitalization rates of discharged patients (Rosca, Bauer, Grinshpoon, Khaweles, Mester & Ponizovysky, 2006). Patients are being re-hospitalized following a discharge for reasons that include poor quality of healthcare, lack of adequate resources (e.g. human resources) and equipment and/or effective discharge instructions, as well as medical errors. For instance, patients may be re-admitted because insufficient information is given about post-discharge care by the hospital; hospital level factors play a major role in a patient being at a complete lack of access to community-based quality post-hospital care such as rehabilitation; there are preventable medical errors and complications during the initial hospitalization (Li, 2011).

Li (2011) further says that once patients are discharged from a hospital, although they may receive discharge plans from social workers or nurses, they may not understand fully the follow-up care plans and/or be able to manage self-care. After being discharged, patients sometimes do not receive follow-up calls from physicians or nurses nor do they visit their primary care physicians in a timely manner. When the patients start to receive care from physicians, ineffective communication by physicians may also result in the patients not complying with prescribed medication. All of this makes it difficult to deliver care after discharge in a local setting. As a result, emergency rooms have become the site of post-discharge care far too often.

Minnot (2008) outlines multiple other factors that contribute to avoidable hospital re-admissions: they may result from poor quality care or from poor transitions between different providers and care settings. Likewise, such re-admissions may occur if patients are discharged from hospitals or other health care settings prematurely, are discharged to inappropriate settings or do not receive adequate information or resources to ensure continued progression. A lack of system factors, such as coordinated care and seamless communication and information exchange between inpatient and community-based providers, may also lead to unplanned re-admissions.

The researches that were conducted by Van Deventer, Couper, Wright and Tumbo (2008), and Thompson, Neighbors and Munday (2003) raises the following concerns that may lead to re-admission of mental health care uses which included lack of specialized psychiatric units in the primary health care, the absence of specialists, rapid discharge from the referral hospitals leads to relapse, ignorance of Mental Health Care Act and possibility of patient abuse at home by relatives. Other factors leading to re-admission were lack of specialized resources such as specialized and knowledgeable personnel and physical resources such as lack of transport for home visits and inadequate medication depending on the level of care.

### **2.2.2. Type of illness**

Schizophrenia is a chronic mental disease which provokes repulsion of the social and environment of the patients. Stigmatism of schizophrenia patients is one of the causes that they

are hospitalized much more frequently in comparison to other categories of psychiatric patients (Djokic, Petrovic & Vukic, 2008).

Schizophrenia is a chronic, debilitating mental disorder that affects approximately 1% of the general population and causes impairments in patient functioning, such as self-care, interpersonal relationships, and occupational skills. Many schizophrenia patients tended to be repeatedly hospitalized in acute or chronic ward settings instead of returning to their communities. Psychopathology, re-admission and quality of life among patients with schizophrenia under home care case management in Taiwan (Chang, Lin, Chang, Chen, Huang, Liu & Hwu, 2013).

Rosca et al. (2006) report that a diagnosis of schizophrenia is a strong predictor of re-admissions, involuntary admissions and length of stay. One possible explanation is that schizophrenia is the most severe and incapacitating of the mental disorders. The literature shows that earlier age of onset is associated with more severe psychopathology, course and outcome. Furthermore, young people in the early phases of schizophrenia are less stable than older people, and hence they may require more frequent or prolonged hospitalizations. In accordance with that, they also found that early age of onset was a useful predictor of increased number of re-admission (Rosca et al., 2006)

Some psychiatric patients require repeat hospitalizations owing to the risk of danger that they pose to themselves or the public at large. In Canada in 2003-2004, 37% of patients who were admitted to a hospital for a psychiatric illness were readmitted (all-cause re-admissions) within a year of their index admission, compared with 27% of patients with non-psychiatric illnesses re-admitted during the same time period.' Readmission rates were highest among patients with schizophrenia and comorbid substance abuse disorders (53%). The indenture number of a single hospitalization is taken into account, time to re-admission seems to fall shorter with higher numbers of re-hospitalizations in patients with schizophrenic disorders as well as with affective disorders (Mojtabi, Herman, Susser , Sohler & Craig, 2005; Madi, Zhao, & Li, 2007).

Severe mental illnesses are often characterized by a chronic relapsing course that may require repeated hospital admissions (Figueroa, Harman & Engberg, 2004). A substantial body of research in high-income countries (where most inpatient admissions are voluntary) has identified several potential predictors of re-admission following a psychiatric hospitalization: poor access

to post-discharge outpatient services, younger age, more severe clinical diagnosis (e.g. schizophrenia or bipolar disorder), lack of supportive significant others like being unmarried, divorced, or widowed), medication non-adherence, and poor access to adequate housing (Bobier & Warwick, 2005; Yanling, Rosenheck, Mohamed, Yuping and Hongbo, 2014).

### **2.2.3. Type of treatment given to the users**

While the ability to predict which patients are at high risk for re-admission is not an exact science, numerous studies have identified that adverse medication events are at the very core of the re-admission problem. This also includes patient non-adherence to prescribed drug therapy, which by itself leads to treatment failures and wasted resources costing the government billions annually and leading to re-admissions of patients to the hospital (Institute for Safe Medication Practice, 2012).

Clozapine is known to be effective in treating schizophrenia patients with comorbid alcohol use disorders. However, few prospective studies have examined the effect of clozapine on community survival of the patient, which is one of the most important indicators of success for patients with schizophrenia. A prospective, naturalistic, observational, community-survival-analysis study was conducted which compared the effect of clozapine and risperidone on two-year psychiatric hospitalization rate and time to hospitalization in the treatment of patients with schizophrenia and comorbid alcohol use disorders. The finding was that the clozapine treated patients were re-admitted to hospital significantly later than the risperidone treated patients (Kim, Kim & Marder, 2008).

### **2.2.4. Non-adherence to psychiatric treatment**

In 2003 the World Health Organization defined adherence as the extent to which a person's behavior—taking medication, following a diet, and/or executing lifestyle changes - corresponds with agreed recommendations from a health care professional. According to Sajatovic, Velligan, Weiden, Valenstein & Ogedegbe (2010) non-adherence is a serious problem in psychiatric treatment and compromises effectiveness. In schizophrenia, full or partial non-adherence can

exceed 60% and is associated with relapse, hospitalization, and elevated health care costs. In bipolar disorder, non-adherence ranges from 20% to 60% and is associated with poorer outcomes, elevated rates of relapse, hospitalization, suicidal behavior, and greater costs of care. Thirty percent of patients stop taking antidepressants after one month and 45–60% after 3 months. Inadequate adherence to antidepressants may lead to increased recurrence, severity, and disability, poorer responsiveness to future treatment, and greater health care cost (Sajatovic, 2010).

The underlying causes for higher re-admissions rates among psychiatric patients may vary across different communities and health care systems. However, two major contributing factors to frequent re-admission are believed to be lack of insight and medication non-adherence, which are well documented in this population. In 2007, the cost of re-hospitalization of patients with schizophrenia owing to medication non-compliance was estimated to reach US\$1.5 billion in the United States (Nakhost, Perry & Frank, 2012).

The level of partial or non-adherence in patients with schizophrenia is as high as 60%, resulting in a higher risk of relapse, re-admission and suicide attempts and is a major contribution to the economic burden of schizophrenia, poor adherence to medication and psychosocial treatment is prevalent among individuals with schizophrenia, which increases their likelihood of relapse and re-hospitalization (Schennach-Wolff, Jäger, Seemüller, Obermeier, Messer & Laux, 2009).

Information regarding factors related to re-admission of major psychiatric disorders is an index of prognosis and a means of estimating costs and service requirements. For example, results of register-based studies of psychiatric re-admission have found that patients with a prior history of hospitalization were more likely to be hospitalized than those who had not previously been hospitalized and that younger age of illness onset predicts a higher risk of re-admission. Studies on time to re-admission using survival analysis suggest that patients who are readmitted during a follow-up period are most likely to be readmitted in the early period of a follow-up (Ching-Hau, Ming-Chao, Li-Shiu, Chieh-Hsin, Cheng-Chung & Hsien-Yuan, 2010).

Weight gain due to medication has been linked with non-adherence and subjective distress. Obese individuals are more than twice as likely as those with a normal body mass index to miss their medication and more than 70% of patients described weight gain due to antipsychotics as

extremely distressing, which was higher than that for any other side-effect (Mitchell & Selmes, 2007).

Sexual dysfunction is a significant source of distress and may be linked to poor adherence. Study done on DSM–IV schizophrenia patients who were receiving an antipsychotic but no other medications associated with sexual side-effects. Sexual dysfunction occurred in 45.3% of the group and was associated with significantly lower ratings on global quality of life. Rosenberg, Bleiberg and Koscis (2003) examined the effects of sexual side-effects on adherence. They found that 62.5% of men and 38.5% of women felt that their psychiatric medications were causing sexual side-effects; 41.7% of men and 15.4% of women admitted that they had stopped their medications at some point during treatment because of sexual side-effects. Importantly, 50% of the sample ‘never or infrequently’ spoke about sexual functioning with their primary mental healthcare providers, and 80% of the women with sexual side-effects had not discussed sexual dysfunction with their mental healthcare providers, and they were re-admitted back to the hospital (Mitchell & Selmes, 2007).

The self-stigma, self-esteem, self-efficacy, insight, and psychosocial treatment adherence among 86 individuals with schizophrenia were assessed. The results revealed that high self-stigma, low self-esteem, and poor insight were significant predictors of treatment adherence further leading to re-admission of mental health care users. Among these predictors, self-stigma was shown to be the strongest in terms of its prediction power. Self-stigma is defined as a self-discredit of individuals by internalizing negative stereotypes prescribed to them and/or their social group. Self-stigmatized individuals are likely to possess low self-esteem and poor adherence behaviors (Tsang, Fung & Chung. 2010).

It has been reported that non-adherence affects the course of the illness adversely and increases its economic burden. Non-adherence to treatment decreases the quality of life, causes re-admission to the hospital and increases the risk of suicide (Colom & Lam, 2005).

The study conducted by Omranifard et al. (2008) indicates that lack of insight of mental health care users about their condition and non-compliance to psychiatric medication are possibly causes of re-admission in the psychiatric hospital. They indicated that the mental health care

users lack insight to their condition and thus to the medication they are supposed to take after discharge at home.

### **2.2.5. Substance abuse**

Substance abuse is an important component responsible for repeated admissions of psychiatric patients, though age, peer pressure and social stresses were also factors identified (Ayorinde, Gureje & Lawal, 2004). Substance abuse disorders are conditions resulting from the inappropriate use of alcohol, prescription drugs and/or illegal drugs. Behavioral health disorders may also include a range of addictive behaviors, such as gambling or eating disorders, characterized by an inability to abstain from the behavior and a lack of awareness of the problem (American Hospital association, 2012).

Patients with multiple admissions were more likely to have a diagnosis of schizophrenic or affective disorder. It is found that alcohol- and drug-related problems and non-compliance with medication were the most important factors related to frequency of hospitalizations. It seems that a small proportion of patients account for a disproportionately large share of psychiatric hospitalization (Ching-Hau et al., 2010). Besides non-adherence to hospital instruction and abstinence from prescribed and maintenance drugs, there are some other factors that made relapse more frequent in mental illnesses (Sheth, 2005).

This retrospective study conducted by Ching-Hau et al. (2010) evaluated relapse in 22 patients with schizophrenia, comparing substance abusers with non-abusers. Medication compliance was ensured as all subjects were treated with deaconate neuroleptics. Substance abuse was documented by multiple urine drug screens. Substance abusers had a significantly higher re-admission rate to the hospital compared to non-abusers. These data suggest that in the presence of documented medication compliance substance abuse remains a major factor contributing towards relapse. Therefore, good screening for substance use during this phase of the illness may prove useful as a predictor of relapse (Batalla, Garcia-Rizo, Castellví, Fernandez-Egea, Yucél, Parellada, Kirkpatrick, Martin-Santos & Bernardo, 2013).

Screening of substance use may prove useful to prevent readmission after the first episode of psychosis. Misuse of tobacco, alcohol, cannabis and other illicit substances is common among people with psychotic illnesses. A high prevalence of substance misuse is also characteristic of patients with first-episode psychosis, with rates varying from 22% to over 50%. Drug misuse, especially cannabis in the early stages of psychosis, has been associated with younger age of onset, increased symptoms, poorer treatment compliance, higher rates of relapses and more hospitalizations (Batalla et al., 2013).

Prince, Akincigil, Hoover, Walkup, Bilder and Crystal (2009) report that people with drug or alcohol abuse had baseline hospitalization chances that were more than 3 times greater than those of their non-abusing counterparts after adjustment for all other independent variables. These chances were comparable to the adjusted chances of admission relating to comorbid anxiety or personality disorder. By contrast, the adjusted chances of admission associated with co-occurring substance abuse were much greater than were those for medical comorbidity.

Problematic substance use is common among individuals with psychiatric disorders. Patients treated in inpatient psychiatric settings, the presence of a substance use disorder is a strong predictor of poor prognosis and subsequent re-admission (Bobo et al., 2004).

### **2.2.6. Occupational status**

Sfetcu and Pauna (2009) report that when looking at the frequency distribution of hospitalized patients in relation to their occupational status and readmission rates, they observe that most of the patients who are on retirement due to illness (93%) or age (79%) have been admitted before to the hospital while only 55% of patients who are employed as qualified workers have returned in a psychiatric hospital (in max. 1 year). Percentages of readmitted patients who are unemployed persons, housewives and students vary between 60 – 70%. The results are consistent with findings of other authors, showing that the less “occupied” a person is, there is a higher chance that he/she is re-admitted to the hospital (Sfetcu & Pauna, 2009).

Sfetcu and Pauna (2009) have found occupational status as the main indicator which influences the re-admission rates of hospitalized patients, with marital status having a only a reduced

influence and educational factors no influence at all. The contribution of social factors to the re-admission of psychiatric patients represents, therefore, strong evidence that the mental health system should provide appropriate targeted resources and assertive, continuous care management to avoid social crises.

### **2.2.7. Missing appointments**

Patients miss about 20% of scheduled appointments for mental health treatment, almost twice the rate than in other medical specialties. Up to 50% of patients who miss appointments drop out of scheduled care. Many who miss appointments because of slips and lapses later rearrange their appointments without adverse consequences. Those that do not are at risk of further deterioration, relapse and hospital readmission. Predictors of non-attendance are complex and linked with the predictors of missed medication. Service barriers and administrative errors are common but are often overlooked in the absence of feedback from patients. Of prime importance are the therapeutic alliance and degree of 'helpfulness' of the clinician but again these are rarely measured routinely (Mitchell & Selmes, 2007).

Patients who kept a follow-up appointment had a 1 in 10 chance of being re-admitted; for patients who did not keep (or were not offered) an appointment, the chances were 1 in 4. It is possible that the complications of non-attendance differ for new and ongoing patients (Killapsy, 2007). The most common single reason for non-attendance at follow-up appointments is forgetting the appointment, followed by being too psychiatrically unwell. Several authors have observed that patients with schizophrenia who miss appointments are more likely to have lower levels of functioning, to be more severely unwell and also to have substance use problems (Coodin, Staley & Cortens, 2004).

Poor communication between the referring practitioner and the patient may increase non-attendance at an initial appointment. Indeed, patients who agree with their referral are more likely to attend than those who do not (Killapsy, 2007). Research indicates that patients who miss appointments tend to be younger and of lower socio-economic status (Mitchell & Selmes, 2007).

Unplanned hospital re-admission rates are commonly used as an indicator of insufficient care coordination following an inpatient stay for psychiatric disorders. Longer lengths of stay, appropriate discharge planning, and follow-up visit

s after discharge contribute to fewer re-admissions, indicating that re-admission rates reflect the overall functioning of mental health services rather than the quality of hospital care (Lin & Li, 2008).

### **2.2.8. Stigma and discrimination**

Stigma is cited by mental health service users above poverty, isolation and homelessness as a main source of social exclusion in both people with current and those with previous mental health problems. The overall attitudes towards such people remain, in most respects, as profoundly negative as they were a decade ago despite the improvements in public awareness and knowledge about mental illness (Chang et al. 2013). For some individuals, the problems are compounded by additional discrimination on the grounds of their ethnicity, cultural background or sexuality. As many as nine out of ten people using mental health services say they experience discrimination in more than one area of life (Thornicroft, 2006).

A label of having a mental illness makes it harder to get life, personal or holiday insurance and can affect access to leisure facilities and other community activities. Negative attitudes to mental ill health can adversely affect policy development, usually through omission of relevant mental health issues. In the media, mental illness is typically represented in distorted stereotypes, which can foster fear and stigma among the general public. It also contributes to false and extremely damaging perceptions of the violence caused by people with mental health problem (King & McKeown, 2003).

### **2.2.9. Social factors**

The study that was conducted by Durbin, Lin, Layne and Teed (2007) shows that early re-admission is associated with more previous hospitalizations, comorbid substance use, major

depression, absence of family support, and the use of conventional versus atypical antipsychotic medications. Lower global function and symptom severity at discharge are not associated with early re-admission. Staff prediction of re-admission was poor. Early re-admission was associated with instability of clinical condition at first discharge and failure to prescribe medication for affective psychosis patients. Medication discontinuation was also a significant factor leading to re-admission.

Individuals who have been referred to community psychosocial support units after their most recent discharge have about 20% lower odds of multiple re-admissions than those referred to usual outpatient care. Among residents of the same city, those who live closer to the hospital were more likely to have multiple re-admissions. The adjusted multivariate hierarchical analysis revealed that a diagnosis of schizophrenia or psychotic symptoms was associated with multiple re-admissions, as were younger age at first admission and a greater number of previous admissions (Silva et al. 2009).

Aspects of a patient's social situation after discharge were found to be influential in all models: Living in an urban surrounding was associated with a higher risk of re-admission and living in an institutionalized or precarious setting with a diminished risk for re-admission. Patients' social functioning at the time of discharge displayed a protective effect for re-admission in all models, as well as employment (Frick, Frick, Langguth, Landgrebe, Hübner-Liebermann & Hajak, 2013).

#### **2.2.10. Other factors**

Patients with comorbid mental and physical health conditions are readmitted for a broad range of reasons. Specifically, these patients have multiple health conditions, may lack a strong support system, and may not adhere to treatment regimens. These factors can impede recovery and increase the likelihood that patients will return to the hospital (American Hospital Association, 2012).

One study found that heart attack patients who were depressed were more likely to be readmitted in the year after discharge. Another study concluded that patients with severe anxiety had a threefold risk of cardiac related re-admission, compared to those without anxiety. Among

children, the risk of re-admission was highest during the first 30 days following a first psychiatric hospitalization and remained elevated until about 90 days post-discharge. This finding underscores the vulnerability of patients during the immediate post-discharge period and highlights the importance of integrated care and post-discharge support services (American Hospital Association, 2012).

A high re-admission rate among persons discharged from inpatient psychiatric treatment may reflect the fact that there is a lack of closer supervision associated with aftercare of the psychiatric patients which leads to greater likelihood of psychiatric patients to be re-admitted while in some the communities there is a lack of adequate accommodations for such patients and can be used as an indicator of inadequacy or inappropriateness of community based aftercare. (Lin & Li, 2008).

Mental health care users with restricted length of stay were more likely to be re-admitted. For each day that the requested length of stay was reduced the odds of re-admission increased by 3.1%. Risk of early re-admission was greater for those with medication noncompliance, substance abuse, disruptive behaviors, not discharged into a structured treatment program and without adequate discharge planning for housing and finances (Durbin et al. 2007).

### **2.3. CONCLUSION**

This chapter has given different reasons that can lead to readmission of mental health care users in the psychiatric hospital. The reasons may range from, hospital factors, type of illness, stigma and discrimination, missing appointments, type of treatment given to the users, occupational status, substance abuse, non-adherences to medication to other different factors. Chapter 3 will deal with methodology in detail.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1. INTRODUCTION**

In this chapter, the researcher discusses how the study was conducted, the research approach and research design which were followed, the participants for the study, the criteria which were used to select them and where the study was conducted and how trustworthiness was ensured. The aim of the study was to explore the factors leading to re-admission of the mental health care users at the Thabamoopo Psychiatric Hospital, Limpopo province.

#### **3.2. STUDY SITE**

The study was conducted in the Thabamoopo Hospital. Thabamoopo is a specialised psychiatric hospital under Department of Health in the Limpopo Province, South Africa, ±60km south of Polokwane, in the Capricorn District at Lepelle-Nkumpi Local Municipality. This hospital renders 24 hours mental health care service.

Thabamoopo hospital renders comprehensive mental health care services for three districts which are Capricorn, Waterberg and Sekhukhune. The hospital renders rehabilitation and re-integrates mental health care users into their communities and provides clinical training to students from Limpopo College of Nursing, University of Limpopo Medunsa and Turfloop campuses and Tshwane University of Technology.

The main services of the Thabomoopo Hospital are Acute Services, Sub-acute Services, Chronic Services, Forensic Services and Intellectual Disability Services.

#### **3.3. RESEARCH METHODOLOGY**

The research approach used in this study was qualitative. A qualitative method is an investigation of a phenomenon, typically in an in-depth and holistic fashion through the collection of rich narrative material using a flexible research design (Polit & Hungler, 2008).

Qualitative approaches in health research allow description and promote the understanding of different patient experience. The basis of qualitative studies is that they generally aim to seek answers to questions about the what, how or why of a phenomenon (Babbie & Mouton, 2009). In this study the researcher reflected the realities as encountered by mental health care users and their relatives in the process of re-admission in the Thabamoopo Hospital.

Based on the features of qualitative research as explained by Babbie and Mouton (2009), the study was conducted in the natural setting of social actors. The researcher focused on the process rather than the outcome by asking each participant questions based on their responses. The primary aim was an in-depth descriptions and understanding of the factors leading to re-admission of the mental health care users.

### **3.4. RESEARCH DESIGN**

According to LoBiondo-Wood and Haber (2010), research design is the overall plan for deciding how information is to be collected and analysed, including specifications for enhancing the trustworthiness of the study. The research design used in this study is phenomenology. Phenomenology is a school of thought that emphasises a focus on people's subjective experiences and interpretations of the world. That is, the phenomenologist wants to understand how the world appears to others (Polit & Hungler, 2008).

The goal of phenomenological research is to fully understand the essence of some phenomenon. This is usually accomplished with long, intensive individual interviews. The purpose is to describe and interpret the experiences of participants in order to understand the essence of the experience as perceived by the participants. A phenomenological research problem focuses on what is essential for the meaning of the event, episode, or interaction. It also focuses on understanding the participants' voice. The problem can be stated directly or less directly. Usually there is a single, central question in the research. Several sub-questions are used to orient the researcher in collecting data and framing the results (Kellydubose's Blog, 2010).

In this study the researcher aimed at exploring factors leading to re-admission of mental health care users in the Thabamoo Hospital by obtaining data through personal, in-depth, semi-structured interviews.

### **3.5. POPULATION AND SAMPLING**

#### **Population**

A population is a complete set of participants that possess some common characteristics that are interest to the researcher (Brink, 2006). The population of the study was all mental health care users who are discharged and re-admitted in the Thabamoo Hospital and the relatives taking care of the mental health care users. The population size was 80.

#### **Sampling**

Sampling is a process of selecting a portion of the designated population to represent the entire population (LoBiondo-Wood & Haber, 2010). Purposive sampling was used to select the participants for this study. It was used in this study because it is a type of non-probability method in which the researchers select participants for the study on the basis of personal judgment about which was the most representative for the study (Brink, 2006).

Mental health care users who were re-admitted and the relatives of the re-admitted mental health care users were requested to participate in the study. The admission book was used to identify the re-admitted mental health care users. Twelve (12) participants were considered; Ten (10) stable mental health care users and two (2) relatives were considered until the data saturation was reached.

#### **Inclusion criteria**

In this study all mental health care users above the age of 18 years, who are re-admitted at Thabamoo Hospital and are stable, were included in the study and the relatives taking care of

re-admitted mental health care users who came to visit the re-admitted mental health care users were included in the study. Participants included in the sample were selected to meet specific criteria.

The following criteria for including mental health care users in the sample were used.

They should:

- Have been re-admitted at Thabampo Hospital.
- Be mentally stable in order to consent to participation.
- Be willing to participate.
- Be 18 years or older.
- Be of either sex or any race

The family members of the mental health care users had to meet the following criteria to be included in the sample.

They should be:

- Living with the Mental Health Care User
- Mentally sound
- Willing to participate
- 18 years or older
- Be of either sex or any race

### **Exclusion criteria**

Unstable re-admitted mental health care users were excluded from the study and also re-admitted mental health care users who are below the age of 18 years.

### **3.6. DATA COLLECTION**

Data collection is gathering of information needed to address a research problem (Polit & Hungler, 2008). The data were collected using a semi-structured interview method. According to De Vos, Strydom, Fouche and Delpont (2005) semi-structured interview instruments are used in order to gain a detailed picture of the participant's beliefs about, or perceptions or account of a particular topic. The method gives the researcher ability to follow up participants interesting avenue that emerge in the interview and the participants are able to give a fuller picture.

A semi-structured interview guide was used, field notes were taken, and a tape recorder was used to collect data from mental health care users who were re-admitted during the course of the study in the Thabamooopo Hospital and the relatives taking care of them.

#### **Conducting a semi structured interview**

The researcher made sure that the interview was scheduled in advance at a designated time. The location was quiet (the doctor's consulting rooms were used). The interview was organized around a set of predetermined questions; an interview guide was used. The researcher asked other questions as they emerge from dialogue. The interview lasted from 30 minutes to an hour.

#### **Check list for points of explanation before interview**

The researcher shared the purpose of the interview with the participants before conducting the interview and clarified the topic under discussion and the format of the interview. The participants were told about the approximate length of interview. Confidentiality was assured. The researcher asked the permission to use the digital recorder, explained its purpose and further explained who would listen to the recording. The participants were assured that they might seek clarification of questions, decline to answer a question and that there was an opportunity during the interview to ask questions.

#### **Interview preparation**

Burns and Grove (2006) recommend that interviews are held in a quiet, private room and it has been suggested that the participant should be given the choice of venue. Interviews were conducted in a comfortable quite, private room environment where seats were carefully arranged. However, there were times where other mental health care users would come and disturb the process.

## **Interview process**

Uys and Middleton (2013) describe the interpersonal nursing competencies that the researcher can use to obtain information from the patients. The term interpersonal nursing competencies refer to the particular techniques of communication that the mental health nurse uses with the patient. It is these techniques that make communication between the nurse and patient qualitatively different from that between friends and lovers. These skills may require considerable discipline and practice before being integrated by the nurse to become part of the personal communication style. The purpose of using these therapeutic competencies is to help create a relationship with the patient that he or she experiences as safe, consistent and trustworthy. Once this is established, the patient can explore his/her world-view of relationships and whatever else may be causing difficulty or pain.

Therapeutic communication competencies that the researcher will use as outlined by Uys and Middleton (2013):

- Listening

Listening may imply that the researcher is somewhat passive in the Mental Health Care User's presence. The researcher listened actively to what mental health care users were saying both verbally and non-verbally.

Listening to non-verbal messages

The researcher constantly perceived the Mental Health Care User's body movements; facial expression, quality and tone of voice, gesturers to ensure whether non-verbal message contradicted or confirm what the patient was saying.

Listening to verbal messages

The researcher listened for two types of verbal message namely cognitive and affective messages. With cognitive messages the researcher listened to factual information the mental health care users were conveying and with affective messages the researcher listened to the feelings conveyed by the patient.

- Reflection of feelings

The researcher constantly reflected feelings which involved feeding back to the mental health care users in the researcher's own words, the feelings conveyed by them.

- Timing

The researcher determined the patient's readiness before reflecting his/her feelings. She waited for the patient to finish the sentence and for the reasonable amount of time to elapse before making a reflection, thus giving the patient adequate time to hear the reflection.

- Depth

The researcher determined the Mental Health Care User's ability to receive reflections before going ahead and reflecting feelings to him/her.

- Language and terminology

The language that the researcher used was appropriate to the culture, level of education and intellectual ability of the patient.

- Paraphrasing

The researcher restated the Mental Health Care User's basic message in similar, but fewer words. The researcher translated to the patient the raw data that she is expressing into more precise words, without adding new ideas to the message.

- Clarifying

The researcher made sure she was clarified by the Mental Health Care User if she heard correctly where she could not make sense of the Mental Health Care User's message and where the mental health care users may have given the researcher a lot of information, which needed to be clarified.

- Focusing

The researcher used a focusing technique to direct the attention and the conversation between the Mental Health Care User and the researcher to an important topic or detail. Focusing was used as a way of helping the Mental Health Care User to get in touch with their feelings.

- Questioning

The researcher used open ended questions to get information from the mental health care users.

- Using of silence

Silence was used to allow both the researcher and the Mental Health Care User to think, gather their thought and explore issues further. It motivated the patients to talk, share thoughts or feelings.

- Confrontation

In the process of confrontation the researcher brings a discrepancy to the attention of the patient. This was done empathically to allow issues to be explored in a more moderately regulated fashion.

- Probing

The researcher used probing during interview in order to understand the mental health care users and their responses better.

### **Recording the interview**

An audio recorder was used as it's said it is the most common method of recording interview data (Rubin & Rubin, 2005). A permanent record of the interview is important and the use of a digital recorder is effective and easy. It contributes to a more relaxed atmosphere because the interviewer is freed from the distraction of note taking and can concentrate on interacting with the participant and allows an accurate and verbatim transcription of the interview. Although concerns have been expressed that the interviewee and interviewer might feel inhibited by the presence of the recorder, it can be surprising how quickly a rapport is developed in the author's experience (Braun & Clarke, 2006; Rubin & Rubin, 2005). Interviews were conducted in Sepedi and English and were tape-recorded with the permission of the participants. Then information was transcribed and analyzed to ensure that the research questions were related to the purpose of the investigation. The interviews were recorded and transcripts were made and translated into English by the researcher. The researcher then met with her supervisor and the Independent Coder to reach a consensus regarding the identification of themes and sub-themes.

## **Transcription**

The interviews recorded were transcribed verbatim. This is more challenging than might be expected and is an aspect of the research process that Di Cicco-Bloom and Crabtree (2006) say has not been fully explored. The researcher worked on capturing the wording accurately, playing the recorder back several times to increase accuracy.

## **3.7. DATA ANALYSIS**

Data analysis involves preparing data for analysis, conducting different analyses, moving deeper into understanding the data, representing data, and making an interpretation of the larger meaning of the data (Cresswell, 2009). Recorded interviews were transcribed verbatim and analysed using the descriptive analysis technique described by Tesch (in Creswell, 2009). The eight steps as stated by Cresswell (2009) are:

- The researcher got a sense of the whole by reading all the transcriptions and written field notes carefully which was followed by writing down some ideas as they came to mind. The researcher carefully and repeatedly read the transcripts of all the participants and understood them.
- The researcher rationalized the coding for the existence or frequency of concepts by listing all topics, covered by participants. The researcher grouped similar topics, and those that did not have association were clustered separately.
- The researcher analysed transcriptions of the interview, and went through them asking “what is this about?” and “what is the underlying meaning?”
- The researcher abbreviated the topics as codes next to the appropriate segments of the text. The researcher differentiated by coding the concepts of the collected data to include all meaningful instances of a specific code’s data. Interview schedules and field notes in the separate note books were then colour coded appropriately.
- The researcher developed themes and categories from coded or associated texts and reduce the total list of categories by grouping topics that relate to each other. This has been accomplished by drawing lines between categories that showed interrelationships and categorizing the topics into smaller groups according to the heading that appear in the

results section of the study. The researcher specifically chose coding for the existence or frequency of concepts occurring regarding the factors leading to re-admission of mental health care users at the Thabamoopo Hospital.

- The researcher analysed the results by coding certain segments of the texts attached to certain meaningful key and codes. In practice, this involved reading and re-reading the texts to make sense of the patterns and themes that emerged from the data. In this study, the researcher communicated the analysis of results in the form of themes and categories.
- The researcher collated the coded data belonging to each category in order to perform a preliminary analysis.
- The researcher finally decided on the abbreviation for each category and arranged the codes alphabetically. The researcher ensured privacy and confidentiality of irrelevant information throughout the study.

### **3.8. MEASURES TO ENSURE TRUSTWORTHINESS**

Trustworthiness refers to the ability of the researcher to convince themselves and the participants that the findings of the inquiry are trustworthy. Qualitative research is trustworthy when it accurately represents the experience of the studied participants. There are suggested four criteria for developing the trustworthiness in qualitative research: credibility, dependability, confirmability and transferability (Polit & Hungler, 2008).

#### **Credibility**

According to Polit and Hungler (2008), credibility refers to confidence in the truth of the data and interpretations of them. The truth value of this study was obtained from the mental health care users and their relatives on the factors that lead to re-admission of mental health care users to the hospital. Credibility was achieved through prolonged engagement, the researcher spent three (3) months on data collection activities and debriefing where the researcher reviewed and explored various aspects of this study with parties interested. During data collection the researcher verified what the participants said; and credibility was also achieved through observation of non-verbal cues, the use of well understandable language and discussions with experts in research.

Triangulation was used, which, according to Polit and Hungler (2008), is the use of multiple referents to draw conclusions about what constitutes the truth. The researcher used a phenomenological approach that encompassed qualitative, semi-structured interviews, field notes and observations to collect quality data about the phenomenon under study.

Credibility is achieved through the following features

- Prolonged engagement. The researcher stayed in the field until data saturation occurred.
- Persistent observation. The researcher consistently pursued interpretations in different ways, in conjunction with a process of constant and tentative analysis. She was looking for multiple influences and searched for what counts and what doesn't count.
- Triangulation. The best way to elicit the various and divergent constructions of reality that exist within the context of a study is to collect information about different events and relationship from different points of view. This means asking different questions, seeking different sources, and using different methods. The researcher used the semi-structured interview which allowed her to ask different questions as the participants were responding.
- Peer-debriefing. This is done with colleague of similar status who is outside the context of the study, who has general understanding of the nature of the study and with whom one can review perceptions, insights and analysis. The peer takes the position of the devil's advocate, questions the working hypothesis, assists the working hypothesis, and assists one in the decision regarding which steps to take and so on.
- Member check. One should go to the source of the information and check both the data and the interpretation. The aim is to assess the intentionality of respondents, to correct for obvious errors, and to provide additional volunteer information. It also creates an opportunity to summarise what the first step of the data analyses should be and to assess overall adequacy of the data, in addition to individual data points. The literature was consulted to conclude the findings.

### **Confirmability**

Confirmability refers to the degree to which the findings are the product of the focus of the inquiry and not the biases of the researcher (Babbie & Mouton 2009), a confirmability audit trial must ensure that conclusions, interpretations and recommendations can be traced to their source and if they are supported by the inquiry (Babbie & Mouton 2009). The following were used to ensure confirmability of data when a trial was conducted: field notes and tape-recorded information of raw data available, categorising data using codes and summarising of data analysis and developing themes from the coded data.

### **Transferability**

Transferability refers to the extent to which the findings can be applied in another context or with other participants (Babbie & Mouton 2009). The researcher applied transferability by combining all factors that differ from all individuals leading to re-admission of mental health care users in the Thabamooopo Hospital. Although each respondent may have had their different factors leading to his or her re-admission, all factors were used to make the recommendations that will prevent re-admission of mental health care users.

### **Dependability**

Dependability refers to the stability of data over time and over conditions (Polit & Hungler, 2008). In this study the supervisor did an inquiry audit by structuring the data and by using supporting documents like field notes. The researcher reviewed the literature to verify the findings; the tape-recorded information was used as supporting information.

## **3.9.ETHICAL CONSIDERATIONS**

The following ethical principles as outlined by Parahoo (2006) have been adhered to in this study. These principles assisted in safeguarding patient's right and safety.

- **Ethical clearance and permission to conduct study**

Ethical clearance was obtained from MREC then permission to conduct the study was obtained from the Limpopo Department of Health, from the Thabamooopo Hospital, and from the participants selected for the study.

- **Informed consent**

Information about the importance, purpose and objectives of the study was provided to the participants in a language they could understand. A written consent form was given to the participants to sign as a way of proving agreement to participate in the study.

- **Privacy, anonymity and confidentiality**

Privacy of the participants was maintained in this study by not interviewing the participants in public but by interviewing participants in private consulting rooms of the hospital. All information obtained from the participants was treated as confidential and instead of real names, numbers were allocated to the participants to observe anonymity.

- **Justice**

The principle of justice encompasses the right to fair treatment and the right to privacy. The right to fair treatment: the participants were tactfully treated by respecting their beliefs, habits, culture and lifestyle. An opportunity was provided for each participant to ask questions and to air his or her feelings. The right to privacy was respected because the researcher offered each participant to interview them individually in a private area and by treating data collected with confidence.

The principle of justice refers to equal share and fairness. The researcher adhered to the crucial and distinctive features of this principle by avoiding exploitation and abuse of participants. All the contributions of the participants are acknowledged. The researcher also implemented the principle of justice by listening to every participant without judging them.

### **3.10. CONCLUSION**

In this chapter the researcher has discussed how the study was conducted, explained which research approach and research design were followed, described how data were collected and analysed and who were the participants, and which criteria were used to select those participants, and explained where the study was conducted and how trustworthiness was ensured. Chapter 4 will deal with discussions of results and literature control.

## CHAPTER 4

### DISCUSSION OF RESULTS AND LITERATURE CONTROL

#### 4.1 INTRODUCTION

This chapter describes the findings of the data collected from mental health care users and their relatives on factors leading to re-admission of mental health care users in the Thabamopo Hospital. Four themes emerged from semi-structured interviews, each one of which lasted between 30 to 60 minutes. The themes and sub-themes generated from the study are explained in this chapter. The results will be discussed in relation to the literature available to either support or give a different view based on the themes.

#### 4.2. THE PARTICIPANTS OF THE STUDY.

**Table.4.1.** Characteristics of participants

<b>Characteristic</b>	<b>Number</b>
<b>Participants</b>	
Mental health care users	10
Relatives	02
<b>Gender</b>	
Male	11
Female	01
<b>Age</b>	18-54
<b>Place of residence</b>	
Town	01
Semi-rural	02
Rural	09
<b>No of readmissions</b>	
2 admissions	02
3 admissions	04

4 admissions	03
6 admissions	01
7 admissions	01
8 admissions	01
<b>Mental illness</b>	
Schizophrenia	12
<b>Education level</b>	All the participants are literate grade 5 = 1 grade 7 = 2 grade 10 = 4 grade 11 = 1 grade 12 = 2 tertiary = 2

### **Gender**

Gender in the study was dominated by the male mental health care users. This was due to the fact that the population of the mental health care users at the hospital is predominantly male. Men had volunteered to take part in the study. Only one female consented to take part in the study and she was the relative to one of the mental health care users in the ward.

### **Participants**

Ten mental health care users consented to take part in the study and two relatives to the mental health care users. The Mental health care users were stable during the time of the interviews and they were willing to take part in the study.

### **Number of Admissions**

Number of admissions for mental health care users ranged from two to eight. This was achieved through the help of the mental health care practitioners in the ward and the admission book available in the ward.

### **Nature of illness**

The mental health care users interviewed had declared that they were suffering from schizophrenia. They were all suffering from the same mental condition of schizophrenia

### **Age**

The age of the mental health care users who were re-admitted ranged from 18 to 60, and they all consented to take part in the study (this included the ages of the relatives who took part in this study).

### **Place of residence**

The Mental health care users interviewed were from different places of residences across the province of Limpopo. Nine of them were from the rural villages, two from the location and one of them was from town.

## **4.3. DISCUSSION OF FINDINGS**

Data analysis yielded four themes and eight subthemes which are listed in table 4.2.

**Table.4.2: Themes and sub-themes.**

<b>Themes</b>	<b>Sub-themes</b>
1. Substance abuse	1.1.Abuse of dagga 1.2.Abuse of alcohol
2. Non-adherence to psychiatric medication	2.1.Side effects 2.2.Lack of insight
3. Nature of illness	3.1. Schizophrenia
4. Social problems	4.1.Lack of family support 4.2.Family disorganisation 4.3.Psychological distress

### **4.3.1. Theme 1: Substance abuse**

Substance abuse has emerged as a major reason that has caused re-admission of mental health care users to the hospital. Substance abuse disorders are conditions resulting from the

inappropriate use of alcohol, prescription drugs and/or illegal drugs. These behavioral health disorders may also include a range of addictive behaviors, characterized by an inability to abstain from the behavior and a lack of awareness of the problem (American Hospital Association, 2012; Maharaj, O'brien, Gillies & Andrew, 2013). There is strong evidence for the association of drug and/or alcohol misuse and aggressive behavior which can lead to re-admission (Burnette, Ilgen, Frayne, Luca, Mayo & Weitlauf. 2008; Chermack, Murray, Walton, Booth, Wyrobeck & Blow, 2008).

The retrospective study conducted by Ching-Hau et al. (2010) evaluated relapse in 22 patients with schizophrenia, comparing substance abusers with non-abusers. Medication compliance was ensured as all subjects were treated with deaconate neuroleptics. Substance abuse was documented by multiple urine drug screens. Substance abusers had a significantly higher re-admission rate to the hospital compared to non-abusers. These data suggest that in the presence of documented medication compliance substance abuse remains a major factor contributing towards relapse.

#### 4.3.1.1. Sub-theme 1.1: Abuse of dagga

Most Mental health care users reported to be using drugs as a result of abuse of dagga hence they have been re-admitted to the ward. Dagga (Marijuana) is a green or grey mixture of dried, shredded flowers and leaves of the hemp plant *Cannabis Sativa*. The drug contains a number of substances called cannaboids that affect the brain, heart and lungs (Duckworth and Freedman, 2013).

Marijuana causes a person to feel “high,” which can involve peaceful feelings such as being happy, silly, hungry or tired. People with mental illness are more likely to also experience negative emotions such as depressed mood, anxiety including physical symptoms of shortness of breath and heart palpitations or even paranoia. These reactions are most likely related to the interaction of marijuana with certain chemicals in the brain, including the neurotransmitter dopamine (Duckworth & Freedman, 2013). Based on dagga abuse the participants gave the following information:

Participant no. 2 “... *I stopped taking medications and started smoking dagga. I did not believe that I was mentally ill. I told myself that it was not dagga that made me sick. I thought that my sickness was a result of witchcraft. Somebody was bewitching me...Even if I am sick it can be other things but not dagga. I insisted that dagga doesn't make anyone sick. I even asked them why in Jamaica there are no mentally ill people and I was told that in Jamaica dagga is legalized and there are many Rastafarians. I told myself that since Rastafarians from Jamaica are not sick, I can never be sick. I also observed around and noticed that there are old men who started smoking dagga from childhood up to today but they are not sick. That had made me believe that I can never be mentally ill because of dagga*”

Participant no. 3 “*I started smoking dagga in 1978. I started smoking it because my father was not treating me well. I was all well as I grew up. My father used to give me small amount of money when I went to school. When I got to school, I would buy dagga and sell it to the students at the school with the intention of getting more pocket money. That was what I did. I learned to use dagga that time.*”

Participant no. 4 “*Yes I was taking drugs. I was taking dagga, beer, glue*”

Participant no. 4 “*I started taking dagga and glue. My mother told me she was going to return me to hospital. I stopped taking them but the time I stopped I had already lost weight. So when I came to the hospital for review the doctors noticed that there was something wrong with me. They found out that I was abusing dagga.*”

Participant no 11 “*...I think in the combination of things, dagga and not taking medication...*”

Participant no 12 “*...he (my son) continued smoking dagga...*”

This is confirmed by Batalla et al. (2013) who report that dagga abusers have a significantly higher re-admission rate to the hospital compared to non-abusers and gave the information that substance abuse remains a major factor contributing towards relapse. Therefore, good screening for substance abuse during this phase of the illness may prove useful as a predictor of relapse

Screening of substance use may prove useful to prevent re-admission after the first episode of psychosis. Misuse of tobacco, alcohol, cannabis and other illicit substances is common among people with psychotic illnesses. A high prevalence of substance misuse is also characteristic of

patients with first-episode psychosis, with rates varying from 22% to over 50%. Drug misuse, especially cannabis in the early stages of psychosis, has been associated with younger age of onset, increased symptoms, poorer treatment compliance, higher rates of relapses and more hospitalizations (Batalla et al., 2013).

Prince et al. (2009) report that people with drug or alcohol abuse had baseline hospitalization odds that were more than 3 times greater than those of their non-abusing counterparts after adjustment for all other independent variables. These odds were comparable to the adjusted odds of admission relating to comorbid anxiety or personality disorder. By contrast, the adjusted odds of admission associated with co-occurring substance abuse were much greater than were those for medical comorbidity.

#### 4.3.1.2. Sub-theme 1.2: Abuse of alcohol

Some of the mental health care users reported that they were readmitted in the hospital because they had abused alcohol

Participant no 4: *“I only found out now after relapse when the doctors asked if I was taking beer. When I told them I was taking beer, they said that was the reason why I had relapsed, because I was taking beer almost every day.”*

Participant no 6: *“They said that they are from the hospital and they were told that a mentally ill person must not mix beer with medication. That is when they called the social worker. The social worker called me while I was at the tavern and found out that I was indeed drinking. He organized that I must come for review. I then came, and I was re-admitted...Yes it was beer, my younger brother said if I continue taking beer he would never come take me again”*

Prince et al. (2009) together with Xafenias, Diakogiannis, Iacovides, Fokas and Kaprinis (2008) reported that people with alcohol abuse had baseline hospitalization odds that were more than 3 times greater than those of their non-abusing counterparts after adjustment for all other independent variables. These odds were comparable to the adjusted odds of admission relating to comorbid anxiety or personality disorder. By contrast, the adjusted odds of admission associated with co-occurring substance abuse were much greater than were those for medical comorbidity.

It is found that alcohol related problems and non-compliance with medication were the most important factors related to frequency of hospitalizations. It seems that a small proportion of patients account for a disproportionately large share of psychiatric hospitalization (Ching-Hau et al., 2010).

#### **4.3.2. Theme 2: Non-adherence to psychiatric medication**

WHO (2003) defines adherence as the extent to which a person's behavior such as taking medication, following a diet, and/or executing lifestyle changes, corresponds with agreed recommendations from a health care professional. According to Sajatovic et al. (2010), non-adherence is a serious problem in psychiatric treatment and compromises effectiveness. In schizophrenia, full or partial non-adherence can exceed 60% and is associated with relapse, hospitalization, and elevated health care costs. In bipolar disorder, non-adherence ranges from 20% to 60% and is associated with poorer outcomes, elevated rates of relapse, hospitalization, suicidal behavior, and greater costs of care. Thirty percent of patients stop taking antidepressants after one month and 45–60% after 3 months. Inadequate adherence to antidepressants may lead to increased recurrence, severity, and disability, poorer responsiveness to future treatment, greater health care cost and re-admission (Sajatovic et al., 2010; Balikci, Erdem, Zincir, Bolu, Zincir, Ercan, & Uzun. 2013 ).

It has been reported that non-adherence affects the course of the illness adversely and increases its economic burden. Non-adherence to treatment decreases the quality of life, causes readmission to the hospital and increases the risk of suicide (Colom & Lam, 2005). The following sub-themes were discovered under non-adherence

##### **4.3.2.1. Sub-theme 2.1: Side effects**

The participants mentioned the side effects as the contributory factors for them not comply with the treatment.

Participant no 1: *“Oh yes I was, I even knew the names of the tablets I was taking. The thing is I was taking tablets irregularly. Sometimes I would take the Disipal only just to do away with the side effects. I would only take Disipal, and then in the evening I would take only Epilim 600 and sleep”*

Participant no. 4: *“Yes I did even though I think I was given a low dose medication. I was taking Serenace. Then I suffered side-effects I was shivering the whole body, after the side effects I went to Mankweng Hospital, the doctor changed my medication and I started taking Risperdal 1mg only. Even when I was re-admitted again in this hospital I was taking Risperdal 2mg but I was still psychotic. I thought that Risperdal was a low dose. I was taken back to Serenace I then became ok.”*

Participant no 8: *“I happened to change my treatment twice because of side-effects but the medication I am taking now it’s working well for me.”*

Hamer and Haddad (2007) gave information about the types of side effects that can lead to non-adherence which contribute to re-admission of mental health care users. They said that antipsychotic drugs are associated with adverse effects that can lead to poor medication adherence, stigma, distress, impaired quality of life and re-admission to the hospital. Antipsychotics are associated with a wide range of potential adverse effects which can affect the patient in several ways. This includes the stiffness, slowness of movement and tremor of antipsychotic-induced Parkinsonism) can make it difficult for a patient to write, fasten buttons and tie shoelaces, leading to reduced quality of life. The blank ‘mask-like’ expression, tremor, stooped posture, drooling and abnormalities of gait (including lack of arm swing) are easily observable by others and mark the patient out as ‘different’, hence contributing to stigma. When severe, the festinate gait may result in falls and injury, particularly hip fracture in older patients. Patients who recognise the link between these problems and antipsychotic medication may miss out doses or stop medication totally.

Sexual dysfunction is a significant source of distress and may be linked to poor adherence and later readmission. A study has been done on DSM–IV schizophrenia patients who were receiving an antipsychotic but no other medications associated with sexual side-effects (Quinn, Happell & Browne, 2012). Sexual dysfunction occurred in 45.3% of the group and was associated with

significantly lower ratings on global quality of life. Rosenberg et al. (2003) examined the effects of sexual side-effects on adherence. They found that 62.5% of men and 38.5% of women felt that their psychiatric medications were causing sexual side-effects; 41.7% of men and 15.4% of women admitted that they had stopped their medications at some point during treatment because of sexual side-effects. It is also reported that mental health care users never spoke about sexual functioning with their primary mental healthcare providers, and 80% of the women with sexual side-effects had not discussed sexual dysfunction with their mental healthcare providers, and they were re-admitted back to the hospital (Mitchell & Selmes, 2007). This reported avoidance of sexuality in nursing is not restricted to mental health nursing (Mick, 2007; Quinn, Happel & Browne, 2011). It has been reported that nurses have an opportunity to address sexuality users across a broad range of specialty areas (Albaugh & Kellog-Spadt, 2003, Volman & Landeen, 2007).

#### 4.3.2.2. Sub-theme 2.2: Lack of insight

Lack of insight happens when a person cannot appreciate that they have a serious psychiatric illness. Having a lack of awareness raises the risks of treatment and service non-adherence. From the person's or the mental health care user's point of view, if they feel they are not ill, they ask themselves why they should go to appointments, take medication or engage in therapy (National Alliance of Mental Illness. 2014).

Participant no. 2: *"For the second time, after the first admission when I got home I stopped taking medications and started taking dagga. I did not believe that I was mentally ill."*

Participant no. 6: *"I stopped taking medication telling myself that I was not sick."*

Participant no. 2: *"I do take the medications well although I mix them with dagga."*

Participant no. 5: *"I was taking medication even though I was mixing it with the drugs and these two things can never mix; the drugs reduce the strength of medication. The last thing that will happen is that you will end up sick"*

Participant no. 13: *"I sometimes think maybe because he was smoking he would mix drugs and medication that's why it was ineffective."*

Participant no. 3: *“I would take treatment very well for the first five months of my discharge from there I would tell myself that I am healed, then I would stop taking pills, then I will be ill again.”*

Participant no. 7: *“I took medication well and at home I wasn’t smoking. But it happened that one day I went to visit my uncle I left my medication at home. When I came back my sister called the police to take me to the hospital...I had relapsed because I spent too much time at my uncle’s place, then I was taken to Letaba Hospital”*

Participant no 12: *“We know that he was not taking medication very well because for the first time when we came back from the hospital we check how much medication they have given us. At the time he changed condition when knew how much medication he should’ve taken and how much is remaining. When we count we found out that there was still a lot of medication that was not taken and that gave us a lot of concern”.*

The study conducted by Omranifard et al. (2008) indicates that lack of insight of mental health care users about their condition and non-compliance to psychiatric medication are possibly causes re-admission in the psychiatric hospital. They indicate that the mental health care users lack insight to their condition and thus they fail to take the medication they are supposed to take after discharge at home.

The self-stigma, self-esteem, self-efficacy, insight, and psychosocial treatment adherence among mental health care users suffering from schizophrenia were assessed. The results revealed that high self-stigma, low self-esteem, and poor insight were significant predictors of treatment adherence further leading to re-admission of Mental Health Care Users. Among these predictors, self-stigma was shown to be the strongest in terms of its prediction power. Self-stigma is defined as a self-discredit of individuals by internalizing negative stereotypes prescribed to them and/or their social group. Self-stigmatized individuals are likely to possess low self-esteem and poor adherence behaviors and this is common to mental health care users before they get readmitted (Tsang et al., 2010).

The underlying causes for higher re-admissions rates among mental health care users may vary across different communities and health care systems. However, two major contributing factors to frequent re-admission are believed to be a lack of insight and medication non-adherence or defaulting of treatment, which are well documented in this population. In 2007, the cost of re-

hospitalization of patients with schizophrenia owing to medication non-compliance was estimated to reach US\$1.5 billion in the United States, (Nakhost et al., 2012). Substance abuse variables contribute more to non-adherence to treatment (Ingersoll, 2004).

### **4.3.3. Theme 3: Nature of illness**

Most of the mental health care users reported that they were suffering from schizophrenia. According to Chang et al. (2013) many schizophrenia patients tend to be repeatedly hospitalized in acute or chronic ward settings instead of returning to their communities.

Schizophrenia is a chronic and persistent serious mental illness that requires ongoing treatment. Although disease onset may be abrupt, the majority of patients with schizophrenia have a slow and gradual development of various clinical signs and symptoms. Some patients with schizophrenia may present with a range of developmental, behavioral, emotional, and cognitive impairments during childhood, which is characterized as the pre-morbid phase (Tandon, Nasrallah, Keshavan, 2009; Javitt, 2014).

#### **4.3.3.1. Sub-theme 3.1. Schizophrenia**

Schizophrenia is a chronic brain disorder that affects the way a person acts, thinks, and sees the world. People with schizophrenia have an altered perception of reality, often a significant loss of contact with reality. They may see or hear things that don't exist, speak in strange or confusing ways, believe that others are trying to harm them, or feel like they're being constantly watched. With such a blurred line between the real and the imaginary, schizophrenia makes it difficult even frightening to negotiate the activities of daily life. In response, people with schizophrenia may withdraw from the outside world or act out in confusion and fear (Smith & Segal. 2014).

Schizophrenia disease is often characterized by episodes of relapse alternating with periods of complete or partial remission. Successive relapses can reduce the degree and duration of the following remission, worsen disability, and increase refractoriness to future treatment. Relapses are associated with high medical and non-medical costs as well as productivity loss thus re-

hospitalization, which is frequently the most expensive healthcare cost component for psychotic patients, is a relevant relapse measure (Lafeuille, Laliberté-Auger, Lefebvre, Frois, Fastenau & Duh, 2013).

Participant no 1: *“Yes I know, I am suffering from schizophrenia”*

Participant no 2: *“Yes I know my condition. The doctors told me that I am suffering from schizophrenia”*

Participant no 3: *“Yes I am suffering from schizophrenia.”*

Schizophrenia is a chronic mental disease which provokes repulsion of the social and environment of the patients. Stigmatism of schizophrenia patients is one of the causes that they are hospitalized much more frequently in comparison to other categories of psychiatric patients (Djokic et al., 2008).

Schizophrenia affects approximately 1% of the general population and causes impairments in patient functioning, such as self-care, interpersonal relationships, and occupational skills. Many schizophrenia patients tended to be repeatedly hospitalized in acute or chronic ward settings instead of returning to their communities (Chang et al., 2013).

Rosca et al. (2006) reported that a diagnosis of schizophrenia is a strong predictor of re-admissions, involuntary admissions and length of stay. One possible explanation is that schizophrenia is the most severe and incapacitating of the mental disorders. The literature shows that earlier age of onset is associated with more severe psychopathology, course and outcome. Furthermore, young people in the early phases of schizophrenia are less stable than older people, and hence they may require more frequent or prolonged hospitalizations. In accordance with that, they also found that early age of onset was a useful predictor of increased number of re-admission (Rosca et al., 2006).

Some psychiatric patients, especially those suffering from schizophrenia, require repeat hospitalizations owing to the risk of danger that they pose to themselves or the public at large. In Canada in 2003-2004, 37% of patients who were admitted to a hospital for a psychiatric illness were re-admitted (all-cause readmissions) within a year of their index admission, compared with 27% of patients with non-psychiatric illnesses re-admitted during the same time period.' Re-

admission rates were highest among patients with schizophrenia and comorbid substance abuse disorders (Mojtabi et al & Madi et al 2007). Relapses and re-hospitalisations worsen the prognosis of patients with schizophrenia (Knapp, Mangalore & Simon. 2004).

#### **4.3.4. Theme 4: Social problems**

Mental disorders have many social risk factors which are interlinked. Although family difficulties increase the risk for mental disorders, they are clearly determined by the cohort member's low education and financial hardship (Paananen, Ristikari, Merikukka, & Gissler, 2013)

Children raised by their own parents, when those parents share a mutually satisfying relationship, are advantaged on many dimensions, such as psychological adjustment and school attainment (Amato, 2010). Couple distress and separation have a high prevalence in developed countries. Relationship distress is strongly linked to psychological and physical health problems in the adult partners and their offspring and is among the most frequent primary or secondary concerns reported by individuals seeking assistance from mental health professionals (Lebow, Chambers, Christensen & Johnson. 2012; Snyder, Castellani & Whisman, 2006).

##### **4.3.4.1. Sub-theme 4.1: Lack of family support**

Johns, Flaxman, Gomez, Bockian and Hall (2007) found out that the mental health care users who lack social support and visits from the family while in the hospital were prone to be re-admitted in the hospital.

Participant no 4: *“Yes they (my family) never supported me much.”*

Participant no.8: *“I don’t like my sister in law; even the way they treated my mother was not good. They would call my mother names. That could have contributed to my mental illness... Yes I think they listen to their wives too much. I just don’t know where I will get help. Only if a can get a help from a person who can help me I would be happy. I want to be around people who can*

*understand me. These things of living with people like you are cat and they are mouse it's a problem"*

This was confirmed by American Hospital Association (2012) when they said patients with comorbid mental and physical health conditions are re-admitted for a broad range of reasons. Specifically, these patients have multiple health conditions, may lack a strong support system, and may not adhere to treatment regimens. These factors can impede recovery and increase the likelihood that mental health care users will return to the hospital. Stigma is cited by mental health service users above poverty, isolation and homelessness as a main source of social exclusion in both people with current and those with previous mental health problems. The overall attitudes towards such people remain, in most respects, as profoundly negative as they were a decade ago despite the improvements in public awareness and knowledge about mental illness. For some individuals, the problems are compounded by additional discrimination on the grounds of their ethnicity, cultural background or sexuality. As many as nine out of ten people using mental health services say they experience discrimination in more than one area of life (Thornicroft, 2006).

A label of having a mental illness makes it harder to get life, personal or holiday insurance and can affect access to leisure facilities and other community activities. Negative attitudes to mental ill health can adversely affect policy development, usually through omission of relevant mental health issues. In the media, mental illness is typically represented in distorted stereotypes, which can foster fear and stigma among the general public. It also contributes to false and extremely damaging perceptions of the violence caused by people with mental health problem (King and McKeown, 2003).

Family overprotection and lack of care is associated with a higher risk of mental disorders, shedding light on the relative importance of both caregivers in their offspring's disorders. With regard to overprotection, only family overprotection was found to be related to the subsequent onset of mental condition of major depressive disorder. In contrast, family lack of care was longitudinally associated with panic disorder, agoraphobia and alcohol abuse, and paternal lack of care was longitudinally associated with major depressive disorder, dysthymia, social phobia, drug abuse, and alcohol dependence significantly associated with the prevalence and incidence of several mental disorders hence this is what mental health care users suffered before their re-

admission, some resorted to drugs because lack of care from their families. However, the impact of family bonds was found to be small, explaining only 1–5% of the variance in the prevalence and onset of psychopathology in adults (Overbeek, Vollebergh, Meeus, De Graaf and Engels, 2004; Overbeek, Vollebergh and de Graaf, 2007)

#### 4.3.4.2. Sub-theme 4.2: Family disorganisation.

Family disorganization was found to have contributed to the re-admission of the mental health users.

Participant no 3: *“My father is staying with my stepmother in their own house. He built a house for my stepmother. The reason I am not in good terms with my stepmother is that, my stepmother was my father’s maid so she ended up being in a relationship with my father. My mother was divorced because of my stepmother, so this issue disturbed me a lot in my mind. I also think the reason why I failed at school is because of such social problems. Back then there were only few social workers and we black people did not know them. We didn’t know there were people who could help.”*

Participant no 5: *“I had some social problems. The other thing that contributed was the divorce of my parents, my mom and my first stepfather. That contributed in me taking drugs”.*

Vulnerability to both physical and mental illness can originate in the traumatic loss of one or both parents through divorce (Block & Spiegel, 2013). The issue of mental illness with regard to family disorganization was outlined by Desai (2007) who conducted the research comparing children of divorced parents to children with married parents. It revealed that children from divorced homes suffer several mental problems and they are more likely to be readmitted back to the hospital if they were once admitted. They experience high levels of behavioral problems. They don’t do well at school, and they are less likely to graduate from high school. They are likely to be incarcerated for committing a crime as a juvenile. Because the custodial parent’s income drops substantially after a divorce, children in divorced homes are almost five times more likely to live in poverty than are children with married parents. Teens from divorced homes are much more likely to engage in drug and alcohol abuse, as well as sexual intercourse than are

those from intact families. Children from divorced homes experience illness more frequently and recover from sickness more slowly. They are also more likely to suffer child abuse. Children of divorced parents suffer more frequently from symptoms of psychological distress. And the emotional scars of divorce last into adulthood.

Royal College of Psychiatrists (2014) reported that the emotional and behavioral problems in children are more common when their parents are fighting or separating. Children can become very insecure. Insecurity can cause children to behave like they are much younger and therefore bedwetting, 'clinginess', nightmares, worries or disobedience can all occur. This behavior often happens before or after visits to the parent who is living apart from the family. Teenagers may show their distress by misbehaving or withdrawing into themselves. They may find it difficult to concentrate at school. Such social problems can lead to re-admission.

#### 4.3.4.3. Sub-theme 4.3: Psychological distress.

Psychological distress is a general term used to describe unpleasant feelings or emotions that impact ones level of functioning. In other words, it is psychological discomfort that interferes with ones activities of daily living. Psychological distress can result in negative views of the environment, others, and the self. Sadness, anxiety, distraction, and symptoms of mental illness are manifestations of psychological distress (Williams, 2014).

Participant no 4: *“Yha, I had social problems... I had a problem that I had a child at home whom I left home; I took care of that child with the money that my mother left for me. They didn't take care of her at that time I was at school. I wasn't able to provide for the child... I started having stress”.*

Participant no 8: *“Every time I see my daughter I remember her mom. I always wish her mother was alive to see her. She is very bright. She stays with her maternal grandmother. I usually go to see her”.*

Participant no 9: *“The other thing that worries me is that not having parents is difficult. I wish I had also had a sister to take care of me. My brothers are trying but because they are men like me their support is not that much. My brothers have wives and kids and I have nothing in total. My*

*brother told me that I must get a wife. If I had a sister she would get me a wife from church or from where women meet”.*

Participant no 10: *“I was readmitted...Yes and I am also protecting my sister’s job”.*

Participant no 11: *“We were saying is he stressed that he has be taken off from the boarding school. But then even now that for some time he started not going to school, we started noticing some of his friends that they were dubious friends. We were concerned as a family and as parents and then we took him to our private practitioner to assess his situation and then he referred him to Polokwane Hospital where after some evaluation and noticing his aggressiveness they decided that he should come to Thabamooopo hospital”.*

Psychological distress can lead to re-admission of mental health care users. Haines (2005) states that depression can be triggered by other mental illnesses, but it can also lead to certain mental illnesses. These include anxiety disorders, schizophrenia, eating disorders and substance abuse hence there can be re-admissions to psychiatric hospital if once admitted. Together, these conditions affect millions of people each year. Fortunately, they can be treated effectively allowing those affected to lead normal and productive lives. Millions of people abuse drugs or alcohol for a variety of reasons, including coping mechanisms for stress and anxiety or biological factors, such as a genetic tendency and this can lead to re-admission of the psychiatric patients to the hospital.

#### **4.4. CONCLUSION**

In this chapter the researcher managed to explore different factors that led to readmission of mental health care users back to the psychiatric hospital. The factors were grouped into themes which help the researcher to analyze the problems. The themes identified were: substance abuse, non-adherence to psychiatric medication, nature of illness and social problems. Chapter 5 will deal with Guidelines, Limitations and Recommendation.

## **CHAPTER 5**

### **GUIDELINES, RECOMMENDATIONS AND LIMITATIONS**

#### **5.1. INTRODUCTION**

This chapter provides a summary of the research report, and a description of the recommendations of the study. The recommendations are based on the identified themes. The limitations of the study are also discussed.

#### **5.2. SUMMARIES ABOUT THE STUDY**

##### **Aim of the study**

The aim of this study was to explore the factors leading to re-admission of mental health care users at the Thabamooopo Psychiatric Hospital, Limpopo Province.

##### **Research question**

What are the factors leading to re-admission of mental health care users at Thabamooopo Psychiatric Hospital, Limpopo Province?

##### **Objectives of the study**

- To identify factors leading to re-admission of mental health care users in Thabamooopo Psychiatric Hospital, Limpopo Province. This was achieved by conducting interviews with the mental health care users and the relatives of mental health care users who were readmitted in Thabamooopo Hospital.
- To determine the guidelines for prevention of re-admissions of mental health care users in Thabamooopo Psychiatric Hospital, Limpopo Province. This was achieved as a result of the themes and the subthemes that emerged from the data analysis. The conclusion made the researcher to present these guidelines.

### **5.3. FINDINGS OF THE STUDY**

The findings of the study indicated the following themes as already discussed in the previous chapter.

#### **Theme 1: Substance abuse**

The participants in this study declared that they were abusing substances. The main substance that was abused is dagga followed by the abuse of alcohol. This is the main reason that made the mental health care users to be re-admitted. They also admitted to have been taking dagga while in the hospital and mixing dagga with psychiatric treatment.

#### **Theme 2: Non-adherence to medication**

The participants declared that they were not adhering to the to the medication prescription. Some said they stopped taking medication because they thought they were healed while others said there were times when they would visit their relatives far away from home without their medications and that contributed to their relapse and their re-admission.

#### **Theme 3: Nature of illness**

All the mental health care users who were interviewed were suffering from schizophrenia. Mental health care users with schizophrenia have more chances to be admitted to the mental hospital than those who suffered from other mental illnesses.

#### **Theme 4: Social problems**

Some of the participants declared that they had some social problems that contributed to them being admitted to the hospital. The social problems included the divorce of the parents, lack of family support and the stress and psycho-social distresses that comes with daily living challenges.

### **5.4. GUIDELINES TO PREVENT RE-ADMISSION**

In this study, the information gathered from the participants indicated substance abuse, non-adherence to medication, nature of illness and social problems as the themes. The guidelines on these include the following:

## **Substance abuse**

This information can be given to the mental health care users as a way to reduce re-admissions.

- Commit to stop abusing drugs or alcohol

Mental health care users wondering how to quit abusing drugs may find that committing to stop abusing drugs this can be an excellent first step. Getting sober can take a lot of time and effort, so mental health care users who can find reasons to stop and state them with clarity often have better chances for recovery. Whenever the Mental health care users' wants to know how to quit taking drugs or how to stop drinking alcohol, making the commitment to quit must include a firm promise to remain substance-free (Recovery, 2013).

- Setting goals for conquering addiction

More important than knowing how to stop abusing drugs or how to quit drinking alcohol is setting goals that make the process less stressful. Mental health care users should set realistic goals, both for the short and long term. Gradually quitting helps mental health care users prepare for eventually living a drug- or alcohol-free life (Recovery, 2013).

- Find healthy ways to cope with stress.

Many people begin using drugs as a way to deal with stress and tension. The reality is, however, that drugs are only a temporary fix. Finding coping methods such as exercise or meditation can eliminate the urge to try drugs (Seeley, 2013).

- Seek therapy or counseling.

It is not at all uncommon to experience feelings of depression. Many people experience highs and lows that can be difficult to cope with. Drug users often are people who are attempting to self-medicate for their psychological issues. The problem is that drugs do not treat mental issues themselves. They simply treat the symptoms. Working through problems with a mental health professional is a much more effective and long-lasting way of treating a psychological or emotional problem (Seeley, 2013).

- Maintain a lifestyle that makes you happy.

Low self-esteem and depression are major triggers for drug abuse. It is easy to let one aspect of one's life, such as work, become overwhelming, to the point that one does not enjoy or partake in

other important aspects of one's life. Maintaining strong relationships and a healthy balance between physical and mental activity can help to maintain the stability that is needed to stay drug free (Seeley, 2013; Treatment solutions, 2013).

- Have things in your life that you care deeply about.

Whether it's a sport, artistic endeavor, or personal relationships, having something that one is passionate about motivates to stay healthy and mentally and emotionally in shape. If one cares deeply enough about the people and activities in one's life, one is less likely to jeopardize them by experimenting with drugs (Seeley, 2013).

- Be aware of your family's history with substance abuse.

The tendency toward addiction is linked to genetics, so be familiar with any parents or other family members who have struggled with addiction. If you know that you have a higher chance of becoming addicted, take extra precautions to avoid drugs and alcohol (Seeley, 2013).

- Create a support network

There is much evidence that drug mental health care users and alcoholics have much better success rates for recovery if they have a strong network of friends, family and others who have been in the same situation. With the right support system in place, many mental health care users find themselves conquering what they thought was an impossible struggle. With this support, the mental health care users will know there is always someone who understands the issue at hand to talk to and who will help talk the mental health care user down when he or she is feeling tempted. By the same token, the mental health care users should take steps to avoid being around those who have not made the commitment to quit, as old habits can resurface in an instant (Recovery, 2013, Treatment solutions, 2013).

- Live drug or alcohol-free

Once a recovery plan is in motion, it is important to understand that recovery does not happen in a day. Mental health care users should plan how to overcome temptation, as there are always people around who will encourage or pressure them to fall back into old habits. The Mental health care users should also plan how to stop cravings and have a process in place to deal with these as they occur. Distractions such as music, art or exercise can help the process along, as these things break the cycle and create new and healthy habits to replace old ones. Mental health

care users can also make lists during tough times to remind them why they need to get sober and what is at stake should they fail (Recovery, 2013).

### **Adherence to psychiatric medication**

- Mental health practitioners should be aware that mental health care users are more likely to adhere to medication regimens when they are convinced that the medication they are taking is clearly linked to future health and wellness and when they are made an active participant in the decision-making process regarding the medications. Failure to tackle adherence issues early may cost the mental health care practitioners more time and energy later (Jimmy & Jose, 2008).
- Linking a medication schedule with other daily activities can be used. Mental health care users can be told, for example, to place their medication schedule next to their toothbrush as a mnemonic strategy in that they would be reminded of their medication schedule every time they brushed their teeth. A Mental Health Care User's reminders can be linked to other daily routines that match the medication intervals related to the Mental Health Care User's recommended medication dose and the frequency and duration of the medication schedule (Jimmy & Jose, 2008).
- The Mental Health Care User's family can help ensure medication compliance. Routine automated phone call reminders can also serve to periodically remind the Mental Health Care User of the proper medication regimen (Jimmy & Jose, 2008, Gottlieb, 2008; Behavioural Health Evolution, 2014).
- Some health care workers give education, which can include audio-visual aids, and distribute educational materials to mental health care users during evening classes held in the physician's office. The classes serve as an opportunity to inform the Mental health care users about the disease and how best to handle it, including the importance of medication adherence (Jimmy & Jose, 2008). Education and reminders can be helpful,

but if a Mental Health Care User is fully convinced that the medication is causing mental health disorder symptoms, switching medications may be an option to address this problem (Behavioural Health Evolution, 2014).

- Drug manufacturers can also provide once-a-day medications, when feasible, and more user friendly dosage forms. They can offer products that have simpler regimens, rather than multiple-dose regimens, and they can discourage awkward packaging of medications by favoring single-unit packaging (Jimmy & Jose, 2008).
- If the Mental Health Care User reports side effects, or changes the way he or she takes medications due to side effects, prescribers should do their best to address the problem. Full empathic attention to the difficulty and reassurance that it will subside is sometimes enough to reduce the concern. Serious side effects or ones that interfere with functioning should be addressed by changing the timing or dose of the medication, by taking the medication with or without food, or by using another medication to alleviate the problem. At times, a medication switch will be required to address non-adherence (Gottlieb, 2008). The mental health care practitioners must let go the practice of avoiding discussions about the sexual side effects of medication (Higgins, Barker & Begley, 2008; Magnan, Reynolds & Galvin (2005).
- It is important to remind people that medication is one important tool they can use in their own personal recovery path. The Mental health care users may want to shop around for peer support groups to find one that is more supportive than the other of people with co-occurring disorders (Behavioural Health Evolution, 2014).

### **Nature of illness**

Schizophrenia can sometimes run in families, but there is no one specific gene that causes it. It may be a combination of many genes or genetic variations that may put some people at a higher risk for others who get schizophrenia; there may be no signs of a family history of the illness. It

is possible that someone has genes linked to schizophrenia and then faces events that make them more likely to develop the disorder (Robinson, 2005).

There is no way to prevent schizophrenia, but the earlier the illness is detected, the better are the chances to prevent the worst effects of the illness. Schizophrenia is never the parents' fault. But in families where the illness is prevalent, it may make sense to pursue genetic counseling before starting a family. Educated family members are often in a better position to understand the illness and provide assistance. Schizophrenia requires a combination of treatments, including medication, psychological counseling and social support (Smith, Saisan & Segal, 2014).

Psycho-education and self-management education can be employed as the strategies that can assist in reducing the re-admission rate of mental health care users. Psycho-education provides disease-specific information, and self-management education which teaches problem-solving skills which allow patients to take appropriate actions to improve their health (Vreeland, Minsky & Yanos, 2006). The Mental health care users can be educated on the following Schizophrenia Prevention Tactics as outlined by Schizophrenia (2010) and Robinson (2005):

- Don't use street drugs, and moderate any use of alcohol
- Make an ongoing effort to develop your social skills as much as you can
- Avoid social isolation
- Make an ongoing effort to maintain friendships with adults
- Make an extra effort to learn positive perspectives on the world
- Make extra effort to learn how to deal with stress and anxiety
- Seek help from qualified psychologists and psychiatrists if you have problems coping

The patients subjected to continuous follow-up show a trend towards a lower overall risk of re-admission and a significantly reduced risk of involuntary admission (Kikuchi, Abo, Kumakura, Kubota & Nagano, 2013), to the extent that re-admissions may be avoidable. Medication management, group psycho-therapy, and inpatient hospital stays are the primary treatments provided to patients who enter an inpatient psychiatric hospital (Lang, Rohrer & Rioux 2009).

## **Social problems**

Family meetings and collateral contact with patients' family/friends have been useful in understanding the role that families may play in contributing to mental health problems as well as identifying what supportive measures the family can offer. Outcome studies have indicated benefits of family involvement in hospital treatment, although at times patients themselves may be hesitant to involve family due to embarrassment and privacy issues. The use of family meetings and collateral contacts can be useful (Perreault, Tardif, Provencher, Paquin, Desmarais, Pawliuk, 2005)

Smith, Saisan and Segal (2014) said that having a strong support system will speed up recovery. Isolation fuels depression, so the patient should reach out to others, even if he or she feel like rather being alone or does not want to feel like a burden to others. The truth is that most people will be happy that they chose to confide in them; they will be flattered that someone trusts them enough to open up. So, mental health care users should let their family and friends know what they are going through and how they can support them. If support from family and friends, positive lifestyle changes, and emotional skills building are not enough, they should seek help from a mental health professional. There are many effective treatments for depression, including therapy, medication, and alternative treatments. Families with social adversities and with parental mental health problems should be supported to secure children's development (Paananen et al, 2013).

Effective treatment for depression often includes some form of therapy. Therapy gives you tools to treat depression from a variety of angles. Also, what you learn in therapy gives you skills and insight to prevent depression from coming back. Some types of therapy teach you practical techniques on how to reframe negative thinking and employ behavioral skills in combating depression. Therapy can also help you work through the root of your depression, helping the mental health care users understand why they feel a certain way, what triggers depression, and what they can do to stay healthy (Haines, 2005). Previous reviews show that several approaches to couple therapy produce statistically and clinically significant reductions in relationship distress (Sharma, Pandit, Pathak, & Sharma, 2013).

## **5.5. RECOMMENDATIONS**

Based on the findings, the following recommendations were considered for psychiatric incorporating practices which include the mental health care practitioner, the family, the mental health care users and research.

### **Mental health care practitioners should:**

- Provide care and rehabilitation to the mental health care users to the best of their ability.
- Provide relevant medication and teach mental health care users about medications and their importance.
- Do thorough psycho-education on dangers of substance abuse.
- Encourage young couples to go for genetic counseling before marriage for those who are prone to schizophrenia.
- In case of social problems, give information on where to go and also be assisted on how to get there.
- Encourage patients to honor their follow-up dates so that changes on the users can be detected early.
- Provide a follow up visit for mental health care users at home.
- Make contact with the nearest clinics on monthly basis for the progress of the mental health care users.

### **Mental health care users should:**

- Contribute to and participate in their own health.
- Take responsibility of taking care of themselves and taking the treatment.
- Take medications as prescribed.
- Go the hospital as soon as possible when the medication is giving them problems, such as side effects.
- Take the decision to stop substance abuse and seek help if they fail.
- Engage in recreational activities that can take them out of drugs.
- Avoid living with friends who can easily lead them to drugs

- Seek help and ask advices on the situations that can easily disturb their mind.

**The family should:**

- Be supportive to the mental health care users.
- Treat mental health care users as human beings.
- Get to know more about mental illness.
- Assist the Mental health care users into being mentally healthy by reminding them about treatment and the review dates.
- Consider their own mental health, too and seek help where necessary

**Research**

Further research is recommended on the following:

- The impact of the absence of parents on the mental health of the children.
- The influence of the family on the mental health of the mental health care users.
- The experiences of the nurse with regard to re-admission of mental health care users.

**5.6. LIMITATIONS OF THE STUDY**

The study was conducted in one hospital of the Lepelle-Nkupi Municipality in the Capricorn District of the Limpopo Province in South Africa. Therefore, the findings cannot be generalized to other hospitals in other provinces.

**5.7. CONCLUSION**

In order to solve the problems related to re-admission of mental health care users, the mental health care practitioners, mental health care users and the families must be involved. Mental health care practitioners must not get weary of giving the mental health care users and their families' information about the mental illness and what need to be done by both mental health

care users and their families. Family support is important to help mental health care users cope with the situations they are challenged with when they are home.

## REFERENCES

- Albaugh, J. A., Kellogg-Spadt, S. 2003. Sexuality and sexual health: the nurse's role and initial approach to patients. *Urologic Nursing*, 23(3), 227-228.
- Amato, P. R. 2010. Research on divorce: continuing trends and new developments. *Journal of Marriage and the Family*, 72(3) 650–666.
- American Hospital Association. 2012. Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes. Available at <http://www.aha.org/>. Accessed 13 July 2013.
- AmerSiddiq, A. N., Aida, S. A., Zuraida, N. Z. and Abdul Kadir, R. 2010. *Factors Affecting Re-admission in a Teaching Hospital in Malaysia*. Available at <[http://www.academia.edu/184255/Factors\\_Affecting\\_Re-admission\\_in\\_A\\_Teaching\\_Hospital\\_in\\_Malaysia](http://www.academia.edu/184255/Factors_Affecting_Re-admission_in_A_Teaching_Hospital_in_Malaysia)>. Accessed 08 March 2013.
- Ayorinde, O., Gureje, O and Lawal R. 2004. Psychiatric research in Nigeria: Bridging tradition and modernisation. *Journal of Psychiatry*, 184, 536–538.
- Babbie, E. and Mouton, J. 2009. *The practice of social research*. Oxford: Oxford University Press.
- Balikci, A., Erdem, M., Zincir, S., Bolu, A., Zincir, S., Ercan, S. and Uzun, O. 2013. Adherence with Outpatient Appointments and Medication: A Two-Year Prospective Study of Patients with Schizophrenia. Randevu ve tedaviye uyum: Şizofreni olgularıyla iki yıllık ileriye dönük çalışma, *Klinik Psikofarmakoloji Bulteni*, 23(1), 57-64.
- Batalla, A., Garcia-Rizo, C., Castellví, P., Fernandez-Egea, E., Yücel, E., Parellada, E., Kirkpatrick, E., Martin-Santos, R. and Bernardo M. 2013. Schizophrenia, *British Medical Journal*, 146(1–3), 125-131.
- Block, K and Spiegel, S. 2007. Impact of parental divorce on emerging adults self esteem. *Journal of American Academy of Child & Adolescent psychiatry*, 30(3), 349-360

- Bobier, C. and Warwick, M. 2005. Factors associated with readmission to adolescent psychiatric care. *Australia & New Zealand Journal of Psychiatry*, 39(7), 600-606.
- Bobo, W. V., Hoge, C. W., Messina, M. A., Pavlovic, F, Levandowski, D. and Grieger, T. 2004. Characteristics of repeat users of an inpatient psychiatric service at a large military tertiary care hospital. *Military Medicine*, 169(8), 648-653.
- Behavioural health evolution. 2014. Available at <<http://www.bhevolution.org/public/medications.page>>. Accessed 31May 2014.
- Braun, V. and Clarke, V. 2006. *Using thematic analysis in psychology*. Qualitative Research in Psychology. London: Sage.
- Brink, H. 2006. *Fundamental of Research Methodology for health care professionals*. 2<sup>nd</sup> Edition. Lansdowne: Juta & Co.
- Burnette, M. L., Ilgen, M., Frayne, S. M., Luca, E., Mayo, J. and Weitlauf, J. C. 2008. Violence perpetration and childhood abuse among men and women in substance abuse treatment. *Journal of Substance Abuse Treatment*, 35 (2), 217–222.
- Burns, N. and Groves, S. K. 2006. *Understanding nursing research*. 2<sup>nd</sup> edition. Philadelphia: Saunders.
- Chamika, G. 2005. Re-admission of Psychiatric patients. *Australia & New Zealand Journal of Psychiatry*. 39(7), 600-606.
- Chang, L., Lin, Y., Chang, H. W, Chen, Y., Huang, W., Liu, C. and Hwu, H. 2013. Screening for substance use disorders in first-episode psychosis: Implications for readmission Original Research Article. *Journal of the Formosan Medical Association*, 112(4), 208-215.
- Chermack, S. T., Murray, R. L., Walton, M. A., Booth, B. A., Wyrobeck, J. and Blow, F. C. 2008. Partner aggression among men and women in substance use disorder treatment: Correlates of psychological and physical aggression and injury. *Drug and Alcohol Dependence*. 98(2), 35–44.

- Ching-Hau, L. Ming-Chao, C., Li-Shiu, C., Chieh-Hsin, L., Cheng-Chung, C. & Hsien-Yuan, L. 2010. Time to re-hospitalization in patients with major depression vs. those with schizophrenia or bipolar I disorder in a public psychiatric hospital. *Psychiatry research*, 180(3), 74-79.
- Colom, D. and Lam, P. 2005. Psychoeducation: improving outcomes in bipolar disorder. *European Psychiatry*, 1(5), 359–364.
- Concise Oxford Dictionary* .2009: London: Chancellor press.
- Coodin, S., Staley, D. and Cortens, B. 2004. Patient factors associated with missed appointments in persons with schizophrenia. *Canadian Journal of Psychiatry*, 49(3) 145–148.
- Cresswell, J. W. 2009. *Research design, Qualitative. quantitative and mixed methods approaches*. Thousand Oaks. CA:Sage.
- Desai, A. 2007. Implications of war in Northern Uganda on mental health. Available at <<http://brainblogger.com/2007/08/16/implications-of-war-northern-uganda-on-mental-health.html>> Accessed 13 August 2014.
- de Vos, A. S., Strydom, H., Fouche, C. B. and Delport, S. L. 2005. *Research at grass roots*. 3<sup>rd</sup> Edition South Africa: Van Schaick.
- Di Cicco-Bloom, B. and Crabtree, B. F. 2006. Qualitative research interview. *Medical education*: 40(2), 314-341.
- Djokic, N. S., Petrovic, A. M. and Vukic D. V. 2008. Frequency of re-admission of schizophrenia patients. *European Psychiatry*, 23(3), 81-191.
- Duckworth, K. and Freedman, J. L. 2013. *The Other Side of Cannabis: Negative Effects of Marijuana on Mental Health — A Documentary*. Available at <<http://www.othersideofcannabis.com/nami-info.html>>. Accessed 30 March 2014.
- Durbin, J., Lin, E., Layne, C. and Teed, M. 2007. *Journal of Behavioral Health Services & Research*. 23(4), 137-143.
- Figueroa, R., Harman, J. and Engberg, J. 2004. Use of claims data to examine the impact of length of inpatient psychiatric stay on readmission rate. *Psychiatric Services*, 55(5), 560-565.
- Frick, U., Frick, H., Langguth, B., Landgrebe, M., Hübner-Liebermann, B. and Hajak, G. 2013. The Revolving Door Phenomenon Revisited: Time to Readmission in 17'415 Patients with 37'697 Hospitalisations at a German Psychiatric Hospital. *PLoS One*. 8(10), 1-9.
- Gottlieb, H. 2008. *Medication Non-adherence: Finding Solutions to a Costly Medical Problem*. Available at <[http://www.medscape.com/viewarticle/409940\\_5](http://www.medscape.com/viewarticle/409940_5)>. Accessed 13 October 2013.

- Haines, C. 2005. *Depression: The Link between Depression and Other Mental Illnesses*. available at <<http://www.medicinenet.com/script/main/art.asp?articlekey=55161>>. Accessed 14 September 1013.
- Hamer, S. and Haddad, P. M. 2007. Adverse effects of antipsychotics as outcome measures. *The British Journal of Psychiatry*. 191(3), 64-70.
- Higgins, A., Barker, P. and Begley, C. M. 2008. Veiling sexualities: a grounded theory of mental health nurses responses to clinical issues. Psychiatric medications and problems with sexual function, *Journal of Clinical Nursing*, 21(4), 415–423.
- Ingersoll, K. 2004. The impact of psychiatric symptoms, drug use, and medication regimen on non-adherence to HIV treatment. *AIDS Care*. 16(2), 199-211.
- Institute for Safe Medication Practice. 2012. *Reduce readmissions with pharmacy programs that focus on transitions from the hospital to the community*. Available at <<http://www.ismp.org/newsletters/acutecare/showarticle.asp?id=36>>. Accessed 30 May 2013
- Javitt, D. C. 2014. Balancing Therapeutic Safety and Efficacy to Improve Clinical and Economic Outcomes in Schizophrenia: A Clinical Overview. *American Journal of Managed Care*, 20(8), 160-165.
- Jimmy, B. and Jose, J. 2008. Patient medication adherence: daily measures in daily practice. *Oram Medical Journal*, 26 (3), 155-159.
- Johns, M. J., Flaxman, J., Gomez, M. Y., Bockian, N. R. and Hall, M. 2007. Psychotherapeutic home intervention program: Impact on Medicaid readmission rates. *Care Management Journals*, 8(4), 179–186.
- Kartha, A. 2007. Depression is a risk factor for hospitalization in medical inpatients. *Journal of Clinical Psychiatry*, 9(4): 256-262.
- Kellydubose's Blog. 2010. *Ethnographic vs Phenomenological Research Designs*. Available at <<http://kellydubose.wordpress.com/2010/04/06/ethnographic-vs-phenomenological-research-designs>>. Accessed 30 May 2014.
- Kikuchi, H., Abo, M., Kumakura, E., Kubota, N. and Nagano, M. 2013. Efficacy of continuous follow-up for preventing the involuntary readmission of psychiatric patients in Japan: A retrospective cohort study. *International Journal of Social Psychiatry*. 59(30)288-295.
- Killapsy, H. 2007. Why do psychiatrists have difficulty disengaging with the out-patient clinic? Why don't patients attend their appointments? *Advances in Psychiatric Treatment*, 13(2), 435-437.

- Kim, J. H., Kim, D. and Marder, S. R. 2008. Time to rehospitalization of clozapine versus risperidone in the naturalistic treatment of comorbid alcohol use disorder and schizophrenia. *Neuro-Psychopharmacology and Biological Psychiatry*, 32(4), 984-988.
- King, M. and McKeown, E. 2003. *Mental Health and Social Wellbeing of Gay Men, Lesbians and Bisexuals*. Available at <http://www.mindout.org.uk/wp-content/uploads/2012/06/SummaryfindingsofLGBreport.pdf>. Accessed 26 March 2014.
- Knapp, M, Mangalore, R. and Simon, J. 2004. “The global costs of Schizophrenia”. *Schizophrenia Bulletin*, (30) 2, 279– 293.
- Lafeuille, A., Laliberté-Auger, F., Lefebvre, P., Frois, C., Fastenau, J. & Duh M.S. 2013. Impact of atypical long-acting injectable versus oral antipsychotics on rehospitalization rates and emergency room visits among relapsed schizophrenia patients: a retrospective database analysis. *BMC Psychiatric*, 13,221
- Lang, T. P., Rohrer, J. E. and Rioux, P. A. 2009. Multifaceted Inpatient Psychiatry Approach to Reducing Readmissions: A Pilot Study. *Journal of Rural Health*, 25(3), 309-313.
- Lebow, J. L., Chambers, A. L., Christensen, A. and Johnson, S. M. 2012. Research on the treatment of couple distress. *Journal of Marital and Family Therapy*, 38(3), 145–16.
- Li, Z. 2011. *Understanding Preventable Hospital Readmissions: Causes and Best Practices*. Available at <<http://www.hsi.gatech.edu/rebo/images/1/15/Zhuoyang-paper.pdf>>. Accessed 20 August 2013.
- Lin, C. and Li, C. 2008. Hospital Re-admission and Its Correlates Among Psychiatric Patients in Taiwan. *American Psychiatric Association*. 22(2), 1064-1065.
- LoBiondo-Wood, G. and Haber, J. 2010. *Nursing Research*. Westline Industrial Drive: Mosby.
- Madi, N., Zhao, H., and Li, J. F. 2007. Hospital readmissions for patients with mental illness in Canada. *Healthcare Quarterly* . *Healthcare Quarterly*, 10(2), 30-2.
- Magnan, M. A, Reynolds, K. E. and Galvin. E, A . 2005. Barriers to addressing patient sexuality in nursing practice. *Medsurg Nursing*, 14, 282–289.
- Maharaj, R., O'brien, L., Gillies, D. and Andrew, S. 2013. Police referrals to a psychiatric hospital: Experiences of nurses caring for police-referred admissions. *International Journal of Mental Health Nursing*. 22(4), 313-321.
- Mental Health Care Act, No.17 of 2002 (South Africa)*. Government Gazette 6 November 2002, Vol.449, no. G24024.

Metzger, J. 2010. *Preventing hospital re-admissions: the first test case for continuity of care*. 2012. Available at

<[http://assets1.csc.com/health\\_services/downloads/CSC\\_Preventing\\_Hospital\\_Readmission.pdf](http://assets1.csc.com/health_services/downloads/CSC_Preventing_Hospital_Readmission.pdf)>. Accessed on 9 March 2013.

Mick, J. (2007) Sexuality assessment: 10 strategies for improvement. *Clinical Journal of Oncology Nursing*, 11(2), 671– 675.

Minott, J. 2008. *Reducing Hospital Re-admissions*. Available at

<<http://www.academyhealth.org/files/publications/ReducingHospitalReadmissions.pdf>> accessed on 08 March 2013.

Mitchell, A. J. and Selmes, T. 2007. *Why don't patients take their medicine? Reasons and solutions in psychiatry*. Available at <<http://apt.rcpsych.org/content/13/5/336.full>>. Accessed 9 March 2013.

Mojtabi, R., Herman, D., Susser, E., Sohler, N. and Craig, T. 2005. Service use and outcomes of first-admission patients with psychotic disorders in the Suffolk County Mental Health Project. *American Journal of Psychiatry*. 162(3), 1291–1298.

*Mosby's Dictionary of Medicine, Nursing and Health Professions*. 2007 .7<sup>th</sup> Edition: Mosby.

Nakhost, A., Perry, J. C. and Frank, D. 2012 Assessing the Outcome of Compulsory Treatment Orders on Management of Psychiatric Patients at 2 McGill University- Associated Hospitals. *Canadian Journal of Psychiatry*, 57(6), 359-365.

National alliance of mental illness. *Anosognosia (Lack of Insight) Fact Sheet*. 2014. Available at <[http://www.nami.org/Content/NavigationMenu/Mental\\_Illnesses/Schizophrenia9/Anosognosia\\_Fact\\_Sheet.htm](http://www.nami.org/Content/NavigationMenu/Mental_Illnesses/Schizophrenia9/Anosognosia_Fact_Sheet.htm)>. Accessed 18 August 2014.

Omranifard, V.; Yazdani, M.; Yaghoubi, M. and Namdari M. 2008. Re-admission of psychiatric patients. *Iranian Journal of Psychiatry* 3(6), 37-42.

Overbeek, G., Vollebergh, W., Meeus, W., De Graaf, R. and Engels R. 2004. Young adults' recollections of parental bonds: does satisfaction with partner relationships mediate the longi-

tudinal association with mental disorders? *Social Psychiatry & Psychiatry Epidemiology*, 39(3), 703–711.

Overbeek, G., Vollebergh, W. and de Graaf. 2007. Parental lack of care and overprotection. By *Social Psychiatry & Psychiatric Epidemiology*. 42(2), 87-93.

Ovsiew, F. and Munich, R. L. 2008. *Principles of Inpatient Psychiatry*. Lippincott Williams & Wilkins.

Paananen, R., Ristikari, T., Merikukka, M. and Gissler, M. 2013. Social determinants of mental health: a Finnish nationwide follow-up study on mental disorders. *Journal of Epidemiology & Community Health*, 67 (12), 1025-1031.

Parahoo, K. 2006. *Nursing Research Book*. London: Lippincott Company.

Perreault, M., Tardif, H., Provencher, H., Paquin, G., Desmarais, J. and Pawliuk, N. 2005. The role of relatives in discharge planning from psychiatric hospitals: the perspective of patients and their relatives. *Psychiatry Quarterly*, 76(4), 297-315.

Polit, D. and Hungler, P. 2008. *Essentials of Nursing Research: Method, Appraisal and Utilization*. Lippincott Williams and Wilkins.UK.

Prevention. 2014. *Schizophrenia*. Available at <<http://www.prevention.com/health-conditions/schizophrenia>>. Accessed 12 March 2013.

Prince, J. D., Akincigil, A., Hoover, D. R., Walkup, J. T., Bilder, S. and Crystal. T. 2009. Substance Abuse and Hospitalization for Mood Disorder Among Medicaid Beneficiaries. *American Journal of Public Health*, 99(1), 160–167.

Quinn, C., Happell, B. and Browne, G. 2011. Talking or avoiding? Mental health nurses' views about discussing sexual health with consumers. *International Journal of Mental Health Nursing*, 20, 21–28.

Quinn, C., Happell, B. and Browne, G. 2012. Opportunity lost? Psychiatric medications and problems with sexual function: a role for nurses in mental health. *Journal of Clinical Nursing*. 21 (3), 415-423.

Recovery. 2013. *Getting Sober: How to Quit Drinking or Abusing Drugs*. Available at <<http://www.recovery.org/topics/getting-sober-and-drug-free>>. 2014 Recovery.org. Accessed 30 May 2014.

Robinson, K. M. 2005. *Is It Possible to Prevent Schizophrenia* . Available at <<http://www.webmd.com/schizophrenia/features/is-it-possible-to-prevent-schizophrenia>>. Accessed 29 March 2014.

Rosca, P., Bauer, A., Grinshpoon, A., Khaweles, R., Mester, R. and Ponizovysky, A. M. 2006. Rehospitalizations Among Psychiatric Patients Whose First Admission was Involuntary: A 10-Year Follow-Up. *Israel Journal of Psychiatry & Related Science*, 15(04), 57-64.

Rosenberg, K. P., Bleiberg, K. L. and Koscis, J. 2003. A survey of sexual side effects among severely mentally ill patients taking psychotropic medications: impact on compliance. *Journal of Sex and Marital Therapy*, 29, 289–296.

Royal College of Psychiatrists. 2014. *Divorce or separation of parents - the impact on children and adolescents: information for parents, carers and anyone who works with young people*. Available at

<<http://www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/parentscarers/divorceorseparation.aspx>>. Accessed 5 May 2014.

Rubin, H. J., and Rubin, I. S. 2005. *Qualitative Interviewing – The Art of Hearing Data*. 2nd Edition, Sage Publications, Thousand Oaks, London, New York.

Sajatovic, M., Velligan, I. D., Weiden, P. J., Valenstein, M. A. and Ogedegbe, G. 2010. Measurement of psychiatric treatment adherence. *Journal of Psychosomatic Research*, 69(6), 591-599.

Schizophrenia. 2010. *Preventing Schizophrenia - Tactics and Risk Reduction Strategies*. Available at <<http://schizophrenia.com/prev1.htm>>. Accessed 30 May 2014

Schennach-Wolff, R., Jäger, M., Seemüller, F., Obermeier, M., Messer, T. and Laux, G. 2009. Attitude towards adherence in patients with schizophrenia at discharge. *American journal of psychiatry*, 43(16), 1294–1301.

Seeley, K. 2013. *Psych Central*. Available at

<<http://psychcentral.com/blog/archiv.es/2013/08/05/5-steps-to-stop-drug-addiction-before-it-starts>>. Accessed 30 May 2014

Sfetcu, R. and Pauna, C. B. 2009. *The impact of poverty on mental health and well-being and the necessity for integrated social policies. Institute for Economic Forecasting – Romanian Academy.* Available at

<<http://www-sre.wu.ac.at/ersa/ersaconfs/ersal1/e110830aFinal01495.pdf>>. Accessed 30 May 2014.

Sharma, I., Pandit, B., Pathak, A. and Sharma, R. 2013 Hinduism, marriage and mental illness. *Indian Journal of Psychiatry.* 21(3), 243-249.

Sheth, H. C. 2005. Common problems in psychosocial rehabilitation. *International Journal of Psychosocial Rehabilitation,* 10(1), 53– 60.

Silow-Carroll, S., Edwards, J. N. and Lashbrook. A. 2011. *Reducing Hospital Re-admissions: Lessons from Top-Performing Hospitals – The Commonwealth Fund.* Available at <<http://www.commonwealthfund.org/Publications/Case-Studies/2011/Apr/Reducing-Hospital-readmissions.aspx>>. Accessed 12 March 2013.

Silva, N. C., Bassani, D. G. and Palazzo, L. S. 2009. A Case-Control Study of Factors Associated With Multiple Psychiatric Re-admissions. *Psychiatric services,* 60,786-791.

Smith, M., Saisan, J. and Segal. T. 2014. *Depression Symptoms & Warning Signs.* Available at <[http://www.helpguide.org/mental/depression\\_signs\\_types\\_diagnosis\\_treatment.htm](http://www.helpguide.org/mental/depression_signs_types_diagnosis_treatment.htm)>. Accessed 12 March 2014.

Smith, M and Segal, J. 2014. *Schizophrenia: Signs, Types & Causes.* Available at <[http://www.helpguide.org/mental/schizophrenia\\_symptom.htm](http://www.helpguide.org/mental/schizophrenia_symptom.htm)>. Accessed 20 August 2014.

Snyder, D. K., Castellani, A. M. and Whisman, M. A. 2006. Current status and future directions in couple therapy. *Annual Review of Psychology,* 57(2), 317–344.

Tandon, R., Nasrallah, H. A. and Keshavan, M. S. 2009. Schizophrenia, "just the facts" 4: clinical features and conceptualization. *Schizophrenia Research,* 110(3), 1 -23.

Thompson, E. E., Neighbors, H. W. and Munday, C. 2003. Length of stay, referral to aftercare, and rehospitalization among psychiatric inpatients. *Psychiatric Services,* 54(5), 1271–1276.

Thornicroft, G. 2006. *Shunned: Discrimination against People with Mental Illness.* Oxford University Press.

Treatment Solutions. 2013. *5 ways to stop prevent substance abuse*. Available at <<http://www.treatmentsolutions.com/top-5-ways-to-prevent-substance-abuse>>. Accessed 30 May 2014

Tsang, H. W., Fung, K. M. and Chung, C. R. 2010. Self-stigma and stages of change as predictors of treatment adherence of individuals with schizophrenia Original Research Article. *Psychiatry Research*, 180(1), 10-15.

Uys, L. and Middleton, L. 2004. *Mental health nursing, a South African perspective*. 4<sup>th</sup> Edition. Cape Town: Juta.

Uys, L. and Middleton, L. 2013. *Mental health nursing, a South African perspective*. 5<sup>th</sup> Edition. Cape Town: Juta.

Van Deventer, C., Couper, I., Wright, A. and Tumbo, J. 2008. Evaluation of primary mental health care in North West Province-a qualitative view. *South African Journal of psychiatry*, 14(4), 34-40.

Vest, J. R., Gamm, L. D., Oxford, B. A., Gonzalez, M. I., and Slawson, K. M. 2010. Determinants of preventable readmissions in the United States: a systematic review. *Implementation Science*, 5(1), 1-27.

Volman, L. and Landeen, J. 2007. Uncovering the sexual self in people with schizophrenia. *Journal of Psychiatric and Mental Health Nursing*, 14, 411–417.

Vreeland, B., Minsky, S., Yanos, P. T. 2006. Efficacy of the team solutions program for educating patients about illness management and treatment. *Psychiatric Services*, 57 (6), 822–828.

Wall, T. L., Sorensen, J. L. and Batki, S. L. 2003. Adherence to Zidovudine (AZT) among HIV infected methadone patients: a pilot study of supervised therapy and dispensing compared to usual care. *Drug and Alcohol Dependence Journal*, 37(3), 43-48.

Williams, Y. 2014. *What Is Psychological Distress? - Definition, Lesson & Quiz*. Available at <<http://education-portal.com/academy/lesson/what-is-psychological-distress-definition-lesson-quiz.html#lesson>>. Accessed 30 June 2014

World Health Organization. 2003. *Adherence to long term therapy: evidence for action*. Available at <[http://www.who.int/chp/knowledge/publications/adherence\\_introduction.pdf](http://www.who.int/chp/knowledge/publications/adherence_introduction.pdf)> Accessed on 23.06.13

Xafenias, A., Diakogiannis, I., Iacovides, A., Fokas, K. and Kaprinis, G. 2008. Factors Affecting Hospital Length of Stay: Is Substance Use Disorder One of Them? A Study in a Greek Public Psychiatric Hospital. *American Journal on Addictions*. 17 (5), 447-451.

Yanling, Z., Rosenheck, R. A., Mohamed, S., Yuping, N. and Hongbo, H. 2014. Retrospective assessment of factors associated with readmission in a large psychiatric hospital in Guangzhou, China. *Shanghai Archives of Psychiatry*. 26(3), 138-148.

## **APPENDIX 1: INTERVIEW GUIDE**

### **DEMOGRAPHIC DATA**

#### **1. gender /Bong**

Female / Mosadi	1
Male / Monna	2

#### **2. Age group / Mengwaga**

18-25	3
25-35	4
36-45	5
47-60	6

#### **3. Place of residence / Bodulo**

Rural / Magaeng	7
Semi-rural / Lokaiseneng	8
Urban / Toropong	9

#### **4. Level of education / tsa thuto**

Literate / O tsene sekolo	10
Illiterate / Ga wa tsena sekolo	11

## 5. Psychiatric diagnosis / Bolwetši bja monagano.....

### CENTRAL QUESTION / POTŠIŠOKGOLO

What would you say are the reasons for you being re-admitted to Thabamoo Hospital?

E kaba lebaka la gore o amogelwe gape mo bookelong bja Thabamoo ke lefe?

Probing questions

- Do you accept mental illness status?  
O amogela maemo a gago a bolwetši bja monagano?
- How were you taking your treatment during discharge?  
O be o tšea dihlange bjang ge o be o le gae?
- Were your relatives giving you any support?  
A ba ka gae be ba go fa thekgo?
- How different is home care as compared to the hospital care?  
Naa go na le phapano hlokomelong ya bookelong le hlokomelong ya gae?

For the relatives

What do you think are the reasons for your relative to be re-admitted to Thabamoo Hospital?

A na le gopola gore e kaba mabaka afe ao hlotšeng gore motswalle wa gago a amogelwe gape mo bookelong?

Probing questions

- How was your relative's behaviour at home before re-admission?  
O be a itshwere bjang ge a be a le gae pele a bowa bookelong?
- What is the behaviour that lead your relative to be re-admitted?  
Ke maitswaro a fe ao a hlotšeng gore motswalle wa gago a amogelwe gape mo bookelong?

- What recommendations can you make to help avoid situation wherein your relative is re-admitted?

Ke eng se o boneng se ka dirwa gore motswalle wagago a se sa amogelwa gape mo bookelong?

**APPENDIX 2: LETTER FROM HEAD OF DEPARTMENT OF HEALTH,  
LIMPOPO PROVINCE**



**LIMPOPO**  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

---

**DEPARTMENT OF HEALTH**

Enquiries: Latif Shamila

Ref:4/2/2

Takalo LS  
University of Limpopo  
Sovenga  
0727

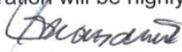
Greetings,

**Factors leading to re-admission of mental health care users in Thabamooop Hospital of Capricorn District, Limpopo Province.**

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
  - Further arrangement should be made with the targeted institutions.
  - In the course of your study there should be no action that disrupts the services.
  - After completion of the study, a copy should be submitted to the Department to serve as a resource.
  - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

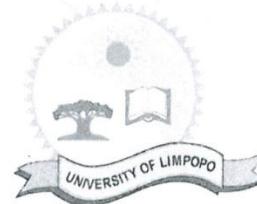
Your cooperation will be highly appreciated.

  
\_\_\_\_\_  
Head of Department

01/04/2014  
Date

# APPENDIX 3: ETHICAL CLEARANCE CERTIFICATE

UNIVERSITY OF LIMPOPO  
Medunsa Campus



## MEDUNSA RESEARCH & ETHICS COMMITTEE

### CLEARANCE CERTIFICATE

MEETING: 09/2013

PROJECT NUMBER: MREC/HS/320/2013: PG

PROJECT:

Title: Factors leading to re-admission of mental health care users in Thabaambo Hospital of Capricorn district, Limpopo Province

Researcher: Miss LS Takalo  
Supervisor: Dr JC Kgole  
Co-supervisor: Prof ME Lekhuleni  
Department: Nursing & Human Nutrition  
School: Health Sciences  
Degree: MCur

#### DECISION OF THE COMMITTEE:

MREC approved the project

DATE: 07 November 2013

*pp Ogunbanjo*  
PROF GA OGUNBANJO  
CHAIRPERSON MREC



The Medunsa Research Ethics Committee (MREC) for Health Research is registered with the US Department of Health and Human Services as an International Organisation (IORG0004319), as an Institutional Review Board (IRB00005122), and functions under a Federal Wide Assurance (FWA00009419)  
Expiry date: 11 October 2016

#### Note:

- i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
- ii) The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Building Solutions for Africa



## APPENDIX 4: INDEPENDENT CODER'S CERTIFICATE

### INDEPENDENT CODER CERTIFICATE

Qualitative data analysis

---

Masters degree in Nursing Science

**TAKALO LINA SEBOLAISI**

THIS IS TO CERTIFY THAT:

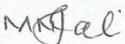
Prof M.N.Jali has coded the following qualitative data:

12 individual interviews and field notes

For the study:

**FACTORS LEADING TO RE-ADMISSION OF MENTAL HEALTH  
CARE USERS IN THABAMOOPO PSYCHIATRIC HOSPITAL,  
CAPRICORN DISTRICT, LIMPOPO PROVINCE**

I declare that adequate data saturation was achieved as evidenced by repeating themes

PROF MN JALI: 

## APPENDIX 5: ENGLISH EDITOR'S CERTIFICATE

Revd. Dr. Lutz Ackermann  
(Independent Researcher)  
198 Berrymead Avenue  
Mondeor, 2091  
Tel: +27 72 3487010  
e-mail: DRLA4 @ directbox.com

15 Oct 2014

### TO WHOM IT MAY CONCERN

This is to confirm, that I, Dr Lutz Ackermann, have read the research thesis entitled

“factors leading to re-admission of mental health care users in Thabamooopo Hospital of  
Capricorn District, Limpopo Province”

by Miss **LINA SEBOLAISI TAKALO**

and that I am satisfied with the quality of work she has produced in terms of structuring the document, in terms of style, grammar and spelling. Suggestions for suitable corrections and improvements have been made to the candidate.

  
(Revd Dr Lutz Ackermann, Mondeor)

**APPENDIX 6: SEMI-STRUCTURED INTERVIEW TAKEN FROM TWELVE INTERVIEWS CONDUCTED FOR THE MAIN STUDY**

**Interview no 2.**

“My name is Sebolaisi Takalo, student from University of Limpopo, Turfloop Campus” (The procedure of obtaining consent continued).

How old are you

*I am 34 years old*

Where do you stay?

*Seshego zone 3 no 1342, location.*

What is your highest education?

*Up to standard 8 and then went to technical / FET.*

Are you working?

*I only had temporary jobs, never worked permanently.*

Do you know your psychiatric condition?

*Yes I know my condition. The doctors told me that I am suffering from schizophrenia.*

Do you accept your mental illness?

*Yes I agree*

Since when were you suffering from mental illness?

*I started being ill in the year 2000 in December.*

What happened for you to realize that you were ill?

*At home they just noticed me starting to throw things away and then I started talking alone. They told me about what I was doing. They also told me that it was not like they were against*

*me. They told me I was sick and I forcibly did things that were not right. I realized that indeed the things they were accusing me of doing were not the things a normal person can do. They showed me that the things I was doing can only be done by mentally ill people.*

How many times were you admitted to the hospital from 2002?

*I was admitted six times, I would come and be discharged and come and be discharged again.*

Can you explain why were you readmitted from 2002 for each time you were discharged?

*The first time I was admitted and discharged....*

Ok, you said for the first time when you were admitted to this institution, you started talking alone and your family noticed you.

*Yes, I was talking things without sense.*

Then what happened the second time?

*For the second time, after the first admission when I got home I stopped taking medications and started taking dagga. I did not believe that I was mentally ill. I told myself that it was not dagga that made me sick. I thought that my sickness was a result of witchcraft. Somebody was bewitching me. I told myself that the medications can not heal witchcraft.*

*I was pretending at home. I could tell them that I was healed and back to normal. I believed that dagga could not make me ill. Even if I am sick it can be other things but not dagga. I insisted that dagga doesn't make anyone sick. I even asked them why in Jamaica there are no mentally ill people and I was told that in Jamaica dagga is legalized and there are many Rastafarians. I told myself that since Rastafarians from Jamaica are not sick, I can never be sick. I also observed around and noticed that there are old men who started smoking dagga from childhood up to today but they are not sick. That had made me believe that I can never be mentally ill because of dagga.*

Can you tell me when did you start taking dagga?

*I started taking dagga in 1994. I was 14 years old then.*

1994?

*I was 14 years and almost 15 years old*

Then you started taking dagga

*Yes I also started smoking cigarettes and drinking beer.*

But then you were still young.

*Yes I was*

14 years?

*Yes*

So you continued smoking?

*Yes I did continue*

What happened for you to start smoking?

*I grew up in Seshego, it's a rough place to grow up. Lots of guys from that place were smoking so I started smoking. I started with cigarettes, and then one day I told myself that I want to start smoking dagga, just to get a taste of it because I already knew the taste of cigarettes. Sometimes I would steal beer especially when my parents were not around. I would take beer and tell my younger sister not to tell anyone about my drinking habits. I was not taking beer full time because I was afraid that if I can take it my parents will notice that I am drunk. With other drugs like dagga it was easy for me to hide it from my parents because I would make sure that there was no trace of the smell on me when I go home.*

How would you stop the smell of dagga on you?

*I would take orange peels, and sometime I would take toothpaste. This toothpaste is not for tooth cleaning but is to remove the smell. I would fill it in my mouth from there I swallow it so that the air that will be coming from my stomach would be minty, because I knew lots of toothpastes has a mint smell.*

*I would wash my hands with soap. Since I was close to home, I would go to the bush when I want to smoke.*

So you are saying that you started smoking dagga from 1994?

*Yes, and it started making me ill in the year 2000*

Is that when you started seeing its side effects?

*Yes, I think I started being ill the time I started taking it overdose.*

What do you mean by overdose?

*Eish, I don't know how to put it. I can't say over necessary because there is no right limit for taking dagga.*

That is what I wanted to understand, according to you what is a normal dose and abnormal dose?

*Normal is when you take a zol-dagga full in the matchbox, so I would buy Aram.*

What is Aram?

*Aram can be like a two quire exercise book in length. In height, it's like loaf bread*

Yho!

*Yes my father was retrenched, so he left his house in Johannesburg with me. I was studying at technical so I would buy that thing. I would smoke it full time. like I would not take time without smoking dagga. I would smoke from 6am until 00h00 every day, and within a day I would take zol equals to half of a pencil, about 12. Some time I would take the zols as long as a full pencil and the thick ones, as thick as Vienna, and the length will be like a pencil. I would smoke it alone mixing it with cigarette.*

*I can't say I was smoking over necessary but I would smoke too much because there is no necessary in smoking dagga*

So is that how intense you were smoking dagga between 1999 and 2000?

*Yes, my parents were giving me lots of money. I was not staying far from school. I would walk to my place during lunch hour, but my parents would send me lots of money. I would use that lunch money for dagga. I never lacked dagga. I had friends who were smoking, so when I did not have money they would give me puffs and when they did not have money I would share what I have with them. I never struggled to have dagga.*

This means you had reached the stage where you were not taking cigarettes?

*I would take cigarette, but the difference is that you can never take cigarette every time, because too much of it is not nice and it makes the mouth dry and makes one to take water often.*

*Zol has its own plug. We would put a small amount of cigarette in it so that it's not bitter to us. When we get the plug, we feel like there is still a need for satisfaction. That's why I would smoke many times. I would feel good and then I had already knew that even if I felt good it would only suffice for a short period of time.*

*I understood that when you are still young you start by not knowing how things are done but as you grow you start to see how things are done.*

So now dagga was part of you?

*Yes it was.*

Would you say it made you to be readmitted in the hospital?

*Yes I was admitted at Groothoek hospital for the second time.*

What year was it?

*It was in 2002.*

*Then I was discharged the same year. In 2003, I stopped taking medication and I was readmitted again*

Why did you stop taking medication in 2002?

*To tell the truth and to be fair, I cannot defend something that I cannot continue doing now. I took medication and mixed it with dagga, and that's how I continued until in 2005 when I was arrested for malicious damage of property due to mental illness. I was then admitted to Thabamoopo Hospital, and then I was transferred to Hayani Hospital. I was told that I was going to stay in Hayani for 5 years because I was problematic and I came back to the hospital often. I stayed in Hayani Hospital for 3 month because the doctor said that it was not easy for the relatives to come see me because I was far and the doctor was not going to be able to talk to them about me. That is when she decided to bring me back to Thabamoopo as she said I had improved a lot for the three month I stayed there. It was already in March when I came to Thabamoop. When I came back to Thabamoopo it was my 4<sup>th</sup> admission in 2006 March.*

What happened for you to do malicious damage of property?

*I fought with my family, when they told me to stop smoking dagga. Like I told you I had a belief that dagga does not cause mental illness, because it did not cause mental illness on other people. I thought I was bewitched.*

So what did u do?

*I broke the windows because I was angry.*

*The fifth time I was admitted was in 2008. I was taking dagga. I was seriously admitted. I did not even see myself when I was coming to this hospital. I was seriously sick. But I had a belief that I can hear what people think. The doctors noticed that I was mentally ill and my file was big.*

What was the problem?

*Every time I would be admitted to this hospital it would be because of dagga. I would via Seshego hospital.*

So what happened the 6<sup>th</sup> time you were readmitted to the hospital

*It was in 2008 when I was shortly discharged because I had improved fast, and there was a complaint that the hospital was full and they wanted to discharge people who were better, and whose families still welcomed them. So they discharged me. I came back in 2009. When I got*

*home I was taken to rehabilitation center. My family took me there so that my dagga addictions can be dealt with. The SANCA people said they cannot keep me because I was already mentally ill.*

*SANCA is not a rehabilitation center. It is a place where addicts get treatment and counseling about the condition you are suffering. They only give some treatment that will remove dagga from the blood. The first time I arrived there they told my father that I do not qualify as their candidate. I needed some rehabilitation. They gave my father a letter to come here (Thabamoopo Hospital).*

Ok let me hear you clearly, you said in 2008 you were admitted and discharged early because of shortage of beds.

*Yes, it was fast because I didn't stay long. In 2006 to 2007 I took about 2 years.*

In 2009 your family took you to SANCA?

*Yes, at SANCA they gave me the letter that I must be admitted in Thabamoopo, and then when I got here the nurses said that I smoke dagga while taking medication, but I was not problematic. I just came here because of SANCA. So they took a decision that I must be readmitted because I was a mentally ill patient. When I got at Thabamoopo they said that I was not psychotic and they referred me straight to forensic ward. They asked me if I was a state patient and I told them I didn't know what a state patient was. The doctors checked the files and told me that I was a state patient. I was declared a state patient in 2006 according to the case I had committed. I was later discharged and not given a leave like any other state patients. Then in 2008 when I was readmitted I was readmitted to the sub-acute ward, not in the forensic ward.*

*I was told that I must go to forensic ward because I was not psychotic after the doctor took time to go through my file and realized that I was a state patient. The doctor said I must stay a bit in the sub-acute ward because I was still coming from home. I stayed for two weeks and then I was transferred to forensic ward. From there I was given a leave. The last leave that I was given was when I was smoking. I do not know what happened for the doctors to give me the leave. I went home and when I got home I was told that I am now old, I must be useful at*

*home. I should not take music as a career because it has no future. They also wanted to help me to do a training that will help me get a proper job. They were worried that I would not become a responsible adult.*

*I want to say when I started fighting with my family and they would tell me to get out of the house and have my own place, then I felt like I was not loved. I then brought myself back to the hospital to talk to social workers to help me with RDP house. When I came here to ask the social worker for RDP house, I also knew that they would be supervising me and making sure that I get my medication regularly. I knew that I was a state patient. I qualified for a house. I also knew that if I had a house I would not run away from it. I knew that state patients are not allowed to stay alone without supervision*

*I understood that it would be easy for me to be monitored. That failed. After it failed I am still in this hospital.*

Can you generalize for me what could be the reason that you were readmitted in Thabampoopo?

*Its only dagga, only that.*

I understand that you were taught many times about the dangers of smoking dagga, what could be the reason for you to go back and smoke again?

*It is the addiction, because I already know how it feels.*

*I know the experience of it, coz I know how it feels*

So do you also have the desire to smoke dagga within the hospital?

*Yes I do sometimes.*

Do you access dagga within the hospital?

*Yes I used to get it from the contractors when they were still building. Recently there is none that I get. I was tested many times for cannabis and the results were negative so the doctor took me to open ward to test me and see if I can survive not taking dagga where I have free movement, and can easily get people who can get me dagga. They are trying to check if I can*

*smoke dagga because I am known as a smoker. If they found me I would not go home. My case is minor according to the doctors. This case has caused me to remain in the hospital.*

Tell me how regularly were you taking medication?

*I do take the medications well, though I mix them with dagga.*

What could be the reason for that?

*It is just that I have cravings for dagga.*

So now if we can take you home there are chances that you will smoke?

*No! Not now. I no longer want dagga.*

*I want to work and have my own house. I have friends who have progressed well in life. I feel this is the time for me to build my own life. I have failed in life and not long I will be 35 soon and even 40 not long. If I cannot make my life worthwhile now it means I have failed.*

*The last time I took dagga it was in 2011 within the hospital from the contractors. I smoked, and it made me ill. I was then taken to acute ward. I was hallucinating. I was taken to the doctor in acute ward. I was in acute ward for 3 months. Then I was brought back to this ward. I was kept in closed forensic ward.*

*From there I used to fight with fellow patients. So my urine was collected for cannabis test and I was found negative. It was found that I was not violent because of dagga. I was checked many times without positive results.*

*Now I have about 2 years not smoking. I can never be its slave because it's no longer in my blood. I am now rehabilitated, the hospital helped me.*

*Now I live well. I no longer live that life where I would feel bad for not smoking. I would feel sick when I didn't smoke dagga but now I am used to healthy life. I am used to live without smoking. I smoke cigarettes only because it's legalized I believe when I will be discharged I will live the way I am now. I am used to this life of not smoking dagga.*

Have you ever taken liquor?

*No I never liked beer, because I vomit when I am drunk*

Tell me about the support you get from home.

*No, at home they give me support. I asked them to assist me with school for basic diploma. My mother said she will assist. But this started to worry me because I am getting old. I also hope to find a partner to start a family. I called them and asked them to take me for carpentry; my mom said that was what she always wanted me to say.*

*I promised them that I would never change. They would take me to a school where they teach practical and help the students to get a job because companies don't hire us. We are only hired by the government because of disability.*

*They also said they saw another school that offers courses such as plumbing and carpentry. They said when I am discharged I will do carpentry. I do door inserting, office doors, ceilings, and if I have start-up capital I can work for myself.*

So when you are home what other support do they give you?

*They encourage me to take medicines. They also remind me to take medication. I do take medications. I know times for taking medication, and even when I travel I take my medication when I go out.*

*I am not ashamed of my mental illness. I am able to tell people about it. I am able to show normal people how brilliant I am. I am also civilized because I know many things in life. I am not worried. But I am aware that I not well educated.*

Thank you for participating, do you have any questions?

*I understood thanks; I have no questions for you. I understood you are doing this for the school work*

Thanks for your time and the information you shared.