University of Venda

# DEVELOPMENT OF A MODEL TO SUPPORT REINTEGRATION OF MALE STATE PATIENTS INTO THEIR FAMILIES IN LIMPOPO PROVINCE, SOUTH AFRICA

**BY**

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**A thesis submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy in Nursing at the University of Venda**

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## DECLARATION

I**, NDIVHALENI ROBERT LAVHELANI**, hereby declare that this thesis for a Doctor of Philosophy in Nursing Degree at the University of Venda, hereby submitted by me, has not been previously submitted for a degree, at this or any other institution, and that this is my own work. All reference materials contained therein have been duly acknowledged.

**Signature: ……...** **Date: …….**

## DEDICATION

This thesis is dedicated to my late parents, Mr Vhulahani Andries Lavhelani and Mrs Mukhethoni Tshililo Elisa Lavhelani, who encouraged me to study until attaining a doctoral degree: *"Ni dzhene tshikolo ni funzee nwananga u swika ni tshi pfi dokotela nwananga."*

It is also dedicated to my wife Dellinah, my three sons, Dzivhuluwani, Mulamuleli and Akonaho, with thanks for their encouragement and support and always wishing me a successful completion of this research study.

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# ABSTRACT

State patients are admitted to the psychiatric hospital after being declared as such by a court of law in South Africa. After successful rehabilitation of state patients at the psychiatric hospital, they need to be reintegrated into their families. Perceptions of family members of male state patients regarding reintegration including development of a model to support such reintegration, is not largely explored in the scientific body of knowledge. The aim of this study was to develop a model to support reintegration of state patients into their families in Limpopo Province, South Africa**.** A qualitative approach using descriptive, explorative, and contextual designs was adopted for this study. The study population was family members whose relatives are male state patients admitted and recorded in the admission register of Hayani Hospital, in Limpopo Province. The study was conducted in two phases of which phase one was a situational analysis, and phase two was the development of the model to reintegrate male state patients into their families. This study was conceptualized within the Social Ecological Model (SEM) of human behaviour (Stokols, 2013), the grounded theory for model development outlined in Dickoff et al. (1968), and the approaches outlined in Chinn and Kramer (2008); Walker and Avant (1995). Model evaluation was done by a group of health professionals, some of whom are advanced psychiatric nurses who are doing masters and doctoral studies, and one doctoral graduate who is also an advanced psychiatric nurse. Presentations were made to this group during peer review sessions who in turn gave critical comments regarding the developed model to support reintegration of male state patients until the final model was accepted. Non-probability purposive and convenient sampling were used to sample a hospital and 10 family members of Venda-speaking male state patients. In-depth individual interviews were used as the instrument to collect data which was pretested on one family member who did not form part of the study. Data was analysed using thematic analysis approach. Data was co-coded by an independent doctoral degree graduate to ensure trustworthiness. Conducting home visits by health professionals came up strongly during data analysis. Credibility, dependability, confirmability and transferability to ensure trustworthiness of the study, as well as ethical considerations were adhered to. The findings of the study yielded two themes, being perceptions of participants regarding reintegration of male state patients, and perceptions of participants

regarding the support needed from family members to reintegrate male state patients. During phase one, the results indicated that family members accept reintegration and also that they indicated the kind of support needed, that lead to phase two of developing a model to reintegrate male state patients. The study was restricted to only one hospital in the Vhembe District out of the five districts of the Limpopo Province.The researcher acknowledges that this study was contextual and that only family members of male state patients were interviewed, the perceptions of family members of female state patients were not heard. The study concluded that there are perceptions that family members of male state patients have regarding reintegration of these patients into their families. Furthermore, family members of male state patients can describe the kind of support that they need in order to reintegrate male state patients into their families. This should be done using the developed model that should involve family members and the community. The study recommends that psychiatric hospitals should implement the model involving family members of male state patients. Furthermore, a longitudinal study should be conducted for a period of 3-5 years to check the effectiveness of the model.

**Key words: family, family members, male state patient, model, reintegration, support**

## ACRONYMS

LOA: Leave of absence

MDT: Multi-disciplinary team

MHCA: Mental Health Care Act

MHCU: Mental Health Care User

MHCUs: Mental Health Care Users

PHC: Primary Health Care

UHDC: University Higher Degrees Committee

U.S.: United States

SEM: Social Ecological Model

WHO: World Health Organisation

WHA: World Health Assembly

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# CHAPTER 1

# OVERVIEW TO THE STUDY

## 1.1 INTRODUCTION AND BACKGROUND

State patients are one of the categories of patients who are mentally ill and are admitted in the health establishment for care, treatment and rehabilitation, after which these patients are given leave of absence (LOA) or discharged back home. Over the past years prior 2002 in South Africa, before the promulgation of Mental Health Care Act, No. 17 of 2002, mental health care had increasingly been rendered in the hospital rather than in the community settings, with recovery as the key in the treatment of mentally ill patients. Male mentally ill patients were and are still found in mental health institutions in large numbers due to rejection by their family members, instead of being discharged back to their families. Mental health institutions remain with large numbers of these male mentally ill patients who are stable and should otherwise be at their homes with their families. Therefore, supporting family members of male state patients in mental health care to interact with mental health care practitioners and discussing how mental illness affects all areas of a person's life, may help to build trust. Furthermore, a study by Mabunda (2018) described perceptions of family members regarding their involvement in caring for mental health care users in long-term mental health hospitals.

State patients are individuals who have been charged with offences involving serious violence and who have been declared unfit to stand trial and/or who are not criminally responsible because of their mental illness or defect. They are referred by the courts for treatment, rehabilitation and indefinite detention at a forensic psychiatric facility. However, many of these state patients may ultimately be released back into the community. As these individuals may be considered a high-risk group, their rates of relapse and recidivism are of importance. There is a paucity of South African literature on the long-term outcome of state patients (Marais & Subramaney, 2015). This study will add more information to the

literature regarding long-term outcomes of reintegrating male state patients into their families.

Labrum, Walk and Solomon (2015) indicate that as a result of deinstitutionalisation and inadequate community support, family members often provide support to relatives with psychiatric disorders such as schizophrenia, bipolar, and major depressive disorders. While there is considerable variation, this support can be immense in volume and very extensive − spanning across domains as discrete as social support, compliance with mental and somatic health treatment, housing, representative payee services, and numerous activities of daily living.

Kokanovic, Brophy, McSherry, Flore, Moeller-Saxone and Herrman (2018) in Australia concluded that enabling supported decision-making in clinical practice, using good communication skills and related attitudes and practices among mental health practitioners in both hospital and community settings, can remove barriers to the stigma attached to mentally ill patients and enhance their stay in their families.

Padmavati (2012) found that community care is emerging globally as an important method of service provision. While obstacles in varying forms remain, the benefits are gradually becoming visible. Mental health services can develop effectively if there is adherence to a principle ethical base, which respects the human rights of individuals living with mental illness.

Allison and Bergin (2013) indicate that, clinicians should give families open models of interacting with them when mentally ill patients are being cared for by family members at their homes. The authors emphasise that rather than remaining within the parameters of one model, it is helpful to be open to other theoretical frameworks that will assist in reintegrating mentally ill patients into their families. Furthermore, many experienced and skilled clinicians working with families align themselves to a particular model and successfully apply this to various clinical situations. However, it is important for clinicians to respond to the needs and

preferences of families and attempt to fit the theoretical model to the family so that the model meets the needs of the family.

Community care requires teamwork and partnership, families often become discouraged, stuck, overburdened, and fatigued by the care of their relatives and end up failing to form the necessary partnership and teamwork (Marimbe-Dube, 2013). Family members alone are not able to take care of their mentally ill patients without support from other community members. When teamwork exists in the community, care for mentally ill patients becomes a success. Family members described their perceptions regarding the reintegration of male state patients into their families.

In Botswana, their only psychiatric institution had become overcrowded, as the number of patients exceeded the bed capacity. There was a shift from hospital care back to community care and families again became responsible for the care of their relatives (Marimbe-Dube, 2013). Furthermore, the shift indicated above did not show any model or guidelines to support the reintegration of male state patients with their families. Therefore, this study described the support needed by families of male state patients to reintegrate these patients with them.

In South Africa, the National Mental Health Policy Framework and Strategic Plan fills a critical gap in our national policy framework and gives added substance to the Mental Health Care Act, No.17 of 2002, which lays out the legal framework for a primarily community and primary health care based mental health system based on human rights. Furthermore, the Mental Health Policy empahasises the notion of people with mental illness or intellectual disability being banished from communities into institutions is out-dated and inhumane. Mental Health Policy places the reintegration of mental health care into general health services and the development of community based care at the centre of interventions. National Mental Health Policy Framework and Strategic Plan document 2013 recognises that a minority of patients do still require specialised in-patient care for varying lengths of time as per National Mental Health Policy Framework and Strategic Plan document (South Africa, 2013).

It can be argued that even the policy indicated above does not cover any model nor guidelines that may be used to support the reintegration of mentally ill patients with their families in South Africa. It is against these policy documents that the researcher was prompted to develop a model that supported the reintegration of male state patients into their families rather than institutionalising them in hospitals.

### 1.1.1 Mental illness

Funk (2016) indicates that successful treatment of disorders of mental illness is a complex issue which often incorporates multiple types of therapy. Mental health care programmes involve various statekeholders such as health professionals, community members, families of mentally ill patients, and patients themselves in decision making regarding mental health issues. Although treatment of mental illness is complex, Thornton (2013) posted that mentally ill patients demonstrate unique physical, mental, emotional, and social patterns that are interrelated, inseparable and continually evolving families.

A study by Egbe, Brooke-Sumner, Kathree, Selohilwe, Thornicroft and Petersen (2014) found that psychiatric stigma was found to be perpetuated by family members, friends, employers, community members and health care providers. Causes of psychiatric stigma identified included misconceptions about mental illness often leading to delays in help-seeking. Experiencing psychiatric stigma was reported to worsen the health of service users and impede their capacity to lead and recover a normal life. Furthermore, the study concluded that media campaigns and interventions to reduce stigma should be designed to address specific stigmatising behaviours among specific segments of the population. Counselling of families, caregivers and service users should include how to deal with experienced and internalized stigma.

WHO (2012) indicates that globally as many as 450 million people suffer from a mental or behavioural disorder. Nearly 1 million people commit suicide every year. Four of the six leading causes of mental disorder in people living with the disability are due to Neuropsychiatric Disorders (depression, alcohol-use disorders,

schizophrenia, and bipolar disorder). One in four families has at least one member with a mental disorder. Bhugra (2016) stipulated that every nation needs to have a National Mental Health Policy which sets the agenda for the planning and delivery of services for individuals with mental illness. Furthermore, planning of health services by various nations should include mental health. The treatment gap for mental disorders is large globally, between 76% and 85% of people with severe mental disorders in low- and middle-income countries receive no treatment. However, in high-income countries people with severe mental disorders range between 35% and 50%.

In addition, World Health Assembly (WHA) indicated that mental disorders can be prevented and be promoted in the health sectors. Therefore, the evidence on the effectiveness of intervention to promote mental health include support of the family members, in voicing their opinions and decision making in the care of mentally ill patients (Bartlett, 2012). There is, however, growing evidence from around the world that families in western countries are scantily supported to provide care required by their family members with mental illness and struggle to provide this support. This is because of community attitudes and beliefs which frequently have an effect on the type of assistance provided to families of individuals with mental illness (Marimbe-Dube, 2013).

Many state patients who are declared as such usually do not show any sign of mental illness at the time of committing a criminal offence. This is why these patients are arrested like any other person for the offence they have committed (South Africa, 1977). This is supported by the WHO which indicates that worldwide, approximately 10 million people are incarcerated due to mental illness, and the WHO reports that the prevalence of mental health problems is 'very high', especially among male inmates. Furthermore WHO reported that although the majority of individuals with mental illness do not exhibit dangerous behaviours, violence and incarceration among mentally ill individuals can place a significant financial and social burden on communities and nations (WHO, 2012a).

WHO further reports that in the United States (U.S.), in the late 2000s, one million adults with serious psychological disorders were incarcerated annually. In a study

conducted by WHO in the Pinellas Country Florida jail, found that not having outpatient mental health treatment was significantly associated with increased risk of misdemeanour arrests and days incarcerated. Having a substance abuse disorder was associated with more days in jail, which is consistent with national incarceration statistics (WHO, 2012a). WHO's reports confirm that mentally ill persons are incarcerated due to the serious danger that they pose to themselves, others and the community. Although WHO reports on incarceration, the Criminal Procedure Act, No. 51 of 1977 of South Africa indicates that mentally ill persons who commit criminal offences should be arrested and taken to a magistrate for trial (South Africa, 1977).

Swanepoel (2015) indicates that mental illness is a disorder (or a disease) of the mind that is judged by experts to interfere substantially with a person's ability to cope with the demands of life on a daily basis. It can profoundly disrupt a person's thinking, feeling, moods and ability to tolerate others. It is because of this disorder that a person who commits an offence and is found not fit to stand trial, is declared as a state patient and as such should be admitted in a designated psychiatric hospital. This is done for the patient to receive treatment, care and rehabilitation so that that the patient is not a danger to themselves, others and the environment.

In South Africa, community-based mental health care is a requirement of the Mental Health Care Act, 17 of 2002 and a central objective of the National Mental Health Policy (MH Policy) Framework and Strategic Plan (2013–2020). Advantages of community mental health services (CMHS) over psychiatric hospital-based care lie not only in that they meet the legal and human rights of mental health care users (MHCUs) to receive care close to home, but also in their modelled cost-effectiveness in terms of improved population coverage.Three core components are listed in the MH Policy: community residential facilities, day care and outpatient services. The bulk of care should be provided by primary health care (PHC) practitioners, with specialist supervision and care for MHCUs with more complex conditions requiring specialised assessment and/or intervention. The MH Policy positions the specialist CMHS back-to-back with general hospital acute psychiatric units within an intervention pyramid. They are tasked with providing continuity of care for the severely ill after hospital discharge, facilitation

of hospital referrals, supervision of PHC, community outreach, and engagement with non-health sectors such as the South African Police Service, local schools and non-governmental organisations. Areas for strengthening district health services are also identified within the MH Policy, and modelled norms and standards for both adult and child and adolescent CMHS are referenced (Robertson & Szabo, 2017).

State patients are declared as such according to Criminal Procedure Act, No. 51 of 1977, due to their mental illness status at the time of committing an act that constitutes a criminal offence (South Africa, 1977).

### 1.1.2 Legislation

In most of the European countries, management of state patients differ according to the laws governing such countries. Although there are differences in European countries, institutionalising those who had committed offences seems to be a common practice. Fan and Wang (2015) posted that in China, the first legislation regarding mentally ill patients was passed in 2013, which specifies conditions for involuntary psychiatric hospitalisation and treatment. The Act further stipulates that the psychiatric patients can only be hospitalised if they are posing a danger to themselves or others, and that family members are not allowed to request hospitalisation of their patients if the stipulated conditions are not adhered to. Similarly, in Sweden a study conducted by Røtvold and Wynn (2015) found that medical doctors used the criteria stipulated in the legislation regarding referral for involuntary admission of mentally ill patients. The criteria covered by the legislation specifies either treatment of the patient or status of dangerousness or even both for involuntary admission.

In the wake of deinstitutionalisation and shorter inpatient hospital stays without matching community mental health spending, the criminal justice system has become responsible for the welfare of the mentally ill. Player (2015) reports that Mental Health Crisis Act (H.R. 3717) in the United States of America would authorise $60 million dollars in federal grants over four years to implement outpatient commitment programmes. Although outpatient commitment orders

were first introduced in the United States, they are also an international phenomenon. Outpatient commitment laws exist in Israel, Canada, Australia, and New Zealand. Amendments to the 1983 Mental Health Act introduced outpatient commitment orders to England and Wales in November 2008. These outpatient commitment programmes indicate that mentally ill patients should be cared for in community settings rather than in hospital settings.

Similarly, deviant behaviours in China that had previously been addressed in psychiatric facilities are now treated as violations of the law, and thus prisons rather than psychiatric institutions now become the actual institutions responsible for the care of mental patients. Arrest becomes a means to manage the deviant behaviour resulting from mental illness, creating tremendous pressure on the criminal justice system. Mentally ill patients often spend unnecessary time in prison. Without access to mental health services upon release, they tend to be rearrested and recycled through the system (Wong, 2013).

South Africa (1977) and Swanepoel (2015) report how section 78(2) of the Criminal Procedure Act, No. 51 of 1977, stipulates the procedure to be followed in the court of law regarding offences committed by mentally ill patients. If it is alleged at criminal proceedings that the accused is by reason of mental illness or mental defect or for any other reason not criminally responsible for the offence charged, or if it appears to the court at criminal proceedings that the accused might for such a reason not be responsible, the court must in the case of an allegation or appearance of mental illness or mental defect, and may in any other case, direct that the matter be enquired into and be reported on in accordance with the provisions of section 79 of the Criminal Procedure Act, No. 51 of 1977.

In South Africa, according to section 78 of the Criminal Procedure Act, No. 51 of 1977, a person who had committed an act that constitutes an offence at the time of the act, and is found that the person suffers from mental illness which makes him incapable of understanding the wrongfulness of his act, shall not be criminally responsible for such act (South Africa, 1977). On the other hand, the Mental Health Care Act, No. 17 of 2002, stipulates that any person who is found by the court of law not able to understand the wrongfulness of his act, shall be admitted

at a designated health establishment as state patient according to section 41 of the said Act (South Africa, 2002).

This is done following court proceedings; where the accused is found to be mentally unstable, the court directs that the accused be sent to the designated health establishment for observation for a period of not more than 30 days as per section 77 of the Criminal Procedure Act, No. 51 of 1977 (South Africa, 1977). The assessing psychiatrists will compile a report on whether the patient is fit to stand trial or not. The observation report should indicate whether the accused was mentally ill during the commitment of an offence or not. If the report revealed that the accused is not fit to stand trial then he or she is sent back to court. The court will then declare the accused as a state patient according to section 78 Criminal Procedure Act, No. 51 of 1977, and be admitted as such, as per section 41 of the Mental Health Care Act, No. 17 of 2002 (South Africa, 1977 & South Africa, 2002).

The Mental Health Care Act, No.17 of 2002, stipulates the conditions of provision of care, treatment and rehabilitation for persons who are mentally ill, including state patients. In terms of the Mental Health Care Act, No.17 of 2002, the person, human dignity and privacy of every mental health care user (MHCU), must be respected. Furthermore, the Mental Health Care Act, No. 17 of 2002 provides steps to be followed by the court when applying for the admission of a patient who is declared as a state patient to a designated specialised psychiatric hospital (South Africa, 2002).

The designated hospital becomes responsible for the rehabilitation of the said state patient. Following a successful rehabilitation of the state patient, the head of health establishment (specialised psychiatric hospital) compiles reports on the mental status of the said patients as directed by mental health regulations, until the patient is fit to be given leave of absence (LOA) in preparation for a conditional discharge of the said patient as stipulated in chapter 4, sub-section 21 of the mental health regulations (South Africa, 2004). The Mental Health Care Act, No.17 of 2002 stipulates the conditions of provision of care, treatment and rehabilitation for persons who are mentally ill, including state patients. In terms of the Mental Health Care Act, No.17 of 2002, the person, human dignity and privacy of every

mental health care user must be respected (South Africa, 2002). The steps provided for in the said Act, prescribes the legal ground on which the mentally ill patients should be admitted to the designated psychiatric hospital in South Africa.

State patients in South Africa are classified as such due to the fact that they have committed a criminal offence and that the court orders them to be admitted in a designated health establishment, following guidelines stipulated by a relevant legislation such as the Criminal Procedure Act, No. 51 of 1977. Furthermore, the study focused on the development of a model to support reintegration of male state patients with their families.

### 1.1.3 Reintegration of state patients

Marais and Subramaney (2015) indicate that there is need for effective psychiatric services in the community to support those state patients who are released from the hospital into their families. Their study concluded that most state patients were out in the community at the end of the 3-year period. The following recommendations are suggested: improved community psychiatric services, especially for those diagnosed with psychotic disorders and mental retardation, with a focus on improving treatment adherence and early detection of treatment defaulters; improved substance abuse rehabilitation programmes and community facilities, as well as strengthening of systems that manage absconders. When there is improved community psychiatric services, reintegration of male state patients into their families can be successful.

A study by Berthelsen, Lindhardt and Frederiksen (2014) in Sweden identified that in mental health, support is crucial to family members and relatives. However, in order to fast-track treatment models, the study reflected that knowledge is needed to strengthen their involvement. This revealed that there is a gap in the involvement of family members on mental health care. The study explored family members' experiences in caring for state patients who are ready to be reintegrated with them, thus improving the quality of mental health care at the designated psychiatric hospital − in Limpopo Province in particular.

Family members are often the primary caregivers of people with mental disorders. The extent of the burden of mental disorders on family members is difficult to assess and quantify, and is consequently often ignored. However, it does have a significant impact on the family's quality of life. In addition to the health and social costs, those suffering from mental illnesses are also victims of human rights violations, stigma and discrimination, both inside and outside psychiatric institutions (WHO, 2012b). This assertion by the WHO, supports the kind of support needed by family members to reintegrate male state patients with them.

When mentally ill patients are being cared for by family members, they become fully involved in community affairs. Mentally ill patients participate in community activities and become accepted by other community members. Their families also are not discriminated by virtue of having a mentally ill patient as a member of the family. This notion is supported by Kukla, Whitesel and Lysaker (2016) who indicate that combining metacognition-oriented therapy with elements of cognitive behavioural therapy and psychiatric rehabilitation, fostered a significantly improved community functioning and attainment of personal goals over time. Furthermore, through the journey of therapy, the mentally ill patients also develop a more coherent narrative about their life, and establish a stable sense of self, and are enabled to become active agents in the world.

### 1.1.4 Perceptions of family members regarding reintegration

Pradeep (2008 cited in Kochher and Bhakhry, 2015) describes the family as a unit which is essential in the treatment and outcome of mental illness. Furthermore, the role of family members contributes to the development of mental disorders in that when an individual is affected by the disorder, the whole family is affected. This occurs when the family is not getting sufficient support and this may lead to development of mental diorders.

Makua (2006 cited in Aphane, 2015) found that physical, psychosocial, financial and developmental support and frustration are experienced by family members. Family members described their perceptions when they are involved in the care

of mentally ill patients. Furthermore, family members are expected and bound to provide physical support to their family member who is mentally ill even when such family member is feeling well. Similarly, Aphane (2015) found that mentally ill patients sometimes refuse to maintain personal hygiene.

When mentally ill patients interact with their family members continuously, they become stabilised. This is supported by Rall (2017) who found that psychotropic medications have a greater impact on mental health care. It was estimated that 65% of the discharged mentally ill patients were as a result of interacting with their families.

The Global Movement for Mental Health which is an international organisation that focusses on mental health issues globally, has brought renewed attention to the neglect of people with mental illness within health policy worldwide. It was observed thorough WHO's programmes worldwide that mentally ill patients are being abused through reports within psychiatric hospitals, informal healing centres, and family homes. International agencies have called for the development of legislation and policy to address these abuses. However, such initiatives exemplify a top-down approach to promoting human rights which historically, has had a limited impact at the level of those living with mental illness and their families (WHO, 2012b). This assertion by WHO calls for the bottom-up approach that will need the considerations of family members in whatever policy or guidelines are being developed.

The findings of a study by Giacco, Luciano, Del Vecchio, Sampogna, Slade, Clarke, Nagy, Egerhazi, Munk-Jørgensen, Bording, Kawohl, Rossler, Zentner, Puschner and Fiorillo (2014), emphasise that patients and families have a desire for information regarding mental illness so that they can take informed decisions about the care of such patients. Furthermore, the desire for information by mentally ill patients is associated with variables, which may change over time, such as symptoms, severity, and the therapeutic relationship. This finding support the researcher's study to develop a model that is based on the perceptions of family members regarding reintegration of male state patients. Furthermore,

family members described the support they need either from the hospital or department to reintegrate male state patients into their families.

### 1.1.5 Family support

Families of mentally ill patients need financial sustenance to maintain the needs of these patients. Amongst other needs, mentally ill patients usually demand that they be given tobacco which family members have to buy for them. It was concluded that family members rely on a government grant, which is insufficient to cater for basic needs − including education of siblings (Makua, 2006 cited in Aphane, 2015).

Family support is essential to successful community based mental health care. This is supported by Roberts, Abu-Baker, Fernandez, Garcia, Fredman, Kamya, Mart, De Leff, Messent, Nakamura, Reid, Sim, Subrahmanian and Vega (2014), who posted that in several countries like China, India, Israel, including Palestine, Japan, Mexico, Peru, Spain, Turkey, Uganda, and the United Kingdom, family therapy needed to be conducted in order to support families of mentally ill patients. Most of the authors in these countries indicated the need to train health workers, especially social workers, to conduct family therapy.

In South Sudan, a study on community attitudes towards mental illness conducted by Ayazi, Lien, Eide, Joseph, Shadar and Hauffis (2014) revealed that the majority of participants favoured a hospital/drug-oriented health care approach rather than community and family care. Participants from urban areas, and those with some education (compared with those who had never attended school), were more likely to believe in family and social intervention rather than the use of hospital/drug-oriented care.

In their study (2014), Ayazi et al. supported the practice in which family intervention is considered good, rather than hospitalisation of the patients. When families of patients who are mentally ill are supported, community care is enhanced, rather than hospitalisation. The results of the study by Ayazi et al.

(2014), supports a practice that family members of mentally ill should be supported when these patients are cared for in the community. This is in line with the aim of the study to develop a model to support the reintegration of male state patients into their families.

In Malawi, a study by Chorwe-Sungani, Namelo, Chiona and Nyirongo (2015) provided valuable information about the views of families regarding nursing care of psychiatric patients. In their study, family members indicated that they are involved in the care of mentally ill patients who are admitted in the hospital, however there is lack of effective cooperation between them and nurses. The lack of collaboration with nurses has caused families to receive inadequate information about the condition of their mentally ill relative. Therefore, it is imperative that family members get sufficient support from nurses and other health care professionals so that reintegration of male state patients with them happen smoothly.

In South Africa, a study conducted by Maluleke, Khumalo, Netshandama, Kutame and Maluleke (2015) revealed different forms of support experienced by mentally ill patients. However, due to a lack of proper support from health care professionals, Department of Health and government, it remains difficult for families to give complete support to these patients, hence the researcher was prompted to conduct the study to develop a model that supports the reintegration of male state patients into their families.

### 1.1.6 Models on reintegration

Svedberg, Svensson, Hansson and Jormfeldt (2014) indicate that there is a lack of research regarding the model called the Psychiatric Rehabilitation Approach from Boston University (BPR). They conducted a study to investigate the outcome of the BPR intervention regarding changes in life situations, use of health care services, quality of life, health, psychosocial functioning and empowerment on mentally ill patients. Furthermore, the study conluded that BPR approach has impact on clients' health, empowerment, quality of life and in particular concerning

psychosocial functioning. However this model did not address the reintegration of mentally ill patients into their families. Instead, the model looks only at the outcome of rehabilitation of these patients whilst they are admitted in the hospital. The researcher's study focussed on the development of a model to reintegrate male state patients into their families.

Orford, Copello, Velleman and Templeton (2010) found that stress-coping models have been popular in health psychology and related disciplines for some time. Individuals may respond to stressful conditions in different ways, and some of those ways may be more effective than others and better for their health. A central idea is that people facing such conditions have the capacity to 'cope' with them much as one would attempt to cope with any difficult and complex 'task' in life. That incorporates the idea of being active in the face of adversity, of effective problem solving, of being an agent in one's own destiny, of not being powerless.

The model of Orford et al. (2010) in the article, is more on coping with stress and not explicit on the model that can support the reintegration of male state patients. Mental illness in the family poses stress and strain and as such family members need to have support in one way or another in order to care for the member who is affected by mental illness.

In South Africa, the National Mental Health Policy Framework (2013) indicates that community mental health should be strengthened to promote reintegration of state patients with their families. State patients who are admitted in the hospital need to be given LOA when they have been successfully rehabilitated. Many such state patients are males rather than females and the details will be explained in the following section dealing with the problem statement. Mabunda (2018) developed a model to promote family involvement in caring for mental health care users in long-term mental health institutions. There is limited information on how male state patients are to be reintegrated into their families after successful rehabilitation at Hayani Hospital. This has prompted the researcher to conduct a study on the development of a model to support the reintegration of male state patients in Limpopo Province, South Africa.

## 1.2 RATIONALE OF THE STUDY

For this study, reintegration of male state patients into their families after succcesful rehabilitation at the hospital is significant. The researcher seeks to reveal how family members of male state patients perceive their reintegration. At Hayani Hospital there are more male state patients than females who are rejected by family members and end up staying in the hospital for a long time. This situation results in many male state patients occupying beds needed for new state patients who need admission for care, treatment and rehabilitation.

However there are activities that the hospital had put in place to address the rejection of male state patients by family members. Hayani hospital conducts multi-disciplinary (MDT) meetings, MDT outreach to the families, social workers' home visits, family days, patients' excursions and mental health awareness campaigns. In addition, local radio stations are used to create awareness among community members, which is not yielding good results as male state patients are still not reintegrated into their families. Despite all these activities, health professionals are unable to successfully reintegrate male state patients into their families.

## 1.3. PROBLEM STATEMENT

The researcher is working at Hayani Hospital and has since observed that most stable male state patients are rejected by their families when they are due for leave of absence or discharged to go home. This is supported by the study conducted by Mabunda (2018) who found that mental health care users (MHCUs) experience rejection by their family members who often display negative attitudes towards acceptance of MHCUs at home. Furthermore, Banyini (2013) asserted that continued hospitalisation may result in relapse of mentally ill patients whilst still admitted in the hospital.

Hayani Hospital is the only designated psychiatric hospital with a functional maximum security ward infrastructure that renders mental health services to male state patients in the Vhembe District of the Limpopo Province, in South Africa.

Male state patients remain in the hospital in larger numbers than their female counterparts as they experience rejection by their family members. After successful rehabilitation of male state patients, the multidisciplinary team (MDT) led by a psychiatrist, grants these patients leave of absence (LOA) so that the process of reintegration with their family is initiated, as outlined in the National Mental Health Policy Framework of South Africa (2013). Secondly, Hayani Hospital has strategies to promote interaction between male state patients and family members, such as annual family day functions in preparation of reintegration of these patients with their families. Lastly, multi-disciplinary team (MDT) members conduct outreach programmes to facilitate reintegration of state patients with their families. The number of male state patients who are successfully rehabilitated and ready for reintegration remains high, even when the hospital is applying the said strategies.

In 2017, between January and June, Hospital Social Workers' records show that there were 60 state patients who were admitted at Hayani Hospital; whilst only 3 (5%) patients out of 60 were females and 40 (66.6%) were stabilised and ready to be reintegrated with their families. Of these 40 stable male patients, 20 (33.3%) were being rejected by their family members. As a result, the hospital remains with high numbers of stable male state patients who are supposed to be with their families. However their families do not visit them, and if they do, they refuse to take them home saying that they are afraid of these patients' behaviour. This is supported by the study conducted by Mabunda et al. (2018) who revealed that family members perceive mental health care users (MHCUs) as being dangerous to self, family and community members at large. Furthermore, MDT meeting reports at Hayani Hospital also indicate that most of the families refuse to accept these male patients when asked to take them home, hence the researcher sought to conduct the study on a model to support the reintegration of male state patients into their families.

Uys and Middleton (2014) support the view that family intervention is the most important milieu for the treatment and rehabilitation of the patients living with

mental illness. Although Hayani Hospital has strategies to facilitate reintegration of male state patients, there is no empirical evidence found of a model to support the reintegration of state patients into their families. The study focussed on male state patients as they are in the majority, as shown by the numbers shown in this section from the social workers. It is in this light that the researcher was prompted to conduct the study on the development of a model to support reintegration of male state patients into their families in the Vhembe District of the Limpopo Province in South Africa.

## 1.4. AIM OF THE STUDY

The aim of the study was to develop a model to support reintegration of male state patients into their families in Vhembe District of Limpopo Province in South Africa**.**

## 1.5. RESEARCH QUESTIONS

The research questions guiding this study were:

- What are the perceptions of family members regarding reintegration of male state patients into their family?
- What kind of support do family members need to reintegrate male state patients into their family?
- What kind of model do family members need to reintegrate male state patients into their family?
- How should the model be validated to ensure that male state patients are reintegrated into their families effectively?

## 1.6. OBJECTIVES OF THE STUDY

The objectives of the study were to:

- explore the perceptions of family members with regard to the reintegration of male state patients into their family

- describe the perceptions of family members with regard to the reintegration of male state patients into their family
- determine the kind of support needed by family members to reintegrate the state patients into their family, and to
- develop a model to support reintegration of male state patients into their families
- evaluate a model to support reintegration of male state patients into their families.

## 1.7. SIGNIFICANCE OF THE STUDY

The study is envisaged to contribute towards the promotion of reintegration of male state patients into their families. The significance of the study is described in detail hereunder.

*Mental health care practitioners*

The study would contribute to the empowerment of health care practitioners in their quest to reintegrate state patients with their families. There would be a change of attitudes of health care practitioners towards the reintegration of state patients with their families. Smooth reintegration of male state patients with their families would be enhanced in designated psychiatric hospitals as the study provided a model to support their reintegration.

*State patients*

When families of male state patients are empowered to be involved in the reintegration process, rejection of state patients would be greatly reduced, resulting in these patients feeling loved and accepted.

*Families of state patients*

Families of state patients would feel empowered during the reintegration process with them, as they would be involved from the beginning to the end.

*Hospital bed occupancy*

The number of institutionalised state patients would be greatly reduced, making beds available for a small minority of state patients who still require specialised in-patient care for varying lengths of time.

*Policy makers*

The study is important because it could assist policy makers in the development of public policies related to the treatment, care and rehabilitation of state patients, especially with regard to their reintegration into their families.

*Body of knowledge*

The findings of the study could contribute to the body of knowledge, especially in psychiatric clinical practice regarding the reintegration of male state patients.

## 1.8. DEFINITION OF CONCEPTS

- **Family**

The family is defined as a group of interacting persons who recognise relationships with each other, based on a common parentage, marriage and/or adoption (South Africa, 2011). In this study, 'family' means parents, guardian and next of kin, including any relatives closer or staying with a state patient who is currently admitted at Hayani Hospital.

- **Family members**

Jumisko, Lexell, and Söderberg (2014) describe family members as people or persons who are considered close enough to constitute a family, be it nuclear or extended − and are related by way of sharing the same clan name and usually stay in the same homestead. In this study, a family member means any person who takes custody of a male state patient.

- **Model**

A representation of reality, such as social workers using the system model to represent the interaction in the family system and to discover where the pathology lies in the family interaction (Barker, 2003). In this study, 'model' means activities that will enable reintegration of male state patients with their families.

- **Reintegration**

According to Mitrotti (2010) reintegration is not just reinsertion but the total transformation of the individual, and the individual concerned is accepted by the group. In this study, reintegration means the process of taking back the male state patient by his family after being granted leave of absence or discharged at Hayani Hospital.

- **State patient**

A person receiving care, treatment and rehabilitation services or using health services at a designated health establishment according to section 41 of the Mental Health Act, No. 17 of 2002 (South Africa, 2002). In this study, a state patient means a person who was sent to Hayani Hospital for admission after being declared as such by a court of law.

- **Support**

Bach (2015) indicates that support is when one gives attention and loving consideration to other people. In this study, support means providing assistance to the families of male state patients in order to reintegrate them successfully.

## 1.9. PARADIGMATIC PERSPECTIVE

A paradigm is a worldview or ideology. A paradigm implies the standards or criteria for assigning value or worth to both the processes and the procedures of the discipline, as well as to the methods of knowledge development within a discipline (Chinn & Kramer, 2008).

The purpose of this study was to develop a model to support reintegration of male state patients with their families in Limpopo Province. Therefore, this study considered three paradigms, namely, meta-theoretical assumptions, theoretical assumptions, and methodological assumptions. These paradigms influence the assumptions that are fundamental to the theoretical reasoning of this study. Each is briefly described as follows.

### 1.9.1 Meta-theoretical assumptions

Meta-theory is defined as assumptions about reality (Brink, 2012). This study's point of departure was the assumption that family is the unit where the individuals belong, irrespective of the health status. Therefore, the ethos of care among individuals should be encouraged and supported. Secondly, grounded on the fact that family members of patients who committed crime do not accept nor consider reintegration with them based on the perceptions they have with that regard. This implies that a model to support reintegration of male state patients was required.

Every person has the ability to become whole. Wholeness is important in the family for individuals to be accepted and reintegrated appropriately. Reintegration of individuals depends on the interaction with his internal and external environment. Internal environment amongst others involves the perceptions one has regarding reintegration with the patient who committed crime. External environment amongst others involves the things that an individual needs to feel supported during reintegration. The researcher believes that support is needed to aid in the reintegration of male state patients with their families.

### 1.9.2 Theoretical assumption

This study was conceptualized within the Social Ecological Model (SEM) of human behaviour (Stokols, 2013): the grounded theory for model development outlined in Dickoff et al. (1968) and the approaches outlined in Chinn and Kramer (2008); Walker and Avant (1995). Each is briefly described below.

*The social ecological model of human behaviour*

The social ecological model explains human behaviour to be multifaceted into four levels, namely; individual, relationship, community, and societal (Stokols, 2013). Reintegration of male state patients who committed crimes is complicated and results from a combination of multiple influences on human behaviour. It is all about how male state patients and family members relate. SEM allowed the determination of the perceptions of family members regarding reintegrating with male state patients and the kind of support the family needs for reintegration to take place. Each level in the SEM was considered as a level of influence and also a key point for reintegration. Through SEM the researcher discovered meanings attached to the complexity of reintegration at individual, relationship, community and societal level. From the perspective of reintegration back to the family, the significance of SEM was needed to work with male state patients and families in a holistic manner.

*Grounded theory for model development*

Phase one of this study would provide information regarding the perceptions of family members regarding reintegration of state patients and the kind of support they need for reintegration to take place. This would be followed by the theoretical framework for the development of the model which would be informed by the six elements of practice theory, as outlined by Dickoff et al. (1968). These are agents, recipients, context, procedure, dynamics and outcomes.

### 1.9.3 Methodological assumptions

The methodological assumptions, which guided this study, were in line with Poggenpoel's (2001) functional approach. This approach implies that research should be functional and should contribute to the body of knowledge and the improvement of quality of life. This study adopted a qualitative approach, using in-depth individual interviews, which produced data that provided an understanding of how family members of male state patients who committed crime, perceived reintegrating with them, as well as what could be done for family members to feel supported in reintegration.

A functional approach was envisaged for the research because the model that was developed would be used to assist government with supporting family members in the reintegration of a male state patient within Limpopo Province. Supporting the family members in the reintegration process would assist the family to understand and accept the male state patient as their own. This would increase family involvement in the rehabilitation of the state patient and avoid rejection of patients by their families, community and society at large.

## 1.10 RESEARCH METHODS

The study methods and reasons given will be discussed in detail in chapter 2. This study was done in two phases. The first phase was a situational analysis, where only a qualitative approach was used. The second phase was the development of a model to support the reintegration of male state patients into their families in Limpopo Province in South Africa.

### 1.10.1 Study setting

This study was conducted in Vhembe District of Limpopo Province. Limpopo Province is divided into five districts; Vhembe, Mopani, Capricorn, Sekhukhune, and Waterberg. Limpopo Province is mostly rural, apart from certain parts of the Capricon District. Most people in the population are unemployed, resulting in their

low socio-economic status. Furthermore, their literacy level is also low − they cannot read or write. The health system beliefs of the people of the Limpopo Province lead them to mostly prefer to consult spiritual and traditional healers first, rather than western medicine healers leading to delay in seeking medical help from this group. Hayani Hospital is the only designated psychiatric hospital with a functional maximum security ward infrastructure which admits male state patients from all the districts of Limpopo Province, especially the Vhembe, Mopani and some parts of the Capricorn districts.

### 1.10.2 Research approach

The study was conducted in two phases; namely, phase one: a situational analysis, and phase two: a model development.

## 1.11 PHASE ONE: SITUATIONAL ANALYSIS

This phase involved the implementation of research methods and the design that provided answers to the research questions formulated in line with the topic under study. The answers obtained in phase one, especially during interviews with the participants lead to the development of the model in phase two of the research approach to support reintegration of male state patients into their families.

### 1.11.1 Research design and methods

Mouton and Marais (1996), Babbie (2011), De Vos (2013), and Burns and Grove (2016), describe the qualitative, explorative, descriptive and contextual design that will be discussed in detail in chapter 2. The research design for this study was qualitative, exploratory, descriptive, and contextual in nature.

*Qualitative*

Qualitative research is a subjective approach which is systematic and used to describe life experience and give it meaning. It is exploratory and descriptive (Burns & Grove, 2016). Qualitative approach was used to allow family members to narrate the depth, richness and complexity inherent in their perceptions of reintegrating with male state patients; secondly their lived experiences regarding the support they need to reintegrate male state patients into their families.

*Exploratory*

The aim of the exploratory research is to get facts, gather new data and determine if there are interesting patterns in the data. Furthermore, exploratory method is typical when a new interest is being examined or when the subject of the study is relatively new (Mouton & Marais, 1996; Babbie, 2011). Perceptions of family members regarding reintegration of male state patients were explored. Furthermore, the kind of support that families of male state patients need to integrate with these patients was explored.

*Descriptive*

Polit and Beck (2016) indicate that the purpose of a descriptive design is to observe, describe and document aspects of a situation as it naturally occurs. Furthermore descriptive design may sometimes serve as a starting point of theory development. Data about the study was gained through in-depth individual interviews where family members gave their in-depth description of their perceptions regarding reintegration of male state patients with them.

*Contextual*

In a contextual study, the researcher can claim to understand the phenomenon if he/she understands it against the background of the whole context, and such context confirms the meaning of the phenomenon concerned (Babbie, 2011). This

study was contextual in that individual interviews were conducted with family members in Limpopo Province in their homes where they stay with their male state patients. Furthermore, the language that was used during interviews was Tshivenda, as the hospital is situated in a region which is predominantly constituted by Venda-speaking family members. The study focused on the reintegration within the context of male state patients. Other forms of reintegration were not entertained and families outside the selected study areas were not included.

### 1.11.2 Population and sampling

*Population*

A population is described as the entire group of persons or objects that the researcher has interest in, regarding the topic to be studied; and further the group meets the criteria the researcher is interested in studying (Burns & Grove, 2016; Brink, 2012). The study population for this study was family members whose relatives are male state patients admitted and recorded in the admission register of Hayani Hospital in Limpopo Province.

*Sampling Method*

A sampling method is described by Burns and Grove (2016) as the process of selecting a sample from the population in order to obtain information regarding a phenomenon in a way that represents the population of interest.

A non-probability purposive sampling was used. The purposive sampling method is based on the judgment of the principal investigator regarding subjects or objects that are typical or representative of the topic being studied, or who are especially knowledgeable about the question at issue. Sampling occurred in two stages namely; sampling of a hospital and a sampling of participants. Details of sampling the method will be discussed in chapter 2.

### 1.11.3 Data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose or specific objective, questions, or hypothesis of the study (Burns & Grove, 2016). Data collection involved preparation, the data collection instrument, and the role of the researcher. These steps will be discussed in detail in chapter 2.

The researcher, as a data collection instrument used effective communication skills to facilitate interviews as described by Babbie (2011), De Vos, (2013), and Brink (2012). All effective communication skills will be discussed in detail in chapter 2.

### 1.11.4 Data analysis

Data analysis guide developed by Tesch and cited in Creswell (2014) was used to analyse data. Tesch provides eight steps cited in Creswell (2014) that should be considered when analysing qualitative data. Details of the steps (one to eight) will be discussed in chapter 2.

### 1.11.5 Literature control

After data analysis, perceptions of family members regarding the reintegration of male state patients and the kind of support they need were identified and literature control was conducted. This will be discussed in detail in chapter 3.

## 1.12 ETHICAL CONSIDERATIONS

The following ethical principles were adhered to during the study, the principles will be explained in full in chapter 2:

- Permission to conduct the study
- Informed consent

- Coercion
- Right to self-determination
- Principle of beneficence
- Principle of justice
- Right to anonymity
- Confidentiality

This is discussed in detail in chapter 2.

## 1.13 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness was ensured through the following measures, which will be clearly explained in chapter 2:

- Credibility
- Transferability
- Dependability
- Confirmability

## 1.14. PHASE TWO: MODEL DEVELOPMENT

This part is described fully in chapter 4 after all the data have been analysed for this study.

## 1.15. DISSEMINATION OF RESULTS

The findings of this research project will be disseminated by the following methods:

- presentation of papers at national and international conferences, seminars and workshops;
- publications in accredited journals;
- presentation to the participants; and
- presentation to Limpopo Department of Health.

## 1.16 OUTLAY OF CHAPTERS

CHAPTER 1: Orientation to the study

CHAPTER 2: Research methodology

CHAPTER 3: Presentation of findings and discussion

CHAPTER 4: Development of a model

CHAPTER 5: Guidelines to operationalise the model

CHAPTER 6: Evaluation, conclusion, limitations and recommendations.

## 1.17. CHAPTER SUMMARY

This chapter introduced an overview of the study, which included the introduction, background of the study, problem statement and significance of the study, aim of the study, research questions and objectives. The research approach, design, methods and theoretical framework as well as phase two of model development which guided the study were also highlighted. Measures to ensure trustworthiness and ethical issues were also described. Furthermore, phase two of model development was highlighted. The next chapter gives a detailed description of the methodology of the study.

# CHAPTER 2

# RESEARCH METHODOLOGY

## 2.1 INTRODUCTION

Chapter one presented the overview of the study. The following aspects are addressed in this chapter: the research approach where a qualitative approach was used; setting in which the study was conducted; population sample and sampling procedures that were used to select the participants; method which was used to collect data from family members of male state patients; measures to ensure trustworthiness, as well as ethical principles that were adhered to during the study.

## 2.2 RESEARCH APPROACH

The research approach has been guided by the Social Ecological Model of human behaviour (Stokols, 2013). The model takes into consideration the world view of people under investigation and uses the outcome to deliver congruent care. The approach of this study was to look at the worldview of the participants and this data formed the basis of model development. The worldview also assisted in developing a model that is congruent with the human behaviour of the participants. This was phase one.

Phase two involved model development in line with the findings from phase one and evaluation of the developed model. A summary of the research process is given in Figure 2.1.

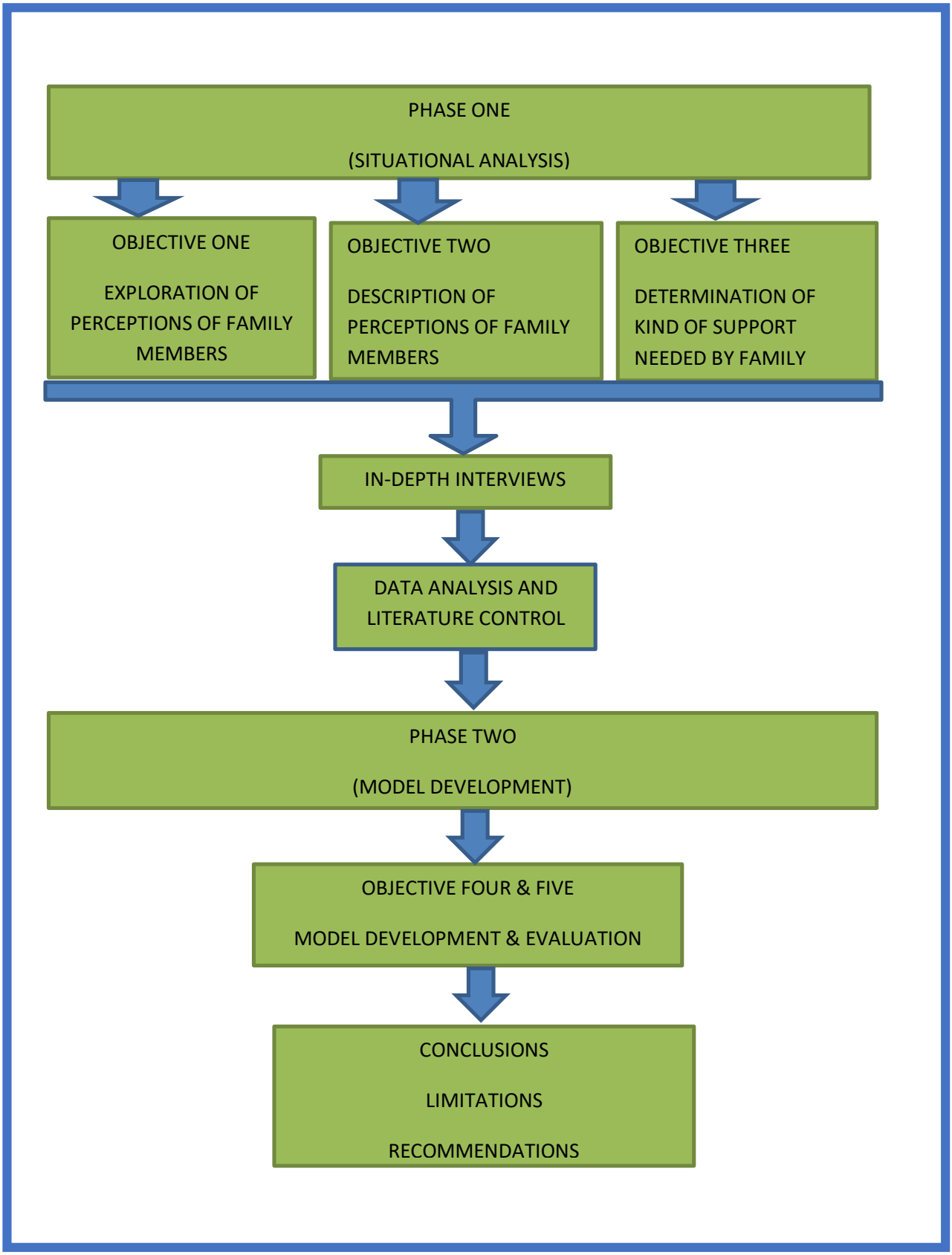


**Figure 2.1 Research process**

Figure 2.1 shows the research process that was followed from phase one which covered situational analysis, until phase two which covered model development and ending with conclusions and recommendations of the study. The figure further shows how the research process is structured in line with the indentified research objectives indicated in chapter 1.

### 2.2.1 Phase one: Situational analysis

The aim of the first phase was to explore and describe the perceptions of family members of male state patients. Furthermore, the support and the kind of model needed by family members of male state patients was also explored and described. In-depth interviews were conducted with family members of male state patients. All information gathered during in-depth interviews was recorded, using a tape recorder and this helped to enrich the data from participants. The information gathered was analysed according to Tesch's eight steps of data analysis (Creswell, 2014). The results were also described against relevant literature. A qualitative approach was used.

#### 2.2.1.1 Qualitative approach

To answer the objective 1-3 stated in chapter one of this study, a qualitative approach using explorative, descriptive and contextual designs was adopted as described by Mouton and Marais (1996), Babbie (2011), De Vos (2013), and Burns and Grove (2016). The main questions were used as point of departure and more questions emanated from the discussion. Participants narrated their perceptions. These perceptions were reflected in words and quotations were used as emphasis of various aspects that were described.

#### Qualitative

Qualitative research is a subjective approach which is systematic and is used to describe life experience and give it meaning. It is exploratory and descriptive (Burns & Grove, 2016). A qualitative approach was used to allow the researcher to explore perceptions of family members as they were be able to narrate the

depth, richness and complexity inherent in their perceptions of reintegrating with state patients, as well as their lived experiences regarding the support they need.

**Exploratory design**

The aim of the exploratory research is to get facts, gather new data and determine if there are interesting patterns in the data. Furthermore, exploratory method is typical when a researcher examines a new interest or when the subject of the study is relatively new (Mouton & Marais, 1996; Babbie, 2011). This study explored the perceptions of family members regarding reintegration of male state patients; the kind of support needed by family members of male state patients in order for male state patients to be reintegrated into their families. Finally, literature was explored extensively during literature control and the development of a model.

**Descriptive design**

Polit and Beck (2016) indicate that the purpose of descriptive design is to observe, describe and document aspects of a situation as it naturally occurs. Furthermore descriptive design may sometimes serve as a starting point of theory development. Data about the study was gained through in-depth individual interviews where family members described their perceptions regarding reintegration of male state patients. To obtain a holistic understanding of the data collected an in-depth description of the identified attributes was made. Again an in-depth description of perceptions of the kind of support they need regarding reintegration was made. A model to support reintegration of male state patients as well as the guidelines for its operationalizing were also described.

**Contextual design**

In a contextual study, the researcher can claim to understand the phenomenon if he/she understands it against the background of the whole context, and such context confirms the meaning of the phenomenon concerned (Babbie, 2011). Similarly, Maree (2012) indicates that contextual studies are those research projects which allow the researcher to be in the actual setting where the participants spend much of their time, in order to gain a deeper understanding of

their situation and only focusing on those aspects which are related to the phenomenon under investigation, without losing focus.

It is believed that human behaviour is influenced in many ways by the environment or setting in which it occurs (De Vos, 2013). The study was contextual in that individual interviews were conducted with family members in Limpopo Province, in their homes where they stay with their male state patients. Furthermore, the language that was used during interviews was Tshivenda as the participants were Venda-speaking family members. The study focused on the reintegration within the context of male state patients. Other forms of reintegration were not entertained and families outside the selected study areas were not included. The developed model was to support reintegration of male state patients into their families.

### 2.2.2 Phase two: model development

Phase two of this study comprised a model development. In developing the model, certain aspects needed to be considered such as situational analysis explained in phase one above, which provided information regarding the perceptions of family members in relation to reintegration of state patients with them, as well as the kind of support they need. The model was developed in an interactive interventive manner using the theoretical framework outlined by Dickoff et al. (1968), approaches by Chinn and Krammer (2008), and Walker and Avant (1995). Details of the model will be discussed in chapter 4.

## 2.3 STUDY SETTING

This study was conducted in Vhembe District of Limpopo Province. Limpopo Province is divided into five districts; those of Vhembe, Mopani, Capricorn, Sekhukhune and Waterberg. Limpopo Province is mostly rural, except for some parts of the Capricorn District. This study was conducted in the Vhembe District where Hayani Hospital is situated, among the family members of male state patients at their homes where they stay with these patients, although the patients were still admitted to Hayani Hospital when the study was conducted. Other districts were not chosen as they do not have a specialised psychiatric hospital

like Hayani with a functional maximum security ward infrastructure, where many state patients who need to be reintegrated into their families are admitted. Although Capricorn District has Thabamoopo specialised psychiatric hospital, it does not have many male state patients who were rejected by their family members. Furthermore, Thabamoopo does not have Maximum Security ward infrastructure that is functional to admit male state patients.

## 2.4. POPULATION AND SAMPLING

### 2.4.1 Target Population

A population is described by Burns and Grove (2016), and Brink (2012) as the entire group of persons or objects that the researcher has interest in, regarding the topic to be studied. Further, the group meets the criteria the researcher is interested in studying. The population for this study was family members whose relatives are male state patients admitted and recorded in the admission register of Hayani Hospital in Vhembe District of the Limpopo Province.

### 2.4.2 Sampling Method

A sampling method is described as the process of selecting a sample from the population in order to obtain information regarding a phenomenon in a way that represents the population of interest (Burns & Grove, 2016; Brink, 2012).

A non-probability purposive sampling was used. The purposive sampling method is based on the judgment of the researcher regarding subjects or objects that are typical or representative of the topic being studied or who are especially knowledgeable about the question at issue (Burns & Grove, 2016). The following table 2.1 illustrates the summary of stakeholders, sampling methods and criteria.

**Table 2.1 Stakeholders, sampling methods and criteria.**

| Stakeholder | Sampling methods | Inclusion criteria | Exclusion criteria |
|---|---|---|---|
| District | Purposive | Have a licensed mental health institution rendering forensic mental health services | Not having a licensed mental health institution rendering forensic mental health services. |
| Hospital | Purposive | Functional designated maximum security ward infrastructure | Non-functional designated maximum security ward infrastructure |
| | | Have high number of rejected male state patients | Fewer number of rejected males |
| Family members | Purposive | Biological relative to a male state patient | Not biological relative to male state patients |
| | | Resides in Vhembe District | Resides outside Vhembe District |
| | | Have a male state patient admitted | Not having the admitted male state patient |
| | | Complete contact details recorded on the hospital register | Incomplete contact details |
| | | Tshivenda -speaking | Not speaking Tshivhenda |
| | | Volunteer to participate in the study | Not willing to participate |

**Three sampling stages**

Sampling occurred in three stages, namely: sampling of the District, hospital and participants. Each is described below.

*Sampling of the District*

At the time of the study, Vhembe District of Limpopo Province in South Africa was purposively selected as it was the only District in Limpopo Province with a specialized licenced mental hospital with a functional Maximum Security Ward infrastructure rendering forensic mental health services (admitting males who committed crimes).

- Exclusion criteria

All other districts in Limpopo Province which do not have a licensed mental institution with a functional Maximum Security Ward infrastructure and do not render forensic mental health services were excluded.

*Sampling of a Hospital*

Within Vhembe District, a specialised licensed mental hospital was purposively sampled as it is the only hospital with a functional maximum security ward where male state patients are admitted. The hospital had 20 male state patients who were rejected by their relatives at the time of data collection.

- Exclusion Criteria

All hospitals without functional maximum security wards infrastructure in or outside Vhembe District were not part of the study.

*Sampling of participants*

All Venda-speaking family members of male state patients who are admitted at the selected specialized mental hospital were purposively sampled. A permission letter was granted by the hospital Chief Executive Officer to access the family members' names that were found in the hospital admission register. Only those

with complete contact details were allocated numbers that were listed. Those without complete contact details were removed from the list and those who were listed were purposively selected. The total number of those with complete contact details were 37 and were recruited telephonically. Out of 37 recruited, 16 family members agreed to participate in the study. However due to data saturation, those who participated were 10.

- Exclusion criteria

Family members who had the following details were excluded from the study, namely; not biologically related to the male state patient; had incomplete contact details on the hospital register; not staying with the male state patient; residing outside Vhembe District; not Tshivenda-speaking; and not willing to participate in the study.

*Sample size*

The actual number of individuals who have been selected as the representatives of the target population are referred to as a sampling size (Swartz; De la Rey; Duncan; & Townsend, 2011). Based on data saturation, a sample comprised of 10 family members who were staying with the male state patient at the time of data collection.

## 2.5 DATA COLLECTION

Data collection is the precise, systematic gathering of information relevant to the research purpose or specific objective, questions, or hypothesis of the study (Burns & Grove, 2011). Data collection involved preparation; data collection instruments; and the role of the researcher. These are discussed below.

### 2.5.1 Preparation of participants

Family members of male state patients were invited telephonically to make an appointment, the study was explained to them and they were recruited to participate in the study. It was also explained to family members that the reason

for interviewing them was that they are experts in the topic of the study, as well as that it will provide a platform for them to talk about their experiences regarding the kind of support they need to reintegrate male state patients with them as family members. This was followed by making telephonic appointments at their homes during the times that were convenient to them. Tentative dates were given, times and venues were agreed to by the participants. Contact numbers of the researcher and those of the participants were exchanged so that changes in the agreed arrangements could be easily followed.

Participants were informed that they were under no obligation to participate in the study, but if they do so, they have the right to withdraw at any stage of the study. Interested family members were interviewed at their homes where they stay with male state patients who are admitted to Hayani Hospital. Explanation on how to operate the audio tape was done, so that participants knew in case they would want to stop it for some reason.

### 2.5.2 Data collection instruments

Data was collected through in-depth individual interviews with family members as participants. This was a one-to-one talk between the researcher and the participants. Family members of male state patients admitted at Hayani Hospital were interviewed using this method as they were found at their homes. The interviews were directed by the following central questions which were followed by further probing questions that were posed during the interviews.

- *As a family member of a patient who committed a crime, could you please share with me your perceptions regarding reintegrating him into your family?*
- *What can be done to make you feel supported for reintegration of the patient who committed a crime, into your family?*

The interviews were then transcribed and translated to English verbatim, for analysis purposes **(Refer to Annexures J1 & J2).** The interview was free-flowing with its structure limited to the focus of the research. In-depth accounts which presented a lively picture of the participants' reality was densely presented in

words as narratives, using individual quotes. The raw data of in-depth interviews was recorded in non-numerical form.

*The role of the researcher*

The researcher was the main research instrument for data collection and observed, interviewed, recorded, analysed, and interpreted as faithfully as possible what participants said as the researcher was interacting with them during data collection. Rapport and trust was established and an attitude of unconditional acceptance, respect, empathy, honesty, openness and modesty was displayed.

Furthermore, the participants were encouraged to feel free to explain their experiences and that no names would be mentioned during the interview. It was also explained that there is no right or wrong answer and the researcher attempted to appear relaxed and as natural as possible. When participants were relating their experiences, the researcher made it a point that his non-verbal responses were consistent with the flow of the story. Effective communication skills to facilitate the interviews were used as described by Babbie (2011); De Vos (2013); and Brink (2012):

- *Listening:* The researcher applied his listening skills, and paid attention throughout the interview process.

- *Probing:* Probing questions were asked, emanating from the participants' answers, to allow participants to give more clarity.

- *Minimal verbal responding*: Minimal verbal responding by nodding the head, saying "mm", "yes", "continue", to allow free flow of information and to encourage participants to talk. This made participants feel more relaxed and more willing to talk about their experiences.

- *Clarifying*: Clarification was always sought on statements that had not been understood in order to avoid assumptions.

- *Reflecting*: Repeating the statements was demonstrated as mentioned by the participant in a question form in order for the participant to expand more on the specified points. Reflecting back to the participants was done in their own words to ensure their understanding of what is being said when the need arose.

- *Focusing*: Participants were given full attention as they deliberated about their own experiences in order to help them focus. This was demonstrated by way of seating arrangements done where the interview was conducted, chairs were the same with no table inbetween. A non-threatening environment was maintained throughout the interview to enable participants to relate their stories without fear. All interviews were conducted at a time that was convenient to participants. The interviews were conducted in a private, comfortable place accessible to the participants in their homes as agreed. Human respect towards the participants was demonstrated and all these factors kept participants focused on the interview.

- *Paraphrasing:* The participant's words were rephrased in another form but with the same meaning. This encouraged them to give more information. Furthermore, paraphrasing of the responses from the participants before asking the next question, was done.

- *Validating*: Participants were observed and their non-verbal communication such as vocalization, facial expression and body gestures were interpreted and transcribed for analysis. All non-verbal communication that was collected during interviews as field notes was transcribed and analysed to give collected data more meaning.

- *Using Silence*: Silence was used by keeping quiet and observation of all the deliberations to allow the participants to think and continue to talk at own pace without interference. Eye contact was maintained and remaining silent was done while demonstrating to participants that they were being listened to. Awareness and hearing was also demonstrated. Furthermore,

active listening to what the participants were saying both verbally and non-verbally was demonstrated. This involved perceiving another person's body movements, facial expressions and quality and tone of voice.

- *Establishing a trust relationship*: The researcher immersed self in the participant's life world in order to better understand their experiences regarding available support to reintegrate male state patients. Mutual trust was ensured to gain cooperation of the interviewee, and also improve the quality of collected data. Partcipants were responded to in a manner that showed that the interviewees were worthy of their disclosure and were not condemned or opposed. Pleasant interpersonal relationship was maintained throughout the interviews.

### 2.5.3 Pretesting

Pre testing is about verifying the ability of the research instrument to collect data and ensuring that the instructions on the instrument are clear (Brink, Van der Walt, & Van Rensburg, 2016). Prior to the actual data collection process, family members of male state patients whose home was near Hayani Hospital were selected and interviewed to check if the questions were phrased in a manner which the partcipants would understand. The said family members were not included in the study.

The first interview was recorded and transcribed **(Refer to Annexure I)**. The transcript was presented to the promoters who indicated that probing was not adequate. Efforts were made to improve the identified gap in subsequent interviews that were included in the study.

## 2.6 DATA ANALYSIS

A data analysis guide developed by Tesch, cited in Creswell (2014) was used to analyse data. Tesch provides eight steps that should be considered when analysing qualitative data, and was applied as follows:

- *Step one: Get sense of the whole*: All the transcripts were carefully read through, to get a sense of the whole several times, to acquaint the researcher with data collected and jotting down some ideas which came to mind.

- *Step two: Pick one document*: The shortest and most interesting document was picked and read through again, making sense out of it. Underlined thoughts that came out were written in the margin. They were later used to group similar topics together.

- Step three: *Clustering together of similar topics*: All the topics were listed and those that were similar were clustered together. These topics were then formed into columns arranged as major topics, unique topics, and leftovers. Leftovers were placed in a separate file in case they would be needed during writing of research findings. Different coloured pens were used to simplify the task.

- *Step four: Abbreviate the topics as codes*: The researcher took the list and then went back to review the data again. Topics were abbreviated as codes and written next to the appropriate segments of the text. Thereafter, the scheme was organised preliminarily to see if new categories and codes emerged.

- *Step five: Describe the topics:* Most descriptive wording for the topics were found and changed into categories or themes and sub themes. The researcher tried, by all means, to reduce the total list of categories by grouping topics that relate to each other and then drew lines between the categories to show interrelationships.

- *Step six: Abbreviate categories*: A final decision was made on the abbreviation for each category and codes, and they were arranged alphabetically. This was done after going through the codes several times, making sure that all codes were noted.

- *Step seven: Assemble data*: Data material belonging to each other were assembled and a preliminary analysis was done. This simplified coming up with the themes and sub-themes based on the grouping.

- *Step eight: Recording*: The existing data was recorded to ensure that no data was missing. Themes and sub-themes were written in tables of which the details will be discussed in chapter 3 where results will be discussed.

## 2.7 LITERATURE CONTROL

Literature was done after data analysis. This ensured that there would be a perfect fit between data and relevant literature, providing a link between previous and present research as described by Mdluli (2005). Furthermore, previous research was used to establish similarities as well as to determine the uniqueness of the present study during data analysis. Again literature review was done during development of the model. Lastly, literature control was done to confirm the results of the investigation and description of the life world of family members of male state patients and the kind of support needed regarding the reintegration.

## 2.8 ETHICAL CONSIDERATIONS

Burns and Grove (2016) define ethics as a branch of philosophy that deals with morality, whilst Polit and Beck (2016) indicate that ethics contain a set of propositions for the intellectual analysis of morality and a means of striving for rational ends, and that ethics in research ensures that the rights of participants are observed, protected and respected. Protection of the rights of the participants wase ensured. The following ethical considerations were observed:

### Permission to conduct the study

The permission to conduct the study was requested from the following:

- A research proposal was presented to the Department of Advanced Nursing Science for quality of research standards and was accepted. It was further presented to the School of Health Sciences Higher Degrees Committee which eventually appoved it **(Annexure A).**
- A proposal was forwarded to the University Higher Degree's Committee for final approval. The University of Venda Research Ethics Committee issued an ethical clearance certificate and permission to conduct the study **(Annexure B).**
- The Limpopo Province Department of Health Research Ethics Committee approval was granted **(Annexure C2).**
- The Vhembe District Department of Health issued a permission letter **(Annexure D2).**
- Chief Executive Officer of Hayani Hospital also issued a permission letter to access records **(Annexure E2).**
- Participants' consent **(Annexure H1 & H2).**

**Informed consent**

Information regarding the aim of the study and the information needed was explained and how data would be collected and used and then a written consent was sought from participants. All this was done to ensure free will to participate in the study after being informed.

**Coercion**

Research involving the family members of patients as significant others in the care of the patients, is an ethical issue. This is the reason why it was necessary that special attention be given to the potential for coercion, undue influence, power disparities as well as being fair when selecting family members to participate in the study. The likelihood that family members' participation may be the result of unintended undue influence, was carefully thought out. The researcher was conscious of his position as a mental health practitioner and the nurse manager at Hayani Hospital where the research took place. To avoid any coercion that may have arisen, the following was done:

A letter to request permission from the Chief Executive Officer of Hayani Hospital was submitted to seek permission to access records of male state patients who are admitted in the institution, in order to obtain names and contact details of their family members.

**The right to self-determination**

This was ensured by allowing participants to decide whether or not to participate in the study and that they have the right to withdraw from the study if they did not wish to continue to participate. An announcement was made when family members were invited telephonically to request permission to participate in the study. Further than that, a letter of informed consent was issued to the family members' at in-depth interviews with their state patients. Family members who were able to read were allowed to do so on their own and then they could make a choice about participating in the study.

**Principle of beneficence**

Beneficence means that the researcher is required to do well, and above all, do no harm (Brink, 2012). The well-being of participants was secured and protected from discomfort and harm. It was explained that there were no legal implications as a result of them giving their opinion about their experiences regarding support available to them as relatives of male state patients.

**Principle of justice**

Participants were selected fairly, conveniently, and were treated fairly. Furthermore, their participation was voluntary.

**Right to anonymity**

The use of real names of participants was prohibited, each participant was provided with a number. The number was used when discussing data. A master list of participants and matching numbers was kept in a safe place.

**Confidentiality**

Participants' names were never mentioned during an interview. Data gathered during the study were made available only to persons directly involved with the

study. It would only be published for the benefit of the researchers and the Department of Health. Anonymity was protected.

## 2.9 MEASURES TO ENSURE TRUSTWORTHINESS

Lincoln and Guba (1999) claim that trustworthiness of a research study is important in evaluating its worth. Trustworthiness refers to the degree of confidence qualitative researchers have in their data as it measures the true value of the study. It embraces four criteria; namely, credibility, dependability, confirmability, and transferability (Polit & Beck, 2016; Speziale & Carpenter, 2007) cited in Khalaf, Abu-Moghli, LoRocco, & Al-Maharma, 2017). The researcher tried and safeguarded trustworthiness by applying Lincoln and Guba (1999) criteria as indicated in Table 2.2 below. All the measures discussed below ensured that the research study was authentic.

**Table 2.2: Measures to ensure trusworthiness**

| Measure | Criteria | Applicability |
|---|---|---|
| Credibility | Prolonged engagement | The researcher has more than 10 years' experience in the clinical field (mental health) in which the study was conducted, and spent 3-4 months in the field work collecting data. Appointments with participants were made telephonically before and also after interviews to make further appointments to validate the data. |
| | Member checking | A summary was made at the end of each interview and a voice recorder was played back to the participants. Literature control was done. |
| | Peer examination | Presented research proposal at departmental and school research committees. University higher degrees committee evaluated the proposal. Data was co-coded by independent |

| | | |
|---|---|---|
| | | coder, professionals evaluated the developed model and the external examiners examined thesis. |
| | Model evaluation | A panel of mental health professionals was purposefully selected to evaluate the research model. |
| | Structural coherence | Data was analysed using Tech's framework of data analysis and the model was developed using Dickoff etal.'s (1968) framework of model development. Model evaluation was guided by Chinn and Kramer while the study was guided by Social Ecological Model (SEM) theory of human behaviour of Stokols (2013). Ethical considerations were adhered to throughout the study. |
| | Researcher authority | The researcher has a sound knowledge of research. Promoters are research experts and independent coder has sound research knowledge and rich experience in the field of mental health. |
| Transferability | Nominate sample | A purposive sample was used. |
| | Dense description | Theories used in the study. Qualitative methodology, study setting and sampling process described fully. |
| Dependability | Dependability audit | Research proposal was presented at departmental and school research committees. University higher degrees committee (UHDC) examined the proposal. Data was co-coded by independent coder and external examiners examined thesis and professionals evaluated the developed model. |
| | Dense description | Theories were used in the study. Qualitative methodology, study setting and sampling process were fully described. |

| | | |
|---|---|---|
| | Code-recode procedure | A consensus discussion was held between the researcher, promoter and independent coder. |
| Confirmability | Confirmability audit | Professionals evaluated the developed model. External examiners examined the report. Researchers at departmental, school and UHDC examined the research proposal. Independent coder used to co-code the data |

**Credibility**

Lincoln and Guba (1999) indicate that truth value asks whether the researcher has established confidence in the truth of the findings from the participants and the context in which the study is undertaken.

Credibility was achieved by ensuring that the population is accurately identified and especially knowledgeable about the phenomenon being studied. In this study, family members who are relatives of male state patients were participants who gave lived experience regarding reintegration during in-depth interviews. Data was transcribed as direct quotations from the participants. Furthermore, credibility was ensured through prolonged engagement, member checking, peer examination, model evaluation, structural coherence and researcher authority. These are discussed below.

*Prolonged engagement*

Prolonged engagements' participants allow identification of recurring patterns, themes, and values for the validation of perspectives. The participants were telephonically engaged during the process of making initial and follow-up appointments. Furthermore, initiation phase was conducted during which the participants introduced themselves to one another in order to establish rapport. The participants were then briefed about the research questions, its purpose and significance.

*Member checking*

Member checking was done throughout the interview by deliberate probing and paraphrasing. At the end of each interview, the researcher summarised what the participants said during the interview. The voice recorder was played back to the

participant to validate what she/he had said. The preliminary findings were discussed with the participants. After data was fully analysed, the researcher went back to participants for a final member check to determine if what was transcribed is what they meant during the interviews.

*Peer examination*

Peer examination was ensured by the researcher presenting the research proposal at departmental and school research committees. University higher degrees committee examined and approved the said proposal **(see annexure A)**. Data co-coded by independent coder, external examiners examined the thesis, and professionals evaluated the developed model.

*Model evaluation*

This was ensured by evaluating the research model by a panel of mental health professionals who were purposefully selected. Details of model evaluation is discussed in chapter 4 of the study.

*Structural coherence*

Data was analysed using Tech's framework of data analysis and the model was developed using Dickoff et al.'s (1968) framework of model development. Model evaluation guided by Chinn and Kramer (2008) while the study was guided by SEM theory of human behaviour and developed by Stokols (2013). Ethical considerations were adhered to throughout the study.

*Researcher authority*

The researcher has a sound knowledge of research. Promoters are qualitative research experts and independent coder has sound research knowledge and has a rich experience in the mental health field.

**Transferability**

Applicability refers to the degree to which the findings can be applied to other contexts and settings or with other groups (Lincoln & Guba, 1999).To ensure transferability, a sample of partcipants was purposefully selected.

*Dense description*

The research context and setting were richly and thoroughly described in detail including what transpired during interviews. The research methodology, findings of the study and theories used to guide the study were also described. A dense description of the research methodology and the findings was done. Furthermore, transferability was ensured by densely describing the background information of participants as discussed in chapter 3 of the study.

**Dependability**

Lincoln and Guba (1999) reflect consistency of the data in research as important because it considers whether the findings would be consistent if the inquiry were to be replicated with the same subjects or similar context.

*Dependability audit*

The researcher presented the research proposal at departmental and school research committees for evaluation of research standards. University higher degrees committee examined the proposal to further ensure that research standards are adhered to. Data was co-coded by independent coder who is an expert in the field of psychiatric nursing and also has a doctoral degree. After data analysis by the reasercher, consensus discussion was held between the researcher, promoter and independent coder to agree on the themes and sub-themes that emerged. and external examiners, examined the thesis and professionals evaluated the developed model. Dependability was further ensured by using the voice recorder which was made available for verification if necessary. Dense description was done as discussed under transferability above.

*Code-recode procedure*

A consensus discussion was held between the researcher, promoter and independent coder to agree on the coded data.

**Confirmability**

Lincoln and Guba (1999) refer to neutrality as the degree to which the findings are a function of the participants and conditions of the research and not of other biases, motivations and perspectives.

*Confirmability audit*

This audit was ensured by professionals evaluating the developed model using Chinn and Kramer's (2008) elements of model evaluation. External examiners examined the report. Researchers at departmental, school and UHDC evaluated the research proposal. Independent coder was used to co-code the data.

Furthermore, confirmability was ensured by playing back the tape-recorded interviews to participants to check if what they had said is what they meant. Data was transcribed verbatim into transcripts before discussing the themes and sub-themes. Furthermore, the researcher tried to be non-judgmental, and strived to report what was found in a balanced way.

## 2.10 CHAPTER SUMMARY

This chapter presented the following aspects: designs of the study, phase one which was situational analysis, the setting in which the study was conducted, population sample and sampling procedures that were used to select the participants, method which was used to collect data from family members of male state patients, measures which were adopted to ensure trustworthiness of the study, and ethical principles that were adhered to during the study. Chapter 3 will present the discussion of study results.

# CHAPTER 3

# PRESENTATION OF THE FINDINGS AND DISCUSSION

## 3.1 INTRODUCTION

Chapter 2 discussed the methodology that was used to conduct this study.This chapter gives detailed information of the presentation and discussion of the findings obtained from collected and analysed data on the development of a model to support reintegration of male state patients into their families in Limpopo Province in South Africa. The description of profile of participants, identified themes and sub-themes that emerged during the data analysis are also presented here.

## 3.2 DESCRIPTION OF THE SAMPLE

The sample for this study consisted of family members of male state patients who have been admitted to Hayani Hospital, as outlined in chapter two. The sample comprised 10 participants recruited from 10 family units and this sample size depended on the saturation of data. Family units were numbered from 1-10, and consisted of interviews with the following family members:

- Family unit no.1- a sister,
- Family unit no.2- a mother,
- Family unit no.3- a mother,
- Family unit no.4- a mother,
- Family unit no.5- an uncle,
- Family unit no.6- a grandmother,
- Family unit no.7- a sister,
- Family unit no.8- a sister,
- Family unit no.9- a brother, and
- Family unit no.10- a daughter.

They all have the responsibility for custody of the male state patient when he is released from the hospital.

The inclusion criteria of family members was guided by the Social Ecological Model of human behaviour (Stokols, 2013). This model explains human behaviour to be multifaceted into individuals and relationships. Therefore, in order to gather demographic information, issue of gender and relation were asked in the first contact with participants. This is displayed in table 3.1 below.

**Table 3.1 Demographic information of participants**

| FAMILY UNIT | RELATIONSHIP TO THE PATIENT |
|---|---|
| No. 1 | Sister |
| No.2 | Mother |
| No.3 | Mother |
| No.4 | Mother |
| No.5 | Uncle |
| No.6 | Grandmother |
| No.7 | Daughter |
| No.8 | Sister |
| No.9 | Brother |
| No.10 | Daughter |

The variables which include gender and relation of the participants with the mental health care user (MHCU) is presented in tables 3.2-3.3 and figures 3.1-3.3 below.

**Table 3.2 Gender information of participants**

| Gender | Frequency | Percentage |
|---|---|---|
| Females | 8 | 80% |
| Males | 2 | 20% |
| Total | 10 | 100% |

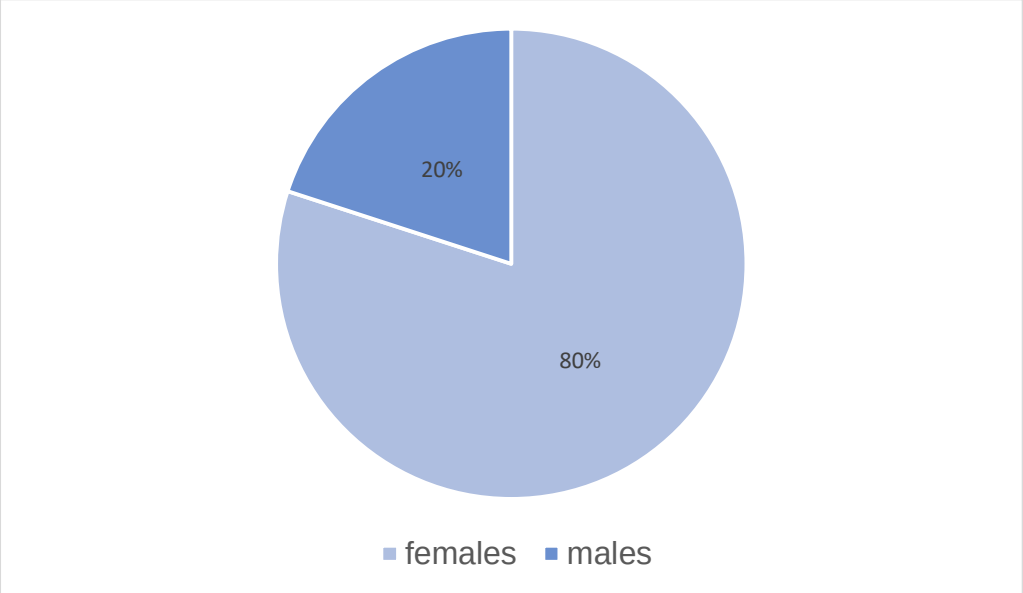


**Figure 3.1: Gender information of participants**

Table 3.2 and Fig 3.1 above illustrates that the majority of participants, namely 8 which is 80% of 10 sampled participants were females, whilst 2 (20%) were males. This is common in Limpopo rural areas owing to the fact that majority of males migrated the province as job seekers to other provinces, living in households being run by females. This is supported by Limpopo Province Department of Health 5-year 2015 – 2020 Strategic Plan report (2015 ) which reported that Limpopo Province's unemployment rate was estimated at 18.1%. Furthermore, females constitute the majority, making up 52.3% (2.73 million) of the province's population.

**Table 3.3 Relationship information of participants and the mental health care user**

| Relationship | Frequency | Percentage |
|---|---|---|
| Mother | 3 | 30% |
| Sister | 2 | 20% |
| Daughter | 2 | 20% |
| Brother | 2 | 20% |
| Uncle | 1 | 10% |
| Grandmohter | 1 | 10% |
| Total | 10 | 100% |

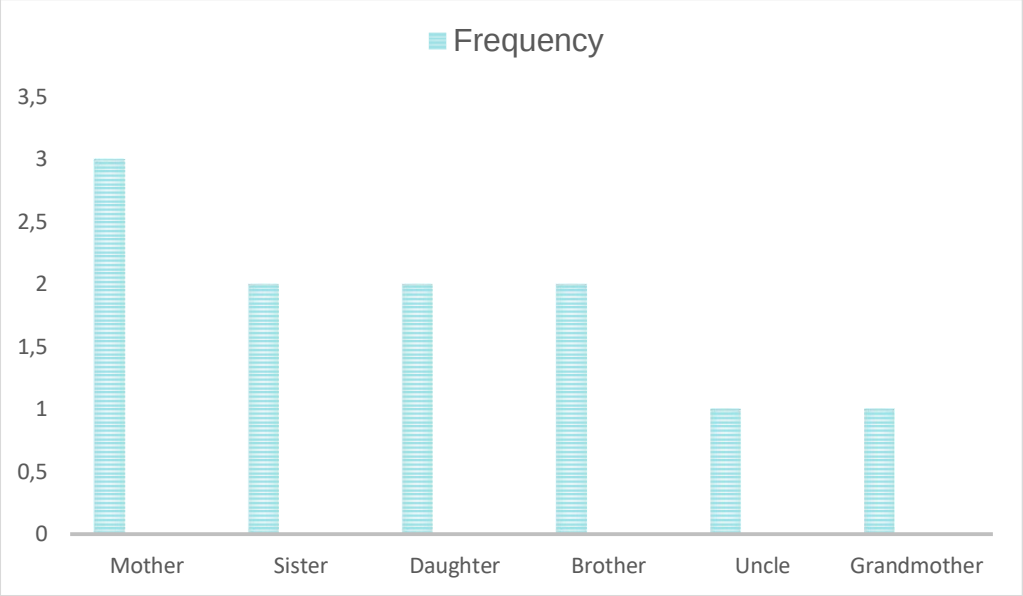


**Figure 3.2: Relationship information of participants and the mental health care user in frequency**

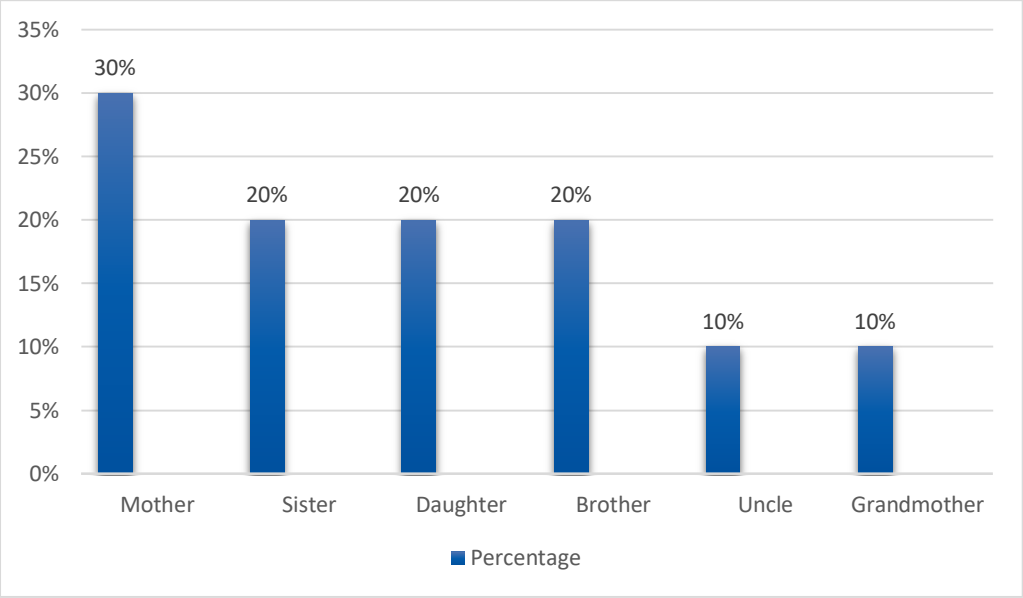


**Figure 3.3: Relationship information of participants and the mental health care user in percentage**

Table 3.3 and figures 3.2; 3.3 above present how the participants are related to the mental health care users. Out of 10 participants, 3 (30%) were mothers, 2 (20%) were sisters, 2 (20%) daughters, 1 (10%), 1 (10%) was a brother, 1 (10%) was an uncle, and 1 (10%) was a grandmother. They are all biological relatives to the male state patients. This is in line with the Social Ecological Model of human behaviour (Stokols, 2013) when perceiving the human behaviour to be multi-dimensional in individuals and relationships.

## 3.3 PRESENTATION OF THE FINDINGS

Data was analysed using Tesch's eight steps of data analysis (Creswell, 2014). Data analysis revealed six themes, namely: family members' expectations of a mental health care user regarding reintegration, family members' perception regarding reintegration, threat to reintegration as perceived by family members, support needed by family members from the hospital regarding reintegration, family members' kind of support they needed from the community relating to reintergration, and family members' kind of support they needed from the government relating to reintergration. These themes as well as sub-themes are discussed in detail with direct relevant quotations from the transcripts to enrich the data. The discussion of the literature follows this

directly and serves to confirm the findings. Table 3.4 below shows the emerged six themes and sub-themes.

**Table 3.4: Themes and sub-themes**

| THEMES | SUB-THEMES |
|---|---|
| 1.Family members expectations on a mental health care user regarding reintegration. | • Complete recovery/recuperation of mental health care user<br>• A mental health care user should be home for short periods of time.<br>• A mental health care user must comply with his medication. |
| 2.Family members perception regarding reintegration. | • Acceptance of reintegration<br>• Reintegration is important.<br>• Family members love their mental health care user.<br>• Return of the mental health care user is a bad thing. |
| 3.Threat to reintegration as perceived by family members. | • Victims family are afraid of the mental health care user.<br>• Community will take revenge of the mental health care user.<br>• Family members are afraid of the mental health care user. |
| 4. Support needed by family members from the hospital regarding reintegration | • The family should be visited by the hospital staff to give them health education.<br>• Victims family should be visited by the hospital staff to hear from them regarding reintegration. |

| | |
|---|---|
| | • The mental health care user must be visited by hospital staff to ensure compliance with treatment. |
| 5. Family members' kind of support they needed from the community relating to reintegration. | • Traditional leaders should be the ones to instruct them to accept the mental health care user.<br>• Community members should agree that a mental health care user be brought back home. |
| 6. Family members' kind of support they needed from the goverment relating to reintegration | • Government should build a house for a mental health care user.<br>• Mental health care users must be employed.<br>• Government should give mental health care user a disability grant. |

### 3.4 DISCUSSION OF THE FINDINGS

The discussion of the findings is done according to themes and each is discussed separately; family members' perception regarding reintegration, threat to reintegration as percieved by family members, family members' kind of support they need from the hospital relating to reintegration, family members kind of support they need from the community relating to reintergration, and family members kind of support they need from the government relating to reintegration.

**Theme 1: Family members' expectations on a mental health care user regarding reintegration**

Most participants indicated their expectations on a mental health care user regarding reintegration yielded the following sub-themes: a mental health care user must be completely healed, a mental health care user should be home for short periods of time and a mental health care user must comply with his medication. This is presented in table 3.5 below.

**Table 3.5: Family members' expectations of a mental health care user**

| THEME | SUB-THEMES |
|---|---|
| Family members expectations of a mental health care user regarding reintegration. | Complete recovery/recuperation of mental health care user |
| | A mental health care user should be home for short periods of time. |
| | A mental health care user must comply with his medication. |

Each sub-theme is discussed separately under the first theme which indicates that family members have expectations of a mental health care user regarding reintegration.

- **Complete recovery/recuperation of mental health care user**

Data revealed that, participants indicated that they would like to see their MHCU completely healed before reintegration could take place.The following quotes depict family members' expectations on the mental health care user regarding reintegration.

*"…If the patient is right I agree that he must come back. My opinion of sending him to Hayani Hospital is that it was difficult for me to stay with him. Things*

*were not good as the child of my daughter (referring to the patient) will sometimes hold me and throw me out the fence you are seeing here. There was no one who can handle him except myself and my late husband who unfortunately passed away at the time of sending him to the hospital. I saw that I cannot handle him, I then requested that he be admitted. I had many trips to the SAPS and magistrate court to arrange for their assistance to me. I even came to Hayani Hospital to see the doctors. He must be healed completely in order for him to come back. I mean that it should be in way that we could interact well with each other with good understanding for each other..."* **Grandmother: Family unit no.6**

Another one said:

*"…What I see is that if these patients are healed they can be released to go home, but the government should come and check whether the patients are continuing to take treatment and that these patients are not troubling the family members, relatives and the community at large. I also see it as important to do something that will make them busy…"* **Sister: Family unit no.7**

This is in congruence with AL-Sagarat, Moxham, Curtis, and Crooke (2014) who concluded that relatives provide immense support to family members who live with a mental illness and involving them in care and treatment will aid recovery. Relatives in this Jordanian study believe that their family members should be more closely involved in their treatment programme and that more visibly structured therapeutic activities are required in hospitals.

Similarly, Ellegaard, Bliksted, Lomborg, and Mehlsen (2017) concluded that involving patients in their own course of treatment can improve both the patients' self-efficacy and their perception of the health care services.

- **A mental health care user should be home for short periods of time**

Some participants regarded the importance of not releasing the MHCUs to their home completely, instead they indicated that MHCUs should be released for shorter periods at first. Furthermore partcipants indicated that releasing MHCUs for shorter periods will allow them to be checked whether they are completely healed or not. The following quotes depict family members' expectations on the mental health care user regarding reintegration.

*"…I am saying that they can come home but not forever. They can be given short stays while being checked, maybe for a week, month or so. When the patient is at home and he does something wrong again if we could allowed to phone the SAPS for assistance or else the hospital to come and take the patient back to the hospital. SAPS usually refuse to assist us..."* **Sister: Family unit no.8**

In agreement with the quotes above, Christ (2014) indicates that home care can fortify and enhance the ability of the natural setting to contain, support, and stabilize the symptomatic individual who would otherwise require a supervised level of treatment. It is argued that the psychiatric care organisation of the near future will be capitated, managed, and patient-centred, rather than organised around service providers. This means that when the patient is cared for at home, he feels loved and supported, thus stabilising his condition.

Furthermore, one of the most valuable aspects of home care within a managed care environment is its potential to re-establish long-term therapeutic alliances for patients, with providers who remain constant over time, and who can be trusted and worked with as partners in devising successful strategies to cope with complex and perplexing serious mental disorders. With its capacity to individualise, underwrite normal functioning, and follow chronic patients over the long-range course of illness, home care is currently the level of service most in synchrony with this developing model (Christ, 2014).

On the other hand, Ellegaard et al. (2017) found that patients mainly admit themselves because of mental conditions, and also due to social and everyday problems and a wish to spare relatives. This indicates that various aspects of the patients' lives have a significant impact on their desire for help and as such patients need to be released home in order to get help from their family members. The purpose of admission varies, but patients mainly hope to obtain peace of mind and prevent symptoms increasing. If the length of stay is not prolonged, patients being discharged experienced the length of stay as appropriate due to the fact that their mental condition has stabilised.

- **A mental health care user must comply with his medication**

Most participants indicated that MHCUs must comply with medication to prevent relapse. This would be achived if health care professionals are checking MHCUs at their homes regularly. This is depicted by the following quotes from the participants.

*"…The hospital should ensure that the patient get his medication…"* **Mother: Family unit no.3**

Another one said:

*"…I like him to come home as a child. The important thing is that I had told him to quit smoking dagga and drinking alcohol so that he will live better as when he was readmitted he was no longer taking his treatments as expected, saying he is not ill…"* **Mother: Family unit no.4**

The above quotes are in line with AL-Sagarat et al. (2014) who indicated the need for greater support from nurses for patients, with the goal of helping them to become more self-sufficient and independent. Finally, relatives of psychiatric patients saw the need for an environment where patients are more able to express their feelings openly.

Similarly, Lawska, Zieba, Lyznicka, Sulek and Póltorakk (2006) revealed that mentally-ill family members expect to be noticed, accepted and sympathised with, so a supportive and accepting environment is indispensable for the optimisation of socio-professional therapy and rehabilitation of the ill.

**Theme 2: Family members' perceptions regarding reintegration**

Most participants indicated their perceptions regarding reintegration which yielded the following sub-themes: acceptance of reintegration, reintegration is important, family members love their mental health care user and returning home is a bad thing. This is presented in table 3.7 below.

**Table 3.6: Family members' perceptions regarding reintegration**

| THEME | SUB-THEMES |
|---|---|
| Family members' perceptions regarding reintegration | Acceptance of reintegration |
| | Reintegration is important |
| | Family members love their mental health care user |
| | Returning home of the mental health care user is a bad thing |

Each sub-theme is discussed separately under the second theme which indicates that family members have perceptions regarding reintegration.

- **Acceptance of reintegration**

Most participants indicated that they would like to have their male state patients to return home. Family members indicated that they accept reintegration. Furthermore, they talked about acceptance of reintegration with regard to

themselves as family members and the community as a whole. The following quotes attest how family members of male state patients perceive acceptance of reintegration of these patients with them.

*"…Myself as a sister to him I see coming back home as a good thing. Myself as his sister I feel that as a human being, he might now be tired of staying in the hospital for a long time as a mentally ill patient who had stayed in the hospital for a long time…"* **Sister: Family unit no.1**

Another one said:

*"… Myself I like it as if I reject him it will be like I am saying that the hospital should take responsibility for caring of my son. I have been given my son by God and He want to see if we accept him back home. If I reject him it will be like I am rejecting my God…"* **Mother: Family unit no.3**

In agreement, Lawska et al. (2006) revealed that mentally-ill family members expect to be noticed, accepted and sympathised with, so a supportive and accepting environment is indispensable for the optimisation of socio-professional therapy and rehabilitation of the ill.

Similarly, Christ (2014) indicates that home care can fortify and enhance the ability of the natural setting to contain, support, and stabilize the symptomatic individual who would otherwise require a supervised level of treatment. It is argued that the psychiatric care organisation of the near future will be capacitated, managed, and patient-centred, rather than organised around service providers. This means that when the patient is cared for at home, the patient feels loved and supported, thus stabilising his condition.

Furthermore, Christ (2014) narrates that one of the most valuable aspects of home care within a managed care environment is its potential to reestablish for patients longterm therapeutic alliances with providers who remain constant over time. Such providers who can be trusted and worked with as partners in devising successful strategies to cope with complex and perplexing serious mental disorders. With its capacity to individualise, underwrite normal functioning, and follow chronic patients over the long-range course of illness, home care is currently the level of service most in synchrony with this developing model.

*"…Yes, I like him to come home as a child. The important thing is that I had told him to quit smoking dagga and drinking alcohol so that he will live better as when he was readmitted he was no longer taking his treatments as expected, saying he is not ill..."* **Mother: Family unit no.4**

One said:

*"…I see it as important for him to come back home. When I look at him he appears like he is healed…"* **Uncle: Family unit no.5**

*Another one said:*

*"…What I am saying is that they can come home but not forever. They can be given short stays…". "…these patients should be allowed to come home even when they are still receiving treatment at the hospital…"* **Sister: Family unit no.8**

This is in line with Ayazi et al. (2014) who revealed that family intervention rather than hospitalisation of the patients is considered to be preferable. When families of patients who are mentally ill are supported, community care rather than hospitalisation is enhanced.

Similarly, Littlewood and Dein (2016) found that families are generally the primary source of support for their sick relatives; they form an important part of

the ‘therapy management group’. Despite the fact that family members were the primary source of support for those suffering from both physical and mental illness, and in many instances provided unquestioning support and caring for their sick relatives, a few informants mentioned that they felt themselves to be a burden on their families and expressed guilt at being dependent upon them. Harmonious family relationships were deemed important for personal mental well-being. Sickness of any significant degree often resulted in a continued grieving by kin over the loss of their relative’s personality and functioning.

Furthermore, family members are generally supportive, they often expressed distress at having lost the sick relative; that they were just not the same person as before, but also the loss of their financial contribution, which is significant in a community that is already economically deprived (Littlewood & Dein, 2016).

This is in line with WHO (2012b) in its Global Movement for Mental Health models initiatives, exemplifies a top-down approach to promoting human rights which, historically, has had a limited impact at the level of those living with mental illness and their families. This assertion by WHO calls for the bottom-up approach that will need the considerations of family members in whatever policy or guidelines are being developed. This calls for family members of male state patients to be involved on how reintegration of these patients should be done rather thatn health professionals making decisions on reintegration.

- **Reintegration is important**

Family members viewed reintegration of male state patients as an important event when the hospital is ready to release the patient back home. The following quotes support the participants’ views on the importance of reintegration.

“…*My perception regarding this question is that I see it as important for those patients to be released back into their families. Myself I like it. My father usually comes home for short periods. He then returns back to the hospital when we realised that things are not right with…”* **Daughter: Family unit no.10**

Another one said:

*"…Community people like him, if he is back they even come to visit him at home..."* **Uncle: Family unit no.5**

This is in congruence with Labrum et al. (2015) whose study revealed that family members perceive reintegration of their relatives with mental illness as important. As a result of deinstitutionalisation and a lack of adequate community supports, family members often provide support to relatives with mental illness. This support can be immense in volume and may include social support, compliance with mental and somatic health treatment, housing and numerous activities of daily living.

Furthermore, family members have a responsibility to provide care to relatives with mental illness and to monitor their behaviour and well-being. Similar to mental health professionals, family members often attempt to prevent, decrease, terminate, or otherwise change behaviours their relative with a mental illness engages in, which they consider problematic (Labrum et al., 2015).

Similarly, Tlhowe, Du Plessis and Koen (2016) found that as the family members explained their process of acceptance, they expressed how they struggled to accept the condition of their mentally ill family members. They indicated that the more they struggled, the more their family members were experiencing problems because they did not receive enough support from them, and they ended up being admitted several times because they relapsed.

- **Family members' love for mental health care user**

Most of the family members indicated that they love their male state patients as they talked about the kind of love towards the patient in terms of either being a mother, daughter, brother, sister or uncle to the MHCU. The following quotes support what the participants said about their love of their male state patients.

"…*I love him so much, he is a gift from God. Just know that I love my son very much to come back…"* ***Mother: Family unit no.2***

Another one said:

"*...I love and accept my father very much. I accept him as my father and the other family members also accept him…"* **Daughter: Family unit no.10**

Another one said:

"…*I love him as my brother from the same mother…" "…does not mean that we have abandoned him as we still love him…"* **Brother: Family unit no. 9**

This is in line with Deist and Greeff (2015) who indicate that once the family was no longer in denial about the condition of their loved one, they were able to develop caregiving strategies that made caring for the mentally ill patient more manageable. Managing the symptoms via medication or tried-and-tested caregiving strategies was deemed crucial to the family's ability to accept and effectively manage the illness and its symptoms. Furthermore, the participants explained that adaptation could only take place once the diagnosis had been accepted.

- **Returning home of mental health care user is a bad thing**

Few participants perceive reintegration as a bad thing although majority of participants indicated it as important. This is supported by what partcipants said in the following quotes.

*"…His reintegration will not be good as he does not love his siblings, nephews and nieces. He does not love them and I do not know where to take them as he does not love them…*"

This perception of family members of seeing reintegration as a bad thing is in line with Sun, Fan, Nie, Zhang, Huang, He and Rosenheck (2014), whose study revealed that family members were more negative towards mental llness

than MHCUs, hence this may affect the reintegration of these patients into their families.

Similarly, Evavold (2003 cited in Rall, 2017) revealed that due to stigma attached to mental illness, MHCUs were hospitalised for long periods and sometimes for the rest of their lives. This makes family members to perceive reintegration as bad thing.

### Theme 3 : Threat to reintegration as perceived by family members

Most participants indicated their perceptions regarding threat to reintegration as perceived by the family members, which yielded the following sub-themes: Victim's family are afraid of mental health care user, community will take revenge on the mental health care user and family members are afraid of the mental health care user. This is presented in table 3.7 below.

**Table 3.7: Threat to reintegration as perceived by family members**

| THEME | SUB-THEMES |
|---|---|
| Threat to reintegration as perceived by family members | Victim's family are afraid of mental health care user |
| | Community will take revenge on the mental health care user |
| | Family members are afraid of mental health care user |

Each sub-theme is discussed separately under the third theme which indicates the threat to reintegration as perceived by family members.

- **Victim's family are afraid of mental health care user**

Some participants talked about how a victim's family members are afraid of the mental health care user. Family members raised concerns around the fear that

a victim's family members have of a mental health care user, which poses a threat to reintegration. The following quotes depict what the participants said about the fear of the victim's family towards the MHCU.

*"…I feel that as a human being, he might now be tired of staying in the hospital for a long time as a mentally ill patient who had stayed in the hospital for a long time. I don't know whether what the victim family had how far had forgiven him or what are they thinking about him, if they see him coming here at home. I really don't know?..."* **Sister: Family unit no.1**

This is in congruence with Marimbe-Dube (2013) who revealed that family members experience helplessness, fear and vulnerability caused by the aggression and violence that the patient displayed prior to admission to a psychiatric hospital. Furthermore, family members felt a deep sense of fear, including powerlessness and helplessness which was an outcome of unpredictable behaviours of the state patients, such as aggression, unpredictable mood swings, hostility, abusive language and mood fluctuation (Marimbe-Dube, 2013).

Similarly, Mabunda (2018) found that family members as well as community people are not safe when the MHCUs are on LOA. Furthermore, MHCUs' deviant behaviour results in these patients being dangerous, which results in families and community people fearing them.

- **Community will revenge to the mental health care user**

Some participants indicated that community people may revenge the MHCU who had committed a criminal offence before he was admitted. Family members assume that if community members revenge the MHCU, reintegration will not be successful. This is supported by the following quotes from the participants.

*"…I like him to come back home but say, the community say if he comes home they will chop him as he had done a lot of damages in this village. People do not pass freely next to our home. He usually assemble stones and throw them to educators as they pass here to school and even to school learners. He will take a chair and put it at the entrance to our home where you passed when you came and demanding money from those who are passing by and some will give him for fear of being hit…"*

This is in line with Flannery and Flannery (2014), who reviewed published findings from 2000–2012 on international precipitants to psychiatric patient assaults in community settings. Their review revealed that patient assaults continue to occur in community settings and support the study's hypothesis that acute psychosis and substance abuse continue to be among the common precipitants identified in the community. Furthermore, they found that although community precipitants are similar to those in inpatient settings, the contexts for such precipitants differ. Even though patients may be properly medicated and sober at discharge, these issues may continue in patients' lives. Psychotic episodes may occur in the community as patients encounter specific major stressors (e.g., death of a parent) or become medication noncompliant.

- **Family members are afraid of the mental health care user**

Some of the participants indicated that they fear MHCUs. They related that their male state patients conduct caused them to develop fear towards them, that if they returned home they would cause troubles. Furthermore, some of the MHCUs hit family members with fists and other objects. The following are certain quotations in this regard.

*"…Just know that I love my son very much to come back, but I am afraid of his bad conduct that if he comes back he will cause troubles. He also hit me with his fist and two of my teeth fell (she showed where the teeth were attached in her mouth)..."* **Mother: Family unit no.2**

Another one said:

*"…My mother is the one who seems to be having fear for him…"* **Sister: Family unit no.1**

Another said:

*"…The one who does not like him is his uncle. He has a fear for him…"* **Sister: Family unit no.4**

Another one said:

*"…the police are also afraid of him…"* **Mother: Family unit no.3**

The above quotes attest that participants fear male state patients as they stay with them at home. This is in line with Rudich and Daichman (2014), who indicate that parents of the severely mentally ill face a daunting task in caring for their children. The chronicity and severity of the illness can be devastating to the family. Among the unintended consequences of the move from long-term or intermediate-term hospital care, has been the conversion of homes to mini-hospitals. This relocation of care from hospital to home has tremendous economic, psychological, and even medical consequences for families who undertake this task. Families taking care of a member who is mentally ill require all their energy to manage the frequent crises associated with these illnesses.

Similarly, Ayazi et al. (2014) found that participants who believed that the mentally ill were dangerous had higher scores on the social distance scale.

On the other hand, Mathanya (2015) revealed that family members with state patients experience tension, stress, anxiety, resentment and depression with the following emotions: hopelessness, powerlessness and destruction in their everyday lives. She further indicates that families with state patients experience much social rejection. Due to poor socialisation between the family and the state patient, the state patient may develop emotional disturbances, which may result in feelings of frustration or anger, and verbal or physical aggression. These feelings could interfere with the mental health restoration and maintenance phase. Furthermore, as the families experience fear,

insecurity, mistrust around the psychiatric state patients, they must be counselled by the professional health care workers before the psychiatric state patients are granted LOA, so that they may be able to gain trust, understand them and live with them. The families may also be referred to support groups so to share their experiences and coping mechanisms.(Mathanya, 2015).

Similarly, Tlhowe et al. (2016) revealed that family members of mentally ill patients expressed their impatience towards the behaviour of their mentally ill relatives. Most of them indicated that they thought that their mentally ill family members were just acting out when they displayed unusual behaviour. They only realised that their family members were ill when they started to become violent, fighting and destroying property. Furthermore, they reveal that it seems that family members experience specific emotions and difficulties when their mentally ill family members are first diagnosed with a mental illness. Monyaluoe, Mokoena-Mvandaba, Du Plessis and Koen (2014), indicate that families of mentally ill family members experience emotional pain, guilt and concern. Family members have to go through a process of acceptance and receive educational information and assistance from health professionals. In this process families discover and apply their strengths to limit relapses of mentally ill family members. It is important that family members caring for mentally ill relatives are involved in their treatment from the onset, and that they are guided through a process of acceptance.

On the other hand, Sharma (2017) revealed similar findings; that living with and caring for an individual with a psychiatric disorder seems inherently stressful due to the fear that they experience towards the mentally ill patients. Relatives of psychiatric patients report a wide range of reactions to their situation. On the whole, these family members endorse having a significantly higher level of psychological distress than the general population. Furthermore, deinstitutionalisation, restricted hospital admission and reduction of length of inpatient treatment have also changed the situation of relatives. Nowadays they are much more involved in the care of patients. Many carers of a person with schizophrenia suffer from ongoing distress, whereas professionals tend to underestimate the family burden. Thus carers feel ignored by mental health professionals.

**Theme 4: Support needed by family members from the hospital regarding reintegration.**

Most participants indicated their perceptions regarding the kind of support they need from the hospital relating to reintegration which yielded the following sub-themes: the family should be visited by the hospital staff to give them health education, victim's family should be visited by the hospital staff to hear from them regarding reintegration and the mental health care user must be visited by the staff to ensure compliance. This is presented in table 3.8 below.

**Table 3.8: Support needed by family members from the hospital regarding reintegration.**

| THEME | SUB-THEMES |
|---|---|
| Support needed by family members from the hospital regarding reintegration. | The family should be visited by the hospital staff to give them health education |
| | Victim's family should be visited by the hospital staff to hear from them regarding reintegration |
| | The mental health care user must be visited by the staff to ensure compliance |

Each sub-theme is discussed separately under the fourth theme which indicates the family members' kind of support they need from the hospital relating to reintegration.

- **The family should be visited by the hospital staff to give them health education**

Most of the family members talked much about the need to be visited by hospital staff to educate them about mental health. This is one kind of support that they need to make reintegration of male state patients a success. The following quotes attest what the partcicipants said about the visit that should be conducted by hospital staff.

*"…what I see is that if nurses at the hospital see that the patient is now better than on the day of admission, they should go to the relatives where the patient stays and tell them in such a way that they can understand that the patient in the hospital is in a state in which he can come home…"* **Daughter: Family unit no.10**

Another one said:

*"…The social workers will visit him regularly to check on him how he is coping…"* **Mother: Family unit no.2**

Another said:

*"…The hospital should make home visits to check him if he is taking treatment. I also think that we should also visit him in the hospital…"* **Mother Family unit no.4**

This is in congruence with Sharifi, Tehranidoost, Yunesian, Amini, Mohammadi and Roudsari (2012) who showed that psychiatric patients who had been discharged to be cared for at home, and are visited at home by doctors and nurses have a lower rate of rehospitalisation than those who are only left to be cared for by their family members.

Similarly, Nørgaard, Søndergaard, Fenger-Grøn, Mors, Nordentoft, Vestergaard and Munk (2016) concluded that schizophrenia and other severe mental illnesses should receive more attention in both general practice and somatic hospitals. Health professionals from hospital settings should also liase

with those health professionals who are in general practice in the community, to assist with the care of mentally ill patients in the community settings.

On the other hand, Monyaluoe et al. (2014) found that home visits to mentally ill patients will ensure that family members are educated on the mental illness that the male state patient is suffering from. This is supported by Tartakovsky (2011); Yap, Reavley, and Jorm (2012) who also found that one of the strengths of families of mentally ill family members is that they seek education on the mental illness of the family members. If families are provided with educational information and are involved in the treatment process, mentally ill family members experience a reduction in symptoms, hospitalisation days and relapses.

- **A victim's family should be visited by the hospital staff to hear from them regarding reintegration**

Some participants indicated that, besides hospital staff visiting the family of MHCU, the victim's family should also be visited. Furthermore, this will enhance support of the concerned MHCU and make reintegration a success. The following are quotes that family members said about visting the victim's family.

*"…I think they should start by visiting the victim family to find out how do they feel about reintegration of my brother as he has been in the hospital for a long time. How will they accept his coming back at home and understand their feeling about his coming back home. They will establish the victim family's main opinion or understanding regarding his coming back. If they see him back how will they feel as he had committed murder which had affected them negatively? He had committed this murder due to mental illness and they may not be comfortable with this even when he had committed murder due to mental illness. They should go and conduct home visit so that they could find out whether they will be happy when he continue to be admitted or how will they feel if they see him back home…"* **Sister: Family unit no.1**

This is in line with Labrum et al. (2015) who found that there was a need for family education organisations to teach relatives more collaborative strategies for preventing and resolving problematic behaviours by their relatives with psychiatric disorders, so that there were fewer undesired consequences. Furthermore they recommended the use of a tool called 'Family Limit Setting Scale' (FLSS), as a valuable component of such education. The tool assists families to set limits to their relatives who are mentally ill, in order to modify their uncontrollable behaviours.

Similarly, a case study by Kukla et al. (2016) indicates that through the journey of therapy, the patient who is cared for in the community regarding his mental status, also developed a more coherent narrative about his life, established a stable sense of self, and became an active agent in the world. This caring of the patient uses three approaches namely: combining metacognition-oriented therapy with elements of cognitive behavioural therapy and psychiatric rehabilitation. This case illustration demonstrates that these three different approaches can be used in a sequential and complementary fashion to foster recovery in the midst of serious physical and mental illness.

- **The mental health care user must be visited by the staff to ensure compliance**

Most of the participants indicated that there is a need for the MHCU to be visited by hospital staftf in order to ensure treatment compliance. Furthermore:

*??They should check his mind whether he is no longer aggressive as he was during his admission. Also check if he is having records of fighting other patients. They should then determine whether his records influence his release so that the community will not fight us if all these issues are not done properly. If he repeats his aggression, the community may think that he does not trouble us as the family instead they may think that we as the family are the ones who are sending him to trouble them. They will not see that he is causing all the*

*troubles because he is mentally ill. I do not have any other input than the ones I said above…"* **Sister: Family unit no.1**

Another one said:

*"…when he is healed, the hospital should not abandon him, it should continue to support me throughout as will not be sure whether the bad spirit or "daragoni" is no longer with him. What I see as very important is that the hospital workers should visit the patient at home so that they do not neglect us with our patient alone without them coming to support us…"* **Grandmother: Family unit no.6**

Another said:

*"…Even when these patients are at home some of them refuse to take treatment that they have been given when they were released from the hospital and as such I see that those nurses from the hospital should come and visit the patient once per week or twice per month to check on how the patient is doing. Those nurses from the hospital should come and visit the patient once per week or twice per month to check on how the patient is doing…"* **Daughter: Family no.10**

Another one said:

*"…The hospital should ensure that the patient get his medication…"* **Mother: Family unit no.2**

This is in line with Mokgothu, Du Plessis and Koen (2015) who concluded that families utilise external strengths as well as internal strengths, in supporting their mentally-ill family member. Recommendations for nursing practice, nursing education and for further research could be formulated. Psychiatric nurses should acknowledge families' strengths and, together with families, build on these strengths, as well as empower families further through psycho-education and support.

Similarly, Berthelsen et al. (2014) identified that the family support on mental health is important. This kind of support needs to be strengthened by health professionals during their visits to the families of mentally ill patients. Family members need knowledge on how to give treatment to patients when they are at home.

On the other hand, Chorwe et al. (2015) in Malawi further support this by providing valuable information about the views of families regarding nursing care of psychiatric patients. In their study, family members indicated that they are involved in the care of mentally ill patients who are admitted to the hospital, although there is lack of effective cooperation between them and nurses. The lack of collaboration with nurses has resulted in families receiving inadequate information about the condition of their mentally ill relative. Therefore, it is imperative that family members receive sufficient support from nurses and other health care professionals so that reintegration of male state patients with them happens smoothly.

**Theme 5: Family members' kind of support they needed from the community relating to reintegration.**

Most participants indicated their perceptions regarding the kind of support they need from the community relating to reintegration which yielded the following sub-themes: Traditional leaders should be the ones to instruct family members to accept the mental health care user. The community should agree that the mental health care user should be brought back home. This is presented in table 3.9 below.

**Table 3.9: : Family members' kind of support they need from the community relating to reintegration**

| THEME | SUB-THEMES |
|---|---|
| Family members' kind of support they needed from the community relating to reintegration | Traditional leaders should be ones to instruct family members to accept the mental health care user |
| | The community should agree that the mental health care user should be brought back home |

Each sub-theme is discussed separately under fifth theme which indicates the family members' kind of support they need from the community relating to reintegration.

- **Traditional leaders should be the ones to instruct family members to accept the mental health care user**

Some participants indicated that they need support from the hospital staff to visit the traditional leader in the community. The traditional leader will be the one to instruct community memebrs to accept the MHCU who is to be reintegrated into his family and the community. The following quotations attest how participants talked about the kind of support they need from the community.

*"I think for the patient to come home is difficult as we fear him. I think the hospital should consider visiting the family of the patient to be reintegrated and also the one which is affected by the crime that the patient had committed the hospital should check if the family like the patient and why they do not like the patient and that what should be done to assist. The mind of the patient should be checked. They should also consult the community through vhakoma and the civic and even the local chief through the khoro (council). I think if all these*

*efforts are done by the hospital it could help the patient to come back home to the family..”* **Uncle: Family unit no.5**

Another one said:

*“..The community should be visited at the headman’s place and educated about accepting the patient. This could be done during traditional council meeting where we will be present as the family members and even himself. This will assist us, as we may agree for him to come home only to find that the community does not want him as this may cause stress to him. It is better for us to hear from the community members.* **Sister: Family unit no. 8**

This is in line with Padmavati (2012) who concluded that community care is emerging globally as an important method of service provision. While obstacles in varying forms remain, the benefits are gradually becoming visible. Mental health services can develop effectively if there is adherence to a principle ethical base, which respects the human rights of individuals living with mental illness within the communities.

Similarly, Hamann, Kohl, McCabe, Bühner, Mendel, Albus, and Bernd (2016) concluded that there are various ways in which patients can facilitate shared decision making (SDM) and play a more active role in it, with patients emphasising being open and honest and psychiatrists emphasising being active in the consultation. Interventions to increase active patient behaviour may enhance SDM in mental health care in the community.

- **The community should agree that the mental health care user should be brought back home**

Some participants indicate that the community should also agree that the mental health care user should come home. This will ensure that reintegration of the MHCU is successful. Participants indicated the importance of involving the community in the care of male state patients when they are reintegrated into their families. The following quote attests to what the community said about the coming home of the MHCU.

*"… I again see it as important that the community to keep them busy like sports wherein one village can compete with another village, I think like that. I think this will keep them away from drugs and alcohol as I see that these substances are the ones that are making them to become mentally ill, not to drink treatment and become dangerous to us and the community…"* **Sister: Family unit no. 7**

This is in line with Ayazi et al. (2014) whose study revealed that participants who endorsed community-oriented attitudes (rather than hospital/drug-oriented attitudes) about health care for the mentally ill were more likely to show a decreased social distance. Participants who believed that the mentally ill were dangerous had higher scores on the social distance scale.

Similarly, Smyth, Siriwardhana, Hotopf and Hatch (2015) confirmed established knowledge from community settings and indicate that social networks and social support exert differential effects on mental health. They furthermore suggest that the particular type of social support may be important. In contrast, different types of social network appear to impact upon poor mental health in a more uniform way.

On the other hand, Francell, Conn and Gray (2008 cited in Mathanya, 2015) found that the carers experienced a lack of support in dealing with their relatives' problems. Similarly Mathanya (2015) found that there is need to educate families about supporting each other and also offer support to the psychiatric state patients. These will help the families to live together in harmony and avoid any psycho-social effects between families. This in turn will encourage harmony in the community in which the MHCU stays.

In agreement further, Kurian et al. (2014) pointed out that mental health care once labelled as institutionalised care has changed into de-institutionalised and home-based care. Moreover, the rising costs of health care in most countries has led to restrictions of institutionalisation and encouraging community care or family care as it enhances speedy recovery. Furthermore, the impact of having a family member with a major mental illness was similar as perceived among family members who were interviewed. Modern medical interventions and technologies have extended the lives of chronically ill persons, which has increased the responsibility of families for caring for these patients.

**Theme 6: Family members' kind of support they needed from the government relating to reintegration.**

Most participants indicated their perceptions regarding the kind of support they need from the government relating to reintegration which yielded the following sub-themes: government should build a house for mental health care users, mental health care users must be employed and government should give them a disability grant. This is presented in table 3.10 below.

**Table 3.10: Family members' kind of support they need from the government relating to reintegration**

| THEME | SUB-THEMES |
|---|---|
| Family members' kind of support they needed from the government relating to reintegration | Government should build a house for mental health care users |
| | Mental health care users must be employed |
| | Government should give mental health care users a disability grant |

Each sub-theme is discussed separately under the sixth theme which indicates the family members' kind of support they need from the community relating to reintegration.

- **Government should build a house for mental health care users**

Participants indicated that another kind of support needed is that the government should build houses for MHCUs. The following quotes depict what the participants said about the kind of support they need from the government in order to reintegrate male state patients into their families.

*"…Let the government build a "tshinari" (RDP house) for him but I will not go to that place. If I go to his house he would be provoked by my presence as he does not like me…"* **Mother: Family unit no.4**

Another one said:

*"…The government should finish the RDP house that it had approved. So that he can have his own place to stay…"* **Uncle: Family unit no.5**

This is in congruence with Bhugra (2016) who states that national governments should work collaboratively with international partners. National stakeholders should provide educational information, ascertain acceptable risk levels, and regulate and legislate as necessary regarding mental health. Tackling the root causes of mental ill health is the responsibility of national governments through reducing poverty, unemployment, and economic disparity, including housing needs for the poor. National governments cannot work in isolation and should partner with local authorities, non-governmental organisations and other partners in community.

- **Mental health care users must be employed**

Most participants indicated that besides government building houses for the MHCUs, it should also provide jobs for these patients. The following depicts what participants said about the support they need from the government regarding providing houses for MHCUs.

*"…The government should provide jobs for him so that he could support himself. In my case his younger brothers are working and if he does not work it will not be good for him. Sometimes he is saying that he wants to go back to school…"* **Mother: Family unit no.2**

Another one said:

*"…The government must create jobs for these patients as they may not be considered due to mental illness, not to see these patients not being able to do things that others can do…"* **Sister: Family unit no.7**

This is in congruence with Bhugra (2016) who states that national governments should work collaboratively with international partners. National stakeholders should provide educational information, ascertain acceptable risk levels, and regulate and legislate as necessary regarding mental health. Tackling the root causes of mental ill health is the responsibility of national governments through reducing poverty, unemployment, and economic disparity including housing needs for the poor. National governments cannot work in isolation and should partner with local authorities, non-governmental organisations and other partners in the community to provide employment for their people.

- **Government should give mental health care users a disability grant**

Most participants indicate the kind of support that they need is that government should give MHCUs a disability grant. This will assist the MHCUs to meet their basic needs when they are reintegrated into their families. The following quotes depict what participants said about government giving disability grants to the MHCUs.

*"…In order feel supported, the government should offer him mundende (Social grant) that will him financially. Mundende will assist him to get food and that he will be able to wash himself and his clothes. He can also get money to marry*

*a woman. Furthermore he will also be able to buy water as there is no water in our village we live by buying it. The family will help him to save money…"*
**Uncle: Family unit no.5**

This is in line with Wark, Hussain and Edwards (2014) who concluded that the issue of ageing with a mental disability was already presenting significant problems for service delivery to this group of people in the New South Wales State and Commonwealth levels. There was consensus across the sector for government, at both State and Commonwealth levels that the implementation of the National Disability Insurance Scheme may be a point at which the State and Commonwealth Government can agree upon the precise mechanisms to support individuals with a mental disability to age in a place without the existing bureaucratic divide. With comprehensive new strategies and support structures underpinning service delivery, both disability and aged-care staff are likely to feel more ready to meet the emerging challenges they are confronting on a daily basis. Equally, the individuals and their families who are ageing in rural and remote areas may benefit from services tailored to meet their changing needs.

## 3.4 CONCLUDING REMARKS

Data indicates that the majority of family members would like to have their patient come back home and be with them. Furthermore, family members expressed their love for male state patients, although a few had reservations over the behaviour of male state patients when they return home. They indicated that male patients display aggression and this makes family members fear them. Some family members indicated that although they fear their male state patients, they would like them to come back home when they are completely stable or healed. Family members indicated that community members also would like their male state patients to return home.

Furthermore, family members of male state patients indicated in various ways regarding the kind of support they need to reintegrate male state patients into their families, such as support from the hospital, department, mmunity and

government. Furthermore, traditional leaders in the community and their members should be educated about the male state patients who are to be reintegrated with their families.

## 3.5 CHAPTER SUMMARY

This chapter presented the results, analysed and discussed the data. Themes and sub-themes that emerged from the data were analysed and discussed. The findings were supported by literature. Chapter 4 will discuss the development of the model in detail.

# CHAPTER 4

# DEVELOPMENT OF A MODEL TO SUPPORT THE REINTEGRATION OF MALE STATE PATIENTS

## 4.1 INTRODUCTION

Chapter 3 presented the results of the data collected concerning the perceptions and lived experiences of family members of male state patients regarding their reintegration into their families. In this chapter, attention will be given to the theoretical framework for the development of the model to support reintegration of male state patients into their families in Limpopo Province, South Africa**.**

The survey list of Dickoff et al. (1968) was used to integrate results of phase one of the study (the situational analysis) and this gave the structure for the theoretical foundation. This survey list was utilized to ensure logical development of the model. During a situational analysis of the study, family members described the kind of support that they need in order to reintegrate male state patients into their families. It is on this basis that the study was directed by what the family members described as the kind of support during phase one of the study, and the theoretical framework by Dickoff et al. (1968) guided the development of the model.

## 4.2. THE THEORETICAL FRAMEWORK FOR THE DEVELOPMENT OF THE MODEL

The theoretical framework for the development of the model was informed by the elements of practice theory outlined by Dickoff et al. (1968). These are context, agents, recipients, procedure, dynamics and outcomes. Elements of practice theory are discussed below.

### 4.2.1 Context

Dickoff et al. (1968) indicate that “In what context is the activity performed? The context is viewed from the aspect of the matrix of activity; it is seen in relation to other things, including persons and other activities, and to see the interrelation of these other factors as constituting an organism, unity, or total context of activity”. Dickoff et al. (1968) refer to the ‘context’ as the setting, location, the physical structure of ward or unit, hospital, or medical centre, time, space, or structure that constitute different elements of the situation in which the activity occurs. The context in which the model should be implemented is the community, home and Hayani Hospital in which male state patients are staying. The hospital where male state patients are admitted is also part of the community. Findings of the study revealed that family members accept reintegration of male state patients to be done at home and the community although the initial activities should start at the hospital.

The context includes community within which there is a home and Hayani Hospital as discussed below, figure 4.2 depicts the context in which reintegration of male state patients should take place.

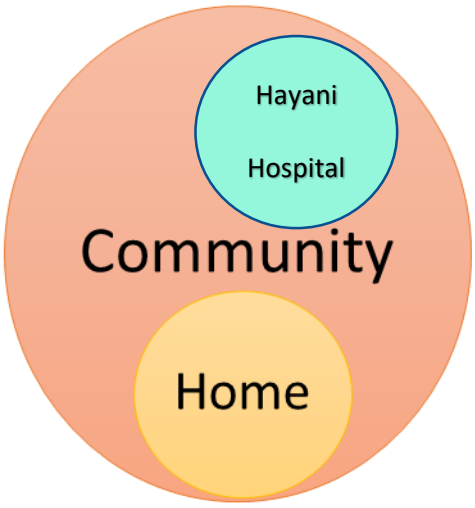


**Figure 4.1: Context**

**Community cultural context -** this context is regarded as important because the socio-cultural beliefs that are shared by the community have an influence on how reintegration of male state patients into their families should be conducted. The community socio-cultural beliefs where this study was undertaken, in some way imposes certain rules on the people who live in such communities.

The role of members of the family with regard to discussions regarding reintegration of male state patients is also culturally determined. This context therefore interferes with the way in which entry into the community by health professionals can be initiated at the homes of male state patients. All events or gatherings in the community are usually approved by the traditional leader and the civic of the community concerned before such gatherings or events may take place. This is supported by a study conducted by Hinton, Aggarwa, Losif, Weiss, Paralika, Deshpande, Jadhav, David Ndetei, Nicasio, Boiler, Lam, Avelar and Fernández (2015) which revealed that the cultural views of patient companions can be a crucial element of the treatment process. This is especially among patients with severe impairments due to mental illness, impacting the accuracy of diagnostic assessment, patient–clinician rapport, family and patient engagement, treatment adherence and retention, and eventual outcome.

The hospital exists within the community and as part the context, health professionals are guided by policies and legislatios that are dscussed hereunder.

**Constitution of South Africa Act, No. 108 of 1996**

Unfair discrimination on any basis, including mental illness is considered illegal in terms of the Constitution Act, No. 108 of 1996. Section 9 of the Constitution provides that every person is entitled to equality before the law and equal protection of the law, and prohibits both the state and any person

from unfairly discriminating directly or indirectly against another person on various grounds (South Africa, 1996). Thus, male state patients are protected by the law from being discriminated on the basis of their status.

**Criminal Procedure Act, No. 51 of 1977**

In South Africa, according to section 78 of the Criminal Procedure Act, No. 51 of 1977, a person who had committed an act that constitutes an offence at the time of an act and is found that he suffers from mental illness which makes him incapable of understanding the wrongfulness of his act, shall not be criminally responsible for such act (South Africa, 1977).

**Mental Health Care Act, No. 17 of 2002**

The Act directs how mentally ill patients are to be cared for, treated and rehabilitated. Chapter 2 of the Act stipulates the rights that should be afforded to mentally ill patients, including male state patients. Further than that, the Act promotes that mentally ill patients should be cared for in the community with their families thus prohibiting institutionalisation.

**Patient's rights**

The White Paper on the transformation of public health services and delivery was introduced in 1997, it entails Batho Pele. It provides a policy framework and a strategy for the transformation of the public service to ensure that patients receive effective and efficient health care. Furthermore, the rights of mentally ill patients are stipulated in the Mental Health Care Act, No. 17 of 2002.

**Concluding statement in relation to Criminal Procedure Act, No. 51 of 1977, Mental Health Care Act, No.17 of 2002 and the Constitution with regards to mentally ill patients and support in the community.**

The Constitution of South Africa promotes human dignity, equality and respect of human rights in providing a safe and discrimination free community living environment for all. Male state patients have rights to a safe living environment that is supportive in the process and this encounter involves professional and ethical values that foster a climate of mutual trust, respect, sharing ideas and assertiveness towards mental health issues. Criminal Procedure Act, No. 51 of 1977 directs how to protect the rights of mentally ill patients during court proceedings if the patient has committed an offence. Supportive intervention model can encourage health care professionals to demonstrate moral and ethical responsibility towards male state patients in health care service institutions and the community.

**South African Nursing Council**

The South African Nursing Council, the body that oversees the licensing of all nurses, states that patients have 'a right to confidentiality'. The ethical and professional codes of practice guide nurses towards maintaining a trusting relationship and providing care that promotes the well-being of their patients, including the obligation to meet the health care needs of mentally ill patients, and apply ethical principles while caring for them.

**Concluding statement of the South African Nursing Council and the Department of Health (DoH) with regards to mentally ill patients and support in the community.**

In South Africa, nurses are ethically bound to keep their mentally ill status confidential, and the DoH which is the employer for the public health care system, oversees the implementation of its national policy framework on

mental health. This includes: safe care of mentally ill patients and reporting of any form of abuse done to mentally ill patients at the hospital and the community.

In the community context, traditional leaders and community leaders exist to support the family units or homes under their area of control. Family members are expected to consult the traditional leader for approval when any person or group of persons want to enter the community in order to consult them at their home. The community believes that it is not acceptable for any activity to be initiated at the homes of any community without consulting the traditional leader of the community. It is also believed that the person who is best suited to talk to the community members to accept the reintegration of male state patients, is the traditional leader and community leaders.

Ayazi et al., (2014) conclude that community-oriented care for the mentally ill patients results in decreased social distance between the family members of mentally ill and the community in which the family resides. Furthermore, information regarding the role of the community both in preventing mental illnesses and in service delivery should be prioritised, as this decreases the social distance between the hospital and the community. The context is constituted by the community cultural context, the home and Hayani Hospital within which reintegration of male state patients is expected to take place. There are common factors that have been identified within the entire context where reintegration is supposed to take place. These are the following:

- The values, norms, attitudes and beliefs of all people involved which is based on their strong cultural beliefs.
- The clear description of roles for each person involved and acceptance of these roles.

These factors influence the extent in which reintegration should take place and hence should be taken into consideration.

**Home context –** home is one of the contexts within which health professionals will interact with the family members of male state patients about reintegration of these patients into their families. The National Association of Housing and Redevelopment in America (2017) defines home as a place of love that one cannot find anywhere else. It is a place where one's problems are resolved and one receives comfort. The context in which the male state patient is reintegrated will be home where he will be shown love and his problems resolved by his family members.

A study by Riley, Høyer and Lorem (2014) revealed that when mentally ill patients take treatment while at home, the environment offered a stable and therapeutic alliance and increased flexibility and less coercion from the hospital set-up. Similarly, Mokgothu et al. (2015) indicate that lately, the tendency of caring for a mentallyill family member at home is common because of the high costs of institutional care, poor institutional care and limited availability of institutional care.

**Hayani Hospital context –** Hayani Hospital is a context with which all the initial activities to start reintegration of male state patients originate. Health professionals initiate the process after they have agreed that the said male state patient should be reintegrated into his family. Health professionals in the hospital play a prominent role in this context as they are the ones who determine the status of readiness of male state patients to reintegrate into their families; and provide the dynamics between them and the recipients for reintegration to happen without any hindrances.

This context is characterized by the different roles that each person plays with regard to caring for the male state patients. It is very important to understand this context and the model tries to address very important dynamics involved in engaging health professionals and family members in therapeutic interaction about reintegration of male state patients into their families.

### 4.2.2 Agent

An agent is any person whose activity leads to the realisation of the goal Dickoff et al. (1968). Findings revealed that health professionals, government and community authorities are the agents whose activities are geared towards the realisation of positive health outcomes. The agent includes health professionals namely; social workers, nurses and doctors as discussed below. Figure 4.2 depicts the agents whose activities are geared towards the realisation of reintegration of the male state patient.


**Figure 4.2: Agents**

**Social workers** are health professionals trained to intervene at the micro and macro levels regarding social matters affecting individuals and families in the communities. Their role is to link the family and hospital in which the male state patient is admitted in order to initiate the process of reintegration of male state patients into their family. This is supported by Abendstern, Tucker, Wilberforce, Jasper, Brand and Challis (2016) who found that non-social work Community Mental Health Team staff were found to place a high value on social worker team membership due to their specific skills,

knowledge and values, and with regard to communication pathways between the hospital and family members of mentally ill patients. Similarly, Ruffalo (2016) found that the role of social workers in the care of mentally ill patients is that of advocating for their right to belong and get the necessary treatment to maintain their mental health.

**Nurses** are health professionals trained to render mental health nursing to male state patients and provide holistic nursing assessment reports about male state patients in the ward. Nurses also are involved in the reintegration process of male state patients into their families. This is supported by Cooper, Gambles and Mason (2014) who claimed that nurses are trained to care for mentally ill patients in acute, chronic and primary health care settings. Furthermore, their study suggests support for professional development of nurses in this area of mental health care.

**Doctors** are health professionals trained to provide medical interventions including treatment of the male state patients. Furthermore, they lead the team of health professionals regarding the medical treatment to be provided to the male state patients in the ward and during reintegration of these patients into their families.

**Other health care professionals** are trained to provide specific health interventions according to their scope of practice as outlined in their laws and regulations that govern their practice. These are professionals like clinical psychologists, occupational therapists, physiotherapists, dieticians and pharmacists. They are also members of MDT that discuss the care, treatment and rehabilitation of male state patients. They contribute when a decision needs to be taken regarding the reintegration of male state patients

Health professionals as agents are further supported by Sarradon, Farnarier and Hymans (2014), who found that mobile outreach teams' objectives by health professionals go beyond the immediate improvement of the health of homeless persons. Instead, it seeks to change their

environment, to give them back their place as citizens in society by enabling them to regain access to their human rights (to housing, to social protection, to civil rights, and to culture), to allow them to rediscover their autonomy by reducing the psychiatric symptoms they suffer, and to help them rebuild a social identity free of stigma.

John (2017) supports that nurses conducting home visits improve the concept of service user involvement and this has gained wide acknowledgement and momentum from various groups in society. Similarly, Dauti (2017) revealed that social workers involved in civil society organisations should advocate for large-scale legal literacy programmes, including providing shelter for the marginalised groups in the community. Furthermore, social workers should foster collaboration between civil society organisations and form alliances with the purpose of increasing pressure over state agencies.

Flanagan (2015) also claimed that health practitioners have a number of intervention modalities available to improve the quality of life of those coping with mental illness related conditions.

Besides health professionals indicated in the study, government as agent is also responsible to render services to the family members that are seen to be supportive in the reintegration of male state patients into their families. Government includes all the departments, municipalities and state owned enterprises whose activities are coordinated by the government in order to deliver services holistically to citizens of the country. Family members indicated the government as agent that should carry out its activities to achieve reintegration of male state patients into their families.

Another group of agents indicated in the findings of the study are community authorities. Community authorities include traditional leaders and civic leaders. Traditional leaders provide leadership in the community and not elected but born to be traditional leaders, while civic leaders are elected by the people in the community. Both traditional and civic leaders have an important role to play in the delivery of services to community. All the activities that the government, department or municipality need to conduct in the community should be done through the traditional and civic leaders.

### 4.2.3 Recipients

The patients' family members were indicated as persons who will receive action from the agents in order to reintegrate them into their families. Recipients are depicted in Figure 4.3.


**Figure 4.3: Recipients**

Recipients are all those persons who receive action from agents and benefit from the activity (Dickoff et al., 1968). The findings of this study revealed that patient, family members, victim's family, and community people are recipients as they benefit from the activities performed by the

agents. The patient, family members, victim's family and community people are considered as recipients who will benefit from the activities of the agents when the male state patients are successfully reintegrated into their families. Furthermore, recipients should take responsibility to learn as the agents will be capacitating them.

South Africa (2011), the Green Paper on families, promoting family life and strengthening it, indicates that the family is a pillar of society, as it influences the way society is structured, organised and functions. The family remains central in the lives of its members, from birth to death, and provides them, among others, with psycho-emotional and economic support. The family has been and continues to be the principal institution in society, playing a vital role in socialisation, nurturing and care, as well as determining the conditions of social reproduction, due to the family deriving its meaning from being both a biological and a social unit. Furthermore, the family continues to be a cornerstone of human civilisation, because of its ability to transmit society's values, norms, morals and more.

Family members as recipients is supported by Mokgothu et al. (2015) who conclude that families utilise external strengths as well as internal strengths in supporting their mentally-ill family member when they receive care from the agents, as discussed in 4.2.2 above. Furthermore, psychiatric nurses should acknowledge families' strengths and, together with families, build on these strengths, as well as empower families further through psycho-education and support.

### 4.2.4 Dynamics

Dynamics involve the power sources for that activity. These are the energy sources that motivate agents to pursue their activities without getting discouraged (Dickoff et al., 1968). Dynamics motivate the agents to carry out the procedure.

The dynamics for this study are open communication and positive listening, mutual trust and respect, acceptance and commitment, empathy and humanity, information sharing and reflective feedback. Figure 4.4 depicts the dynamics that are the energy sources that motivate the agents to carry out the procedure without getting discouraged.

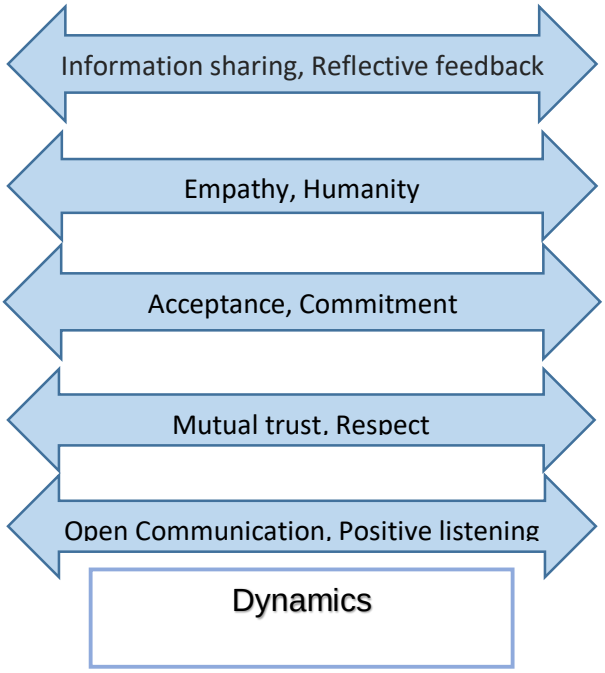


**Figure 4.4: Dynamics**

When the dynamics have occurred between the participants and agents, the procedure could be implemented.

This study revealed what family members indicated as activities that health professionals should carry out, in order for the reintegration of male state patients into their families. The activities indicated by family members cannot occur if dynamics between agents and recipients do not exist as discussed hereunder.

- **Open communication and positive listening**

Communication and positive listening between family members and health professionals can be indicators of a supportive process, since maintaining a reciprocally social and emotional interaction among male state patients and their family members, the community and home environment can impact positively on organisational behaviour. It is in communication and positive listening where the exchange of messages, conveying information, ideas, attitudes, emotions and opinions between health professionals caring for male state patients and the community and home environment, that health care professionals can create an understanding or coordinate activities relating to, initiate and support reintegration of male state patients.

- **Mutual trust and respect**

Self-awareness, mutual trust, respect and good interpersonal relationships are the key features to the development of positive interaction between family members and health care professionals. When mutual trust and respect exist between family members and health professionals, activities indicated by family members can be carried out successfully.

- **Acceptance and commitment**

Support indicated by results of this study requires that all parties involved in the process of reintegrating male state patients into their families accept each other and are committed to work together to reach the set outcome. When health care professionals are willing and committed to the support process when caring for male state patients, they are more likely to rise above the challenges they face. Acceptance and commitment enable one to consciously choose, and when one exercises his/her power of choice

and committing passionately to caring and creating a supportive environment, they experience commitment to an interaction process.

- **Empathy and humanity**

Geer, Estupinan and Manguno-Mire (2000) describe empathy as the ability to understand and identify with another person's point of view, the capacity to experience the same feelings as another. The importance of empathy in the interaction process among family members and their male state patients is the ability to perceive each others' point of view, experience their emotions and behave compassionately so that they are able to express their needs. When health care professionals are empathetic, it builds trust and respect that male state patients are regarded as human beings and not dismissed lightly or thoughtlessly.

- **Information sharing and reflective feedback**

Information sharing and reflective feedback are other key dynamics during interaction between individuals and groups. Results indicate that health professionals need to share information regarding male state patients who are ready to be reintegrated into their families.

### 4.2.5 Procedure

The procedure involves the steps to be taken towards accomplishment of an outcome. The procedure aims at providing sufficient information to enable the activity to be carried out. It safeguards the agent, recipient and the institution in that it provides knowledge and therefore lessens liability to criticism (Dickoff et al., 1968).

The findings revealed the kind of support that participants need for reintegration of male state patients into their families to happen. Furthermore the study revealed the activities that need to be carried out by the agents in order to accomplish reintegration of male state patients into their family namely; conducting home visits, community consultation, talking to the chief, assistance by government to get *mundende* (social grant), build *tshinari* (government house), and provide jobs. The procedure that family members indicated in the findings of the study is depicted in Figure 4.5.


**Figure 4.5: Procedure**

All these activities are accurate in being the procedure that agents should follow in order to achieve the support needed by recipients to reintegrate male state patients. Participants indicated these procedures to inlighten the agents as to what the recipents want for reintegration to take place into their families.

The procedure to be followed by recipients is supported by Goodson, Mackrain, Perry, O'Brien and Gwaltney (2013) in their study, wherein they indicate that home visiting programmes have been successful in engaging and enrolling families who are at high risk for stress, depression and substance abuse. Furthermore, the study revealed that health

professionals are able to meet the unmet mental health needs that would not have been identified without conducting home visits.

Similarly, Ayazi et al. (2014) found that during home visiting, participants who endorsed community-oriented attitudes (rather than hospital/drug-oriented attitudes) about health care for the mentally ill were more likely to show a decreased social distance. Tomlin, Hines and Sturm (2016) describe home visiting as the work done by home visitors that includes addressing many challenges that family members experience, such as maintaining boundaries and managing one's own reactions to children, parents, and overall family situations.

Health professionals need to educate community and family members of mentally ill patients as part of their support to the family members. This is supported by Grace, Burgio, Allen, DeCoster, Aiello and Algase (2016) who found that educating caregivers in non-pharmacologic strategies hold promise for a more balanced bio-psychosocial approach to maintaining mentally ill patients in the community.

### 4.2.6 Outcome

This involves defining an activity from the perspective of an end point or its accomplishment (Dickoff et al., 1968). The aim of this study is to develop a model to supports reintegration. Reintegration of male state patients into their families will be the outcome. Figure 4.6 depicts an outcome of the model which is reintegration of male state patients into their families.

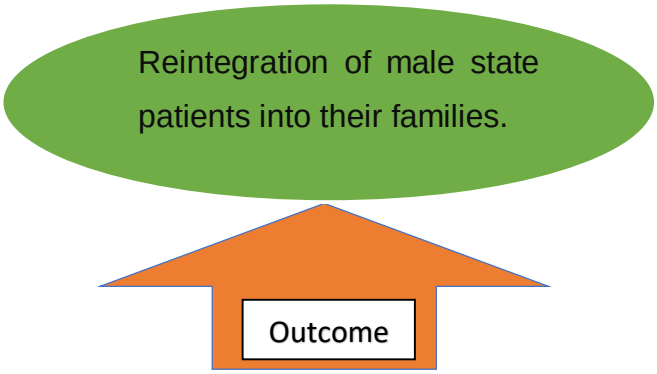


**Figure 4.6: Outcome**

Family members of state patients perceive reintegration as an outcome to achieve the aim of the study.

All activities geared towards the development of a model carried out by the agents and recipients will achieve this outcome. The model that has been developed is going to be a guideline for health professionals on how they can reintegrate male state patients into their families.

## 4.3 MODEL DEVELOMENT

Based on the social ecological model (SEM) of human behaviour theory, the findings in chapter 3 of this study, and the explanation given in the classification of elements of practice according to the model of Dickoff et al. (1968) to support reintegration of male state patients into their family, is discussed. The discussion is under the following headings as described by Chinn and Kramer (2008): the purpose of the model, the theoretical departure assumptions of the model, the relation statement and the nature of structure.

### 4.3.1. Purpose of the model

The purpose of the model is to provide health professionals with the tools and mechanisms to reintegrate male state patients into their families. The developed model may contribute to the quality of care rendered to male state patients when the process of reintegration is initiated and finalised successfully.

### 4.3.2 Theoretical departure and assumptions of the model

The purpose of this study was to develop a model to support reintegration of male state patients into their families in Vhembe District of the Limpopo Province in South Africa. Therefore, the study drew from three paradigms, namely, meta-theoretical assumptions, theoretical assumptions, and methodological assumptions. These paradigms influence the assumptions that are fundamental to the theoretical reasoning of this study. Each is described fully as follows.

#### 4.3.2.1 Meta-theoretical assumptions

Meta-theory is defined as assumptions about reality (Brink, 2012). This study's point of departure is the assumption that family is the unit where the individuals belong irrespective of their health status. Therefore, the ethos of care among individuals should be encouraged and supported. Secondly, grounded on the fact that family members of patients who committed crime do not accept nor consider reintegration with them based on the perceptions they have with that regard. This implies that a model to support reintegration was required.

Every person has the ability to become whole. Wholeness is important in the family for individuals to be accepted and reintegrate appropriately. Reintegration of individuals depends on the interaction with their internal and external environment. Internal environment amongst others involves the

perceptions one has regarding reintegration with the patient who committed crime. External environment amongst others involves the things that an individual needs to feel supported during reintegration. All the external things that family members need as indicated by this theory, were revealed by participants where they indicated the support they need from the hospital, the government and the community in general. It is believed that the support that is needed will aid in the reintegration of a male state patient into their families.

#### 4.3.2.2 Theoretical assumption

This study was conceptualized within the Social Ecological Model (SEM) of human behaviour (Stokols, 2013): the grounded theory for model development outlined in Dickoff et al. (1968), and the approaches outlined in Chinn and Kramer (2008), and Walker and Avant (1995). Each is described in detail below.

The social ecological model of human behaviour

The social ecological model (SEM) explains human behaviour to be multifaceted into four levels, namely; individual, relationship, community, and societal (Stokols, 2013). Reintegration of a person who committed crime (male state patients) is complicated and results from a combination of multiple influences on human behaviour. It is all about how male state patients and family members relate.

SEM theory guided the study in the determination of the perceptions of the family members regarding reintegrating with a male state patient and the kind of support the family need for reintegration to take place. Themes that emerged were: family members' expectations on a mental health care user regarding reintegration, family members perception regarding reintegration,

threat to reintegration as perceived by family members, family members kind of support they need from the hospital relating to reintegration, family members kind of support they need from the community relating to reintegration, and family members kind of support they need from the government relating to reintegration. Each theme yielded at most three sub-themes related to the identified theme.

Each level in the SEM was considered as a level of influence and also a key point for reintegration of male state patients into the family. Through SEM, meanings attached to the complexity of reintegration at individual, relationship, community, and societal level were discovered. From the perspective of reintegration back to the family, the significance of SEM which indicates that human behaviour is multifaceted at individual, relationship, community and societal level, is needed to work with male state patients and families in a holistic manner. The individual as part of the family cannot be reintegrated without the involvement of the family members. The theory guided the study in believing that for reintegration to be successful, the whole family, and community at large should be involved in reintegrating the male state patients.

Grounded Theory for model development

Phase one of this study provided information regarding the perceptions of family members regarding reintegration of state patients and the kind of support family members need for reintegration to take place. Model development was informed by the six elements of practice theory (agents, recipients, context, process, dynamics, and outcomes) outlined by Dickoff et al. (1968), findings of the study and the approaches outlined in Chinn and Kramer (2008), and Walker and Avant (1995) namely; analysing, derivation and synthesizing. Through deductive analysis, synthesis and derivation, the relational statements with regard to each element of practice theory was

used to make the meaningful claims about the model to support reintegration of state patients with their family.

#### 4.3.2.3 Methodological assumptions

The methodological assumptions which guided this study, were in line with Poggenpoel's (2001) functional approach, which implies that research should be functional and contribute to the body of knowledge and the improvement of the quality of life. A qualitative approach following descriptive, explorative, and contextual; using in-depth interviews produced data revealing how family members of male state patients perceive reintegration of these patients with them, as well as what can be done for them to feel supported in reintegration.

Supporting the family members in the reintegration process would assist the family to understand and accept the male state patient as their own. This would increase family involvement in the rehabilitation of the state patient and avoid rejection of state patients by their families, community and society at large. This is supported by Mabunda (2018) who found that family involvement is necessary in the care of mentally ill patients. This improves the quality of care rendered to mentally ill patients, including the protection of their rights as outlined in the Mental Helath Care Act, 17 of 2002.

It is assumed that the model to support reintegration of male state patients into their family, might be able to empower health professionals, community leaders as agents who facilitate the reintegration of male state patients into their families. These agents will reintegrate male state patients in a manner that does not compromise the dignity of patients and family members, thus improving quality care to male state patients.

Furthermore, patient care would be provided economically and efficiently, thus, realizing the concept of 'value for money' as explained in the Batho Pele Principles document (South Africa, 1995).

### 4.3.3 Relational statement of the model

This is a description, explanation, or prediction of the nature of interaction between the concepts of the theory (Chinn & Kramer, 2008). The following relational statements are formulated for the model to support reintegration of male state patients into their families, influenced by the six practice model of Dickoff et al. (1968), the findings of the study and SEM of human behaviour theory.

- Implementation of the model is influenced by the context within which it exists, namely; the context being the community, home and Hayani Hospital where the male state patients are found.
- Stakeholders such as agents and recipients engage each other during the reintegration process.
- It involves interaction and participation between agents who are health professionals, traditional leaders and government and recipients who are the patient, victim's family, family members and community people. Both the agents and recipients engage each other in a responsible and meaningful manner to achieve an outcome which is reintegration of male state patients into their family.
- It allows the recipients to define the kind of support that family members need in order for male state patients to reintegrate with them.
- Dynamics that drive the interaction between agents and recipients are open communication and positive listening, mutual trust and respect, acceptance and commitment, empathy and humanity, information sharing and reflective feedback.

- The procedures to be taken towards the implementation of the model are conducting home visits, community consultation, talking to the chief, assistance by government to get *mundende* (social grant), build *tshinari* (government house) and provide jobs.

### 4.3.4 The structure of the model

According to Chinn and Kramer (2008), the structure of the model gives overall form to the conceptual relationships within it.

The structure of the model was determined by bringing together the elements of practice identified and discussed in 4.2 of this chapter. It is the graphic illustration of how the elements of the model relate to one another. The structure is reflected predominately on two graphic forms, namely, linear and circle. The arrows show how one element relates to the other. The big oval shaped structure represents unity, professionalism and team effort between agents and recipients. The different colours used in the diagram are meant to simplify the distinction of elements and has no significant meaning attached to it. The oval shaped structure represents the context while the agents and recipients are indicated by small circles within the bigger oval shaped structure where they interact with each other within the contexts indicated by the structure. Interaction of agents and recipients is influenced by the dynamics indicated within the horizontal arrows between the agents and recipients. The agents are to follow a procedure that will result in achieving the outcome which is reintegration of male state patients into their families.

Figure 4.7 presents the structure of the model to support the reintegration of male state patients into their families.

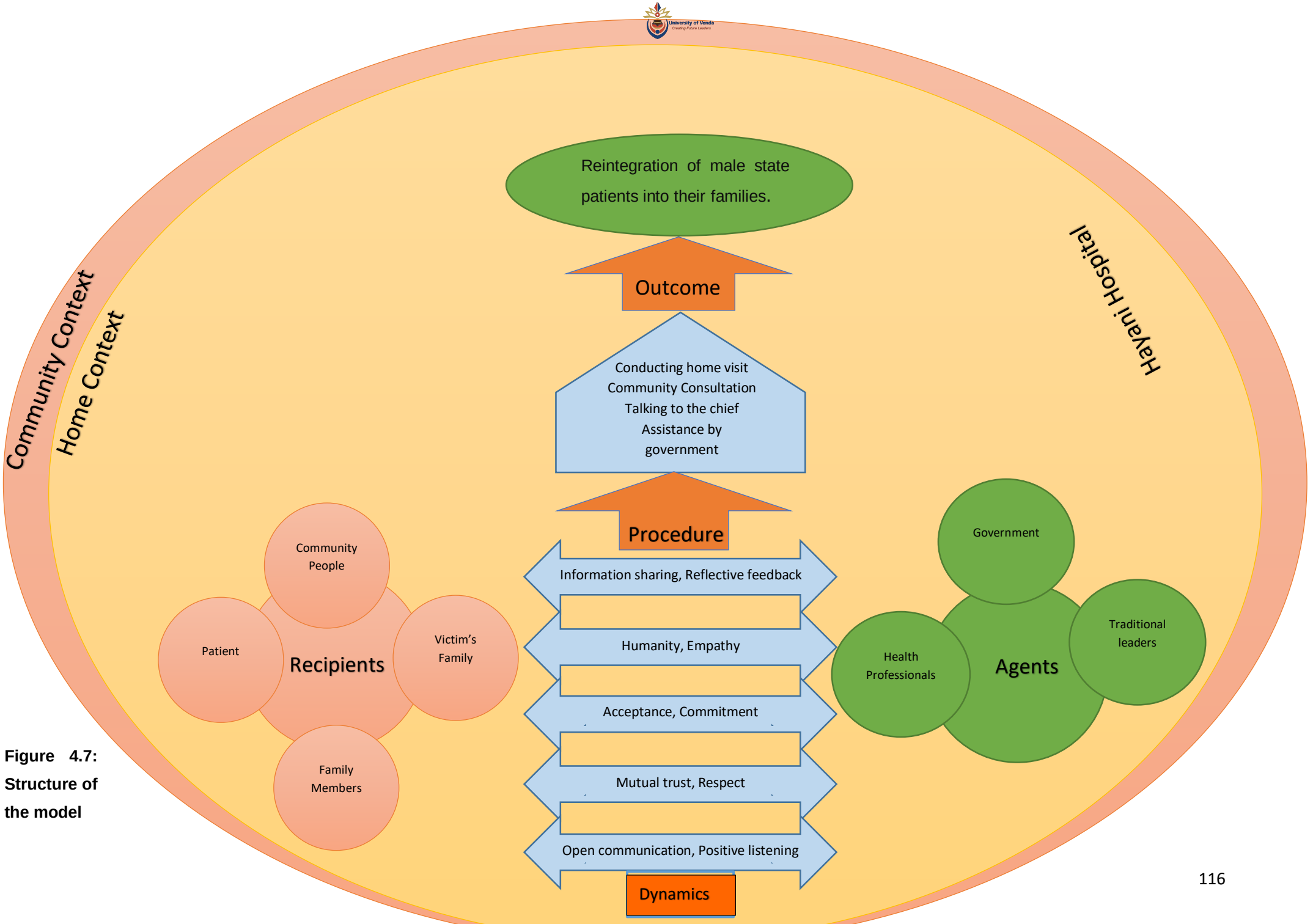


**Figure 4.7: Structure of the model**

## 4.4 EVALUATION OF THE MODEL

An evaluation of the model was conducted in accordance with guidelines in Chinn and Kramer (2008). The criteria for model evaluation by Chinn and Kramer (2008) were selected because the model is based on empirical evidence. The five critical questions necessary for evaluation of the model are as follows: How clear is the model? How simple is the model? How general is the model? How accessible is the model? How important is the model? The model was evaluated by a group of professionals who are doing master's and doctoral degrees in nursing and public health and were purposively selected and consented to partake in the excercise. Table 4.1 represent members of the evaluation group.

**Table 4.1: Model evaluation group**

| Professional Designation | Post-graduate studies | Area of work |
|---|---|---|
| Professional Nurse | PHD nursing graduate (Advanced Psychiatric Nurse) | District Mental Health Coordinator |
| Professional Nurse | Doctoral Nursing Student | District Hospital psychiatric ward |
| Professional Nurse | Doctoral Nursing Student | Hospital Quality Coordinator |
| Professional Nurse | Doctoral Nursing Student | Specialised Psychiatric Hospital |
| Professional Nurse | Doctoral Nursing Student | Regional Hospital general ward |
| Professional Nurse | Master's Nursing Student (Also Masters Public Health Graduate | Nursing Management (Specialised Psychiatric Hospital) |
| Professional Nurse | Master's Nursing Student | District Hospital psychiatric ward |

| | | |
|---|---|---|
| Professional Nurse | Master's Nursing Student (Advanced Psychiatric Nurse) | Regional Hospital psychiatric ward |
| Professional Nurse | Master's Nursing student | PHC clinic |
| 2 Social workers | Master's Public Health students | District social work services |

Selecting health professaionals was supported by Chinn and Kramer (2008). These authors indicate that selecting health professionals to evaluate the model in practice promoting health related goals, is referred as practice-based evidence in health care literature. It is against this literature source that the researcher was prompted to select health professionals who are directly in the care of mentally ill patients in their daily work. Furthermore, health professionals who are experts in psychiatric nursing practice, gave a practice-based evidence of evaluation of the model.

The meetings were held at an agreed central venue within Vhembe District with the assistance of the promoter of the study. The process of evaluation was conducted by allowing the researcher to present the model to the group on two occasions in the presence of the promoter. The first presentation's comments by the group are indicated in orange colour and the second presentation comments are indicated by a blue colour **(See ANNEXURE K1 & K2)**.The group used the criteria outlined by Chinn and Kramer (2008) to evaluate the model. After all the inputs were done to the initial structure of the model, the researcher presented again the second draft of the structure of the model to the group for further evaluation and inputs.

After the second structure of the second draft, model was evaluated by the group, the final structure of the model was then developed as indicated by figure 4.7 (structure of the model) in this chapter. Hereunder follows the discussion on how the model was evaluated by the group using Chinn and Kramer's (2008) criteria of model evaluation.

### 4.4.1 How clear is the model?

Six elements of the practice model according to Dickoff et al. (1968), that is context, agents, recipients, dynamics, procedure and purpose, were used as a basis for describing the model. The major and related concepts formed the structure of the model and therefore the structural clarity and consistency was met. The concepts within the model are well connected and easy to understand as illustrated in different diagrams (figure 4.1-figure 4.6). In the structure, the relationship between concepts are clearly indicated in Figure 4.7. The six elements of practice model according to Dickoff et al. (1968) were clearly placed as per evaluation done by the group. The colours of the six elements were indicated to make the elements clear. The following depicts the comments made by the group to make the model achieve the element of clarity.

**First presentation comments:**

During the presentation, evaluators felt that the model is not clear and that naming all the professionals of the MDT as agents congest the model, therefore they suggest that:

"*The model is not clear with regard to how the context of community, home are reflected on the structure of the model. Moreover Hayani Hospital is not appearing on the context."*

"*Agents: get one concept that will cover nurses, social workers and doctors."*

**Second presentation comments:**

The group then identified that colours were not user-friendly as to which colour is for which stakeholder, therefore they suggest that:

*"…Use the green colour for the agents and orange colour for the recipients..."*

*"…The arrows connecting the items on the model should point upwards rather than downwards…"*

### 4.4.2 How simple is the model?

Model simplicity implies that the number of elements within each descriptive category, the concepts and their interrelationships were kept minimal. The model simplicity was achieved by keeping to the major and related concepts of the study. These concepts are reintegration, male state patient, family, family members and community. The researcher did not add new concepts as this would cause confusion. The number and differentiation of concepts is minimal, but sufficient to structure theoretic relations.

**First presentation comments:**

The evaluators indicated that the model is not simple as it reflected the following which appeared complex to the user of the model as follows:

- Items on the structure seems to be connected to each other like a cycle representing the occurrence of events.
- The outcome is not clearly stated as it is indicated in the description of the structure of the model.

The following comments depict what the group suggested regarding simplicity of the model.

*"…The model is not simple as all items seem to be connected to each other. Home is indicated as separate from the context…"*

*"…The **outcome** should be indicated as 'reintegration of male state patients into their families'…"*

**Second presentation comments**

The evaluators indicated that the model is not simple as it reflects the following which appear complex to the user of the model.

- Items seems to be connected to each other as if there is no starting point and end point.
- The dynamics should be rearranged to make them flow logically.

The following depicts the comments made by the group to make the model simple.

*"…To make the model simpler, indicate the **agents** as health professionals, government and traditional leaders…"*

*"…The **dynamics** should be rearranged from the previous presentation to give them logic and simplicity as follows: open communication and positive listening, mutual trust and respect, acceptance and commitment, empathy and humanity, information sharing and reflective feedback…"*

### 4.4.3 How general is the model?

The model was described as a response to the need for male state patients to be reintegrated into their families. The results of this study indicate that most of the family members accept reintegration of male state patients with them, although few indicated that they fear male state patients. Furthermore, the results indicate the kind of support needed by family members to reintegrate family members with them. The model was therefore developed to support reintegration of male state patients into their families. The developed model can be applied to all hospitals that render care to male state patients in particular, and other mental health care users in general in South Africa. However, it can only be applied to male state patients and MHCUs − not general patients. The group supported what the researcher presented.

### 4.4.4 How accessible is the model?

The Provincial Department of Health in Limpopo will have access to the model and it will be applied within the Departmental mental health institutions. Furthermore, the model would be made accessible to Hayani Hospital, in the Vhembe District: Department of Health where data was collected. The district mental health directorate would be involved so that it would be easier to access other districts in the province. It would be possible

to access the model through library search, publications in accredited journals, attendance of seminars, and national and international conference presentations.

### 4.4.5 How important is the model?

South Africa's government developed, passed and promulgated the Mental Health Care Act, No. 17 of 2002, which is the law which sets out certain procedures that must be followed by certain persons when a mentally ill patient is to be admitted, detained and discharged in hospital. Mental Health Care Act, No. 17 of 2002 also indicates the rights of mental health care users that should be respected by all the people in South Africa (South Africa, 2002). This Act is to ensure protection of people with mental illness and intellectual disability is a national priority. The findings of the study will help to respect the rights of state patients to live with their family members at their homes and community when they are reintegrated with their family members. The following depicts what the group said:

"…*The* ***procedure*** *can be carried out at any institution in South Africa rendering care to state patients…"*

*"…The model can be used as its* ***outcome*** *is reintegrating state patients into their families by health professionals working with these patients..."*

The model would do away with the traditional way of practice by health professionals, as family members would be the ones who directed how reintegration of male state patients should be done, rather than by what health professionals think is the best for the family members. The findings of this study revealed that family members accept the reintegration of male state patients and the kind of support that they need to reintegrate male state patients. The model would close the identified gap in supporting the family members when reintegration of male state patients is to be implemented. It is hoped that with the implementation of the reintegration model in operation, the following would happen:

- The health professionals would have a resource to refer and guide them regarding how to reintegrate male state patients with their families.
- Health professionals shall receive the necessary knowledge and skills required for them to reintegrate male state patients into their families.
- Mental health care users shall be treated with respect and dignity, their rights protected and get the best quality mental health care.

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The developed model adds value to mental health practice and nursing and mental health research. Finally, the developed model creates the gap for other researchers to conduct research when the model will be implemented.

## 4.5 CHAPTER SUMMARY

This chapter focused on the description of the model to support reintegration of male state patients into their families. Emphasis was given to the description of the overview, purpose and structure of the model. The structure of the model included assumptions on which the model was based, formulation of relation statement, the nature of the structure and the description of the process. The model was evaluated in accordance with the criteria set out in Chinn and Kramer (2008). Chapter 5 presents guidelines to operationalize the model.

# CHAPTER 5

# GUIDELINES TO OPERATIONALISE THE MODEL

## 5.1 INTRODUCTION

The previous chapter focused on development and evaluation of the model to support reintegration of male state patients into their families. The purpose of this chapter is to describe the guidelines to operationalise the model.

## 5.2 GUIDELINES TO OPERATIONALISE THE MODEL

Operationalisation is an activity to oversee if the model can be instrumental, or that it can be operational. The final step in model development is the application of the model (Chinn & Kramer, 2008). The application of the model involves a description of guidelines on how the model is to be operationalised. The guidelines for model to support reintegration of male state patients into their families is described according to the social ecological model (SEM) of human behaviour theory, the findings of this study, and the six elements of practice theory according to Dickoff et al. (1968). The six elements practice theory model are as follows:

- Guidelines pertaining to context,
- The agents and recipients,
- The procedure and dynamics, and
- Outcomes.

### 5.2.1 Guidelines for the context

The following guidelines were derived from the data analysis as discussed in chapter 3. Data indicated that the context where implementation of the

model was expected to take place, was the community, home and Hayani Hospital.

- In-service training should be conducted in order to orientate health professionals to determine the feasibility of the model.
- Health professionals should actively participate from the initiation of reintegration when the male state patient is still in hospital until he is released home and to the community.
- The community is where the homes of family members are found and as such reintegration of male state patients finally takes place there. Within the community, home and Hayani Hospital, family members and community members share knowledge on how to take care of male state patients.
- The developed model should be presented to the community during mental health awareness campaigns.
- Within the community, home and Hayani Hospital; family members, community members and health professionals should also engage each other in a meeting where health professionals educate the community and family members regarding implementation of the model in line with Dickoff et al.s (1968) six elements of practice model and SEM theory of human behaviour.
- Health professionals should display communication skills to both the male state patient and family members.
- The community and home as a unit should collectively inquire and look for information from the hospital. Inquiry with regards to reintegration of male state patients should never be left to health professionals as this may cause family members and community members to stop participating in the reintegration process, as sometimes they might feel sidelined by the health professionals.
- Participation at the the community, Hayani Hospital and home level should be all-inclusive and promote active participation by family members.
- Strategies for strengthening the model should be developed to ensure sustainability.

- Clear guidelines should be set for involving the community people and family members during community meetings to gain more current knowledge about reintegration process.
- Collaboration with a district mental health office at community level should be encouraged as they could be used as resource support at district level.

- The people who are in charge of the male state patients receive training through workshops about the model to reintegrate male state patients into their families.
- Collaboration with traditional leaders and civic people within the community should be encouraged where family members can go for assistance or information.
- The hospital should also coordinate with the district Mental Health Review Board to ensure that whatever the professionals are doing regarding mental health services are in line with the Mental Health Care Act, No. 17 of 2002.
- Hospitals should also participate in district, provincial and national activities related to mental health. This will in turn ensure that hospitals receive up-to-date information about mental health issues and implement mental health services correctly.

### 5.2.2 Guidelines for the agents and the recipients

**The agents**

- The agents who are health professionals, community leaders and traditional leaders and mental health review board members, should be aware of their knowledge regarding reintegrationan.
- The agents should create an environment conducive for family members to learn about implemention of the model without feeling sidelined.
- The roles played by the agents in empowering family members regarding the reintegration process should be outlined so that

each one is aware of the duties of self and of the other to avoid conflict.

- Agents must be resourceful and comprehensive with skills and information required to support family members of male state patients and assist them towards the implementation of the model.
- The agents should take it upon themselves to look for more information about issues of reintegration so that during community meetings they have enough information to resolve misunderstandings that family members and community people might have. When agents display a high level of knowledge, family members and community people may learn to trust them.
- The agents should continuously support family members during initial stages of reintegration process to cover a wide range of issues related to the implementation of the model. Continuity would also stimulate more interest and understanding on reintegration which would be beneficial to both the family members and agents.

**The recipients**

- Family members as recipients need to recognise the knowledge deficit that they have regarding the reintegration of male state patients.
- Family members have a responsibility towards their own personal development.
- Family members should take responsibility to learn as the agents will be empowering them.
- They should learn that they need to be active by interaction, participation and authentic collaboration with the agents.

### 5.2.3 Guidelines regarding the dynamics of the model

The dynamics of the model are the agents and recipients' open communication and positive listening, mutual trust and respect, acceptance and commitment, empathy and humanity, information sharing and reflective feedback. The guidelines to operationalise these dynamics are described as follows:

**Open communication and positive listening**

- The health care professionlas and family members can best understand the messages that they each convey by developing interactive listening skills, which involves clarifying, verifying and reflecting.
- There must at all times be a two-way communication between the health care professionals and family members.

**Mutual trust and respect**

- Both health professionals and family members should trust and respect each other to enhance a sense of trust and respect.
- Family members should be willing to be guided and empowered and should also be willing to work towards self-development with the help of health professionals.
- Familiy members must be willing to consult when they need help and health professionals must be ready to assist them.
- For empowerment to take place, agents and recipients must see the need for empowerment to be able to do something about it.

**Acceptance and commitment**

- Health care professionals should be willing to commit time and energy to capacity building activities.
- Both health care professionals and family members should feel obliged to actively participate in the capacity building activities.

- They need to commit themselves and be eager to see the empowerment working for the best results.
- Participation on the part of family members, entails availing themselves for orientation, support, training and help when necessary.
- Participation on the part of the health professionals' entails realising their professional and moral responsibility towards the personal development of family members.
- There should be collaboration between the health professionals and family members and such should receive acknowledgment of each other's responsibility.

**Information sharing and reflective feedback**

- Both health professionals and family members should engage in discussing what has gone right, starting with the family members' views regarding reintegration model followed by the health professionals' views, and then discussion of what needs to be improved, again starting with family members' views followed by those of the health care professionals.

### 5.2.4 Guidelines regarding the procedure

The model to support reintegration of male state patients into their families could be enhanced by the following procedures: Conducting a home visit, community consultation, talking to the chief and assistance by government.

**Conducting a home visit**

- The first step of the model is full and open communication with everyone affected, including the male state patients themselves.
- The MDT should assess the male state patient who needs to be reintegrated with his family and decide collectively to release the patient.

- Health professionals prepare for the initial step of the operationalisation of the model where family members' knowledge gaps and needs are identified regarding the home visit to be conducted by health professionals.
- Both health professionals and family members enter into the interactive awareness process with clear objectives and goals. Through interaction, it is envisaged that health professionals and family members will recognise, acknowledge and reach consensus about a problem situation and its intrinsic drivers, including model's expected contribution.

**Community consultation**

- Health professionals will define and communicate information regarding community consuitation.
- Health professionals and family members set goals and strategies for community consultation. The aim of community consultation is to influence personal development on the family members' point of view for them to commit themselves to the reintegration of male state patients.
- The health professionals should also come up with strategies as to how they are going to deal with dynamics.
- Roles should be discussed as this may have adverse impact on individuals. These activities prepare the family members for activities in the capacity building.

**Talking to the chief**

- The health professionals create an enabling environment in which family members learn how they participate in the reintegration process with members of the community at large.
- The health professionals should make an appointment with the local chief on when to invite community people and family members to a

meeting during which they should educate the community on the care of male state patients at home.

**Assistance by the government**

- Health professionals assist the family in the ways in which the government could support them to reintegrate male state patients into their families.
- The government should assist the family members with social grants and provide government houses where there is a need.

### 5.2.5 Guidelines regarding the outcome of the model

It is envisaged that the outcome representing the elements of recipients, agents and context, will be that male state patients are finally reintegrated into their families after all activities would have been implemented during the procedure.

## 5.3 CHAPTER SUMMARY

Chapter 5 discussed the operationalisation of the model. The guidelines to operationalise the model were described in accordance with the elements of the practice model as described by Dickoff et al. (1968). Chapter 6 focuses on evaluation, justification, limitations, conclusion and recommendations.

# CHAPTER 6

# EVALUATION, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

## 6.1 INTRODUCTION

In chapter 5 of this study, the guidelines on the oprationalisation of a model to support reintegration of male state patients into their families in Limpopo Province, South Africa was discussed in detail. In this chapter, focus is on the evaluation of the study, conclusions, limitations of the study and recommendations.

## 6.2 EVALUATION OF THE STUDY

The study is evaluated against its aim and objectives as set out in Chapter 1.

### 6.2.1 Aim of the study

The aim of the study was to develop a model to support reintegration of male state patients into their families in Limpopo Province, South Africa**.**
Perceptions of family members regarding reintegration of male state patients were explored by the researcher and described by the participants during in-depth interviews. The perceptions regarding reintegration of male state patients were described by the family members assisted by the researcher to develop the model to support reintegration of male state patients into their families in Vhembe District of Limpopo Province in South Africa. This enabled the researcher to achieve the aim of the study.

### 6.2.2 The objectives of the study

The objectives of the study were to:

- explore the perceptions of family members with regard to reintegration of male state patients in their family
- describe the perceptions of family members with regard to reintegration of male state patients in their family
- determine the kind of support needed by family members to reintegrate the state patients into their family
- develop a model to support reintegration of male state patients with their families
- evaluate a model to support reintegration of male state patients into their families.

The study approach was done in two phases. Phase one was a situational analysis and phase two was the development of a model. In phase one, the situational analysis was done by means of a qualitative approach using exploratory, descriptive and contextual designs. Data was collected through indepth individual interviews and analysed according to Tesch's open coding method in order to address the objectives. The objectives of the study were achieved as the perceptions of family members were explored by the researcher and described by family members respectively, in order to design a model to support the reintegration of male state patients into their families. The model was evaluated by health professionals who are experts in the field of mental health as described in chapter 4 of this study. Dense descriptions on the findings were also done against relevant literature. Central to the results elicited from the participants, it was identified that family members accept reintegration of male state patients and dense description of data by participants yielded the kind of support that they need to reintegrate male state patients into their families.

In phase two, the results of the situational analysis and literature gave direction to the development and description of the model. The kind of model was also developed in line with what the partcipants described during in-depth interviews. The survey list of the practice model of Dickoff et al. (1968) was used as a framework for the development of the model. Chinn and

Kramer's (2008) criteria were used to describe and evaluate the model. This was done to address the last objective of the study.

- **Model development**

The findings of the situational analysis (phase one), a literature review, and the theoretical framework for the development of the model formed the basis of this development. The model was developed according to Dickoff et al.s (1968) framework survey list, which includes context, agents, recipients, dynamics, procedure and outcome. These concepts were applied to the development of the model in line with what the participants indicated as the kind of support that they need to reintegrate male state patients into their families.

- **Model evaluation**

The model evaluation was conducted by a group of health professionals who were doing PHD and master's studies using Chinn and Kramer's (2008) questions relating to the model's clarity, simplicity, generalisability, accessibility and importance and is discussed in chapter 4 of this study.

### 6.2.3 Measures to ensure trustworthiness

Table 6.1 gives a summary of how measures to ensure trustworthiness were applied. This ensured that ethical considerations were adhered to throughout the study.

**Table 6.1: Measures to ensure trustworthiness**

| Measure | Criteria | Applicability |
|---|---|---|
| Credibility | Prolonged engagement | The researcher has more than 10 years' experience in the clinical field (mental health) in which the study was conducted, and spent 3-4 months in field work collecting data. Appointments with participants were made telephonically before and also after interviews to make further appointments to validate the data. |
| | Member checking | A summary was made at the end of each interview and a voice recorder was played back to the participants. Literature control was done. |
| | Peer examination | Presented research proposal at departmental and school research committees. University higher degrees committee evaluated the proposal. Data was co-coded by independent coder, professionals evaluated the developed model external and examiners examined thesis. |
| | Model evaluation | A panel of mental health professionals were purposefully selected to evaluate the research model. |
| | Structural coherence | Data was analysed using Tech's framework of data analysis and the model was developed using Dickoff et.al.'s (1968) framework of model development. Model evaluation was guided by Chinn and Kramer while the study was guided by Social Ecological Model (SEM) theory of human behaviour of Stokols (2013). Ethical considerations were adhered to throughout the study. |
| | Researcher authority | The researcher has a sound knowledge of research. Promoters are research experts and independent coder has sound research |

| | | |
|---|---|---|
| | | knowledge and rich experience in the field of mental health. |
| Transferability | Nominate sample | A purposive sample was used. |
| | Dense description | Theories used in the study. Qualitative methodology, study setting and sampling process described fully. |
| Dependability | Dependability audit | Research proposal was presented at departmental and school research committees. University higher degrees committee (UHDC) examined the proposal. Data was co-coded by independent coder and external examiners examined thesis and professionals evaluated the developed model. |
| | Dense description | Theories were used in the study. Qualitative methodology, study setting and sampling process were fully described. |
| | Code-recode procedure | A consensus discussion was held between the researcher, promoter and independent coder. |
| Confirmability | Confirmability audit | Professionals evaluated the developed model. External examiners examined the report. Researchers at departmental, school and UHDC examined the research proposal. Independent coder used to co-code the data |

## 6.3 CONCLUSION

It is probable that the study is original and had contributed to the body of knowledge hence the quality of care to state patients will improve. The model that was developed was based on the descriptions given by family members of male state patients. This study also described and explored perceptions

of family members regarding reintegration of male state patients. Furthermore, the study explored and described the kind of support that family members need to reintegrate male state members into their families. In-depth interviews were analysed using Tech's steps by Creswell (2014).

Themes that emerged were: family members' expectations on a mental health care user regarding reintegration, family members' perception regarding reintegration, threat to reintegration as perceived by family members, family members' kind of support they need from the hospital relating to reintegration, family members' kind of support they need from the community relating to reintegration, and family members kind of support they need from the government relating to reintegration. Each theme yielded at most three sub-themes related to the identified theme and these were discussed in chapter 3.

### 6.3.1 Family members' expectations on a mental health care user regarding reintegration

During interviews, participants revealed their expectations on a mental health care user regarding reintegration into their families. Three sub-themes emerged under this theme, namely: a mental health care user must be completely healed, a mental health care user should be home for shorter periods of time, and a mental health care user must comply with his medication. The results regarding this theme revealed that family members have expectations on mental health care that they narrated during in-depth interviews. These expectations should be considered on or before reintegration is initiated.

### 6.3.2 Family members perception regarding reintegration

Under this theme, four sub-themes emerged which are: acceptance of reintegration, reintegration is important, family members love their mental health care user, and returning home of the mental health care user is a bad thing. Family members narrated how they perceive reintegration in various

ways but commonly they agreed that reintegration is important and as such they accept it, although others have indicated reintegration as a bad thing.

### 6.3.3 Threat to reintegration as perceived by family members

The following three sub-themes emerged under this theme, namely: victim's family are afraid of the mental health care user, community will revenge the mental health care user, and family members are afraid of the mental health care user. Family members narrated the threat that they perceive to hinder the whole reintegration process of the male state patient into his family. Reintegartion could be affected by victim's family being afraid of the male state patient who has committed a criminal offence before he was admitted. This could also cause them to take revenge on the male state patient.

### 6.3.4 Family members kind of support they need from the hospital relating to reintegration

Three sub-themes emerged under this theme during data analysis namely: the family should be visited by the hospital staff to give them health education, victim's family should be visited by the hospital staff to hear from them regarding reintegration, and the mental health care must be visited by hospital staff to ensure compliance with medication. Family members emphasised the importance of hospital staff to conduct home visits to the families of male state patients. Conducting home visits will enble hospital staff to give health education, listen to family members regarding reintegration and ensure that the MHCU is complying with treatment.

### 6.3.5 Family members kind of support they need from the community relating to reintegration.

Under this theme, two sub-themes emerged namely: traditional leaders should instruct them to accept the mental health care user, and the community members should agree that a mental health care user be brought back home. Family members revealed the kind of support they need from the community. They indicated that the traditional leaders should be involved in inluencing the community people to accept the MHCU. Furthermore, community people should agree that the MHCU be brought home; this will make the family members feel supported to stay with the patient at home.

### 6.3.6 Family members kind of support they need from the government relating to reintegration

Three sub-themes emerged under this theme during data analysis namely: government should build a house for the mental health care user, mental health care users must be employed, and government should give mental health care user a disability grant. Family members indicated the kind of support that they need from the government with specific reference to the provision of housing, employment and disability grant for the MHCUs. This will make them feel supported financially to provide care to the MHCU who is reintegrated into their families.

## 6.4. LIMITATIONS OF THE STUDY

This study was restricted to one hospital in Vhembe district only out of the five districts of Limpopo Province.The researcher acknowledges that this study was contextual and that only family members of male state patients were interviewed; the researcher did not get to hear about the perceptions of family members of female state patients. However, the results provide valuable insight and recommendations that can be considered when supporting families with male state patients who are to be reintegrated into their family.

## 6.5. RECOMMENDATIONS

Recommendations are based on the findings of the current study and are directed to the nursing practice and nursing education.

### Recommendations to the nursing practice

It is recommended that specialised psychiatric hospitals should reinforce the use of the model to support reintegration of male state patients with their families. Local communities and family members where patients originate

from should be involved in the reintegration of male state patients with their families.

### Nursing education

Recommendations for nursing education include that psychiatric nurses should receive training on the reintegration of male state patients with their family members, especially with regard to the support they need. This will contribute to relevant and appropriate care in collaboration with families and will also lead to improved quality of care and prevention of recurrent readmissions.

### Further research

In terms of further research, it is recommended that a longitudinal study, tracking the impact of a developed model to support the reintegration of male state patients with their families and its contribution to the improvement of mental health for all should be conducted over a period of 3 to 5 years.

## 6.6 CHAPTER SUMMARY

In this chapter of the study, the following were outlined: evaluation of the study based on the aim and objectives as set out in chapter 1, and they were all achieved. Conclusion based on the themes and sub-themes outlined in chapter 4 as well as limitations and recommendations for the practice and body of knowledge were discussed.

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## ANNEXURE A

## APPROVAL LETTER FROM UNIVERSITY HIGHER DEGREES COMMITTEE

# UNIVERSITY OF VENDA

## OFFICE OF THE DEPUTY VICE-CHANCELLOR: ACADEMIC

TO : MR/MS N.R LAVHELANI

SCHOOL OF HIMAN AND SOCIAL SCIENCES

FROM: PROF J.E. CRAFFORD

DEPUTY VICE-CHANCELLOR: ACADEMIC

DATE : 23 FEBRUARY 2018

**DECISIONS TAKEN BY UHDC OF 23RD FEBRUARY 2018**

Application for approval of Thesis research proposal in Human and Social Sciences: **N.R Lavhelani (11534338)**

Topic: "Development of model to support re-integration of male state patients with their families in Limpopo Province, South Africa."

| | | |
|---|---|---|
| Promoter | UNIVEN | Prof. M. Maluleke |
| Co-promoters | UNIVEN | Prof. D.U Ramathuba |
| | UNIVEN | Prof. M.L Netshikweta |

**UHDC approved Thesis proposal**

Senior Professor L.B. Khoza
**DEPUTY VICE-CHANCELLOR: ACADEMIC**

**ANNEXURE B**

**ETHICAL CLEARANCE LETTER FROM UNIVERSITY OF VENDA RESEARCH AND ETHICS COMMITTEE**

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
**Mr NR Lavhelani**

Student No:
11534338

PROJECT TITLE: **Development of a model to support re-integration of male state patients with their families in Limpopo Province, South Africa.**

PROJECT NO: **SHS/18/PDC/06/0905**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

| NAME | INSTITUTION & DEPARTMENT | ROLE |
|---|---|---|
| Dr M Maluleke | University of Venda | Supervisor |
| Prof DU Ramathuba | University of Venda | Co - Supervisor |
| Prof ML Netshikweta | University of Venda | Co - Supervisor |
| Mr NR Lavhelani | University of Venda | Investigator – Student |

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: May 2018
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Senior Prof. G.E. Ekosse

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2018 -05- 10
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950λ LIMPOPO PROVINCEλ SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 **FAX** (015) 962 9060
*"A quality driven financially sustainable, rural-based Comprehensive University"*

**ANNEXURE C1**

**Application to Limpopo Province Department of Health to Conduct Research**

**PERMISSION LETTER TO THE LIMPOPO PROVINCIAL DEPARTMENT OF HEALTH**

P.O.BOX 472

VHUFULI

0971

THE HEAD OF DEPARTMENT

LIMPOPO PROVINCIAL DEPARTMENT OF HEALTH

PRIVATE BAG X9302

POLOKWANE

0700

Dear Sir/Madam,

**RE: REQUEST TO CONDUCT A RESEARCH STUDY AT THE DEPARTMENTAL HEALTH FACILITIES**

I am Ndivhaleni Robert Lavhelani, a student at the University of Venda, pursuing PhD in Nursing. I hereby request for permission to conduct a study on "Development of a model to support the reintegration of male state patients into their families in Limpopo Province, South Africa".

The aim of the study is to develop a model to support the reintegration of male state patients with their families in Limpopo Province.

**The objectives of the study** are to:

- explore the perceptions of family members with regard to reintegration of male state patients into their family
- describe the perceptions of family members with regard to reintegration of male state patients into their family
- determine the kind of support needed by family members to reintegrate the state patients into their family
- develop a model to support reintegration of male state patients into their families

To achieve the aim and objectives of the study, I need to interview family members of male state patients who are admitted at Hayani Hospital. I therefore need permission to access admission registers of patients at Hayani Hospital in order to obtain contact details and physical addresses of family members of male state patients.

The study will be done under the supervision of Dr M. Maluleke, Professor D.U. Ramathuba, and Professor M.L. Netshikweta. Participants will be provided with the information leaflet about the purpose of the study and its objectives. The study will involve in-depth semi-structured interviews and will not interrupt service delivery at the hospitals. Ethical considerations in the study will include privacy, confidentiality and informed consent. The proposal has been approved by University of Venda Research and Ethics Committee.

Find attached my research proposal.

Your support will be appreciated.

Yours Sincerely

……

Ndivhaleni Robert Lavhelani

Student Number: 11534338

Telephone Numbers: 084 467 8159 / 015 963 7600/7691

E-Mail: Ndivhaleni.Lavhelani@dhsd.limpopo.gov.za or nrlavhelani@gmail.com

## ANNEXURE C2

## APPROVAL LETTER FROM LIMPOPO DEPARTMENT OF HEALTH

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Stander SS (015 293 6650)

Ref:LP_ 2018 07.006.

**Lavhelani NR**
**University of Venda**
**Private bag X5050**
**Thohoyandou**

Greetings,

**RE: Development of a model to support re-integration of male state patients with their families in Limpopo**

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
   - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
   - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
   - In the course of your study there should be no action that disrupts the services, or incur any cost on the Department.
   - After completion of the study, it is mandatory that the findings 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.
   - The above approval is valid for a 3 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.
   - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.

Head of Department

29/06/2018
Date

**Private Bag X9302 Polokwane**
**Fidel Castro Ruz House, 18 College Street. Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.**
**Website: http/www.limpopo.gov.za**

***The heartland of Southern Africa – Development is about people!***

**ANNEXURE D1**

**Application to Vhembe District Health Department to Conduct Research**

PO BOX 472

VHUFULI

0971

THE DISTRICT CHIEF DIRECTOR

VHEMBE DISTRICT DEPARTMENT OF HEALTH

PRIVATE BAG X5009

THOYANDOU

0950

Application for Permission to Conduct Research

Dear Sir/Madam

I, the researcher, am currently pursuing a PhD in Nursing at the University of Venda hereby applying to be granted permission to conduct the study at your hospital.

The title of the study is “Development of a model to support the reintegration of male state patients into their families in Limpopo Province, South Africa”. Participants will be the family members of male state patients admitted at Hayani Hospital, Limpopo Province.

The aim of the study is to develop a model to support the reintegration of male state patients into families in Limpopo Province.

**The objectives of the study** are to:

- explore the perceptions of family members with regard to reintegration of male state patients into their family
- describe the perceptions of family members with regard to reintegration of male state patients into their family

- determine the kind of support needed by family members to reintegrate the state patients into their family
- develop a model to support reintegration of male state patients into their families

To achieve the aim and objectives of the study, I need to interview family members who are family members of male state patients who are admitted at Hayani Hospital. I therefore need permission to access admission registers of patients at Hayani Hospital in order to obtain contact details and physical addresses of family members of male state patients.

Looking forward to your positive response in this regard.

Yours faithfully,

Mr Lavhelani N.R.

**ANNEXURE D2**

**APPROVAL LETTER FROM VHEMBE DISTRICT DEPARTMENT OF HEALTH**

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OFHEALTH
VHEMBE DISTRICT

Ref: S5/6
Enq: Muvari MME
Date: 13.07. 2018

Dear Sir/Madam

**PERMISSION TO DO RESEARCH ON " Development of a model to support the reintegration of male state patients into their families in Limpopo Province, South Africa" : Lavhelani N.R**

1. The above matter refers.

2. Your letter received on the 13.07. 2018 requesting for Permission to do research in our facilities is hereby acknowledged.

3. The District has no objection to your request.

4. Permission is therefore granted for the practicals to be conducted within Vhembe District.

5. You are however advised to make the necessary arrangements with the facilities concerned.

Wishing you success in your endeavours.

..... 13/7/2018
CHIEF DIRECTOR DATE

Private Bag X5009 THOHOYANDOU 0950
OLD parliamentary Building Tel (015) 962 1000 (Health) (015) 962 4958 (Social Dev) Fax (015) 962 2274/4623
Old Parliamentary Building Tel: (015) 962 1848, (015) 962 1852, (015) 962 1754, (015) 962 1001/2/3/4/5/6 Fax (015) 962 2373, (015) 962 227

The heartland of Southern Africa – development is about people

**ANNEXURE E1**

**Application to Hayani Hospital to Conduct Research**

PO BOX 472

VHUFULI

0971

THE CHIEF EXECUTIVE OFFICER

HAYANI HOSPITAL

PRIVATE BAG X2272

SIBASA

0970

Application for Permission to Conduct Research

Dear Sir/Madam

I, the researcher, am currently pursuing a PhD in Nursing at the University of Venda hereby applying to be granted permission to conduct the study at your hospital.

The title of the study is “Development of a model to support the reintegration of male state patients into their families in Limpopo Province, South Africa”. Participants will be the family members of male state patients admitted at Hayani Hospital, Limpopo Province.

The aim of the study is to develop a model to support the reintegration of male state patients into families in Limpopo Province.

**The objectives of the study** are to:

- explore the perceptions of family members with regard to reintegration of male state patients into their family
- describe the perceptions of family members with regard to reintegration of male state patients into their family

- determine the kind of support needed by family members to reintegrate the state patients into their family
- develop a model to support reintegration of male state patients into their families

To achieve the aim and objectives of the study, I need to interview family members who are family members of male state patients who are admitted at Hayani Hospital. I therefore need permission to access admission registers of patients at Hayani Hospital in order to obtain contact details and physical addresses of family members of male state patients.

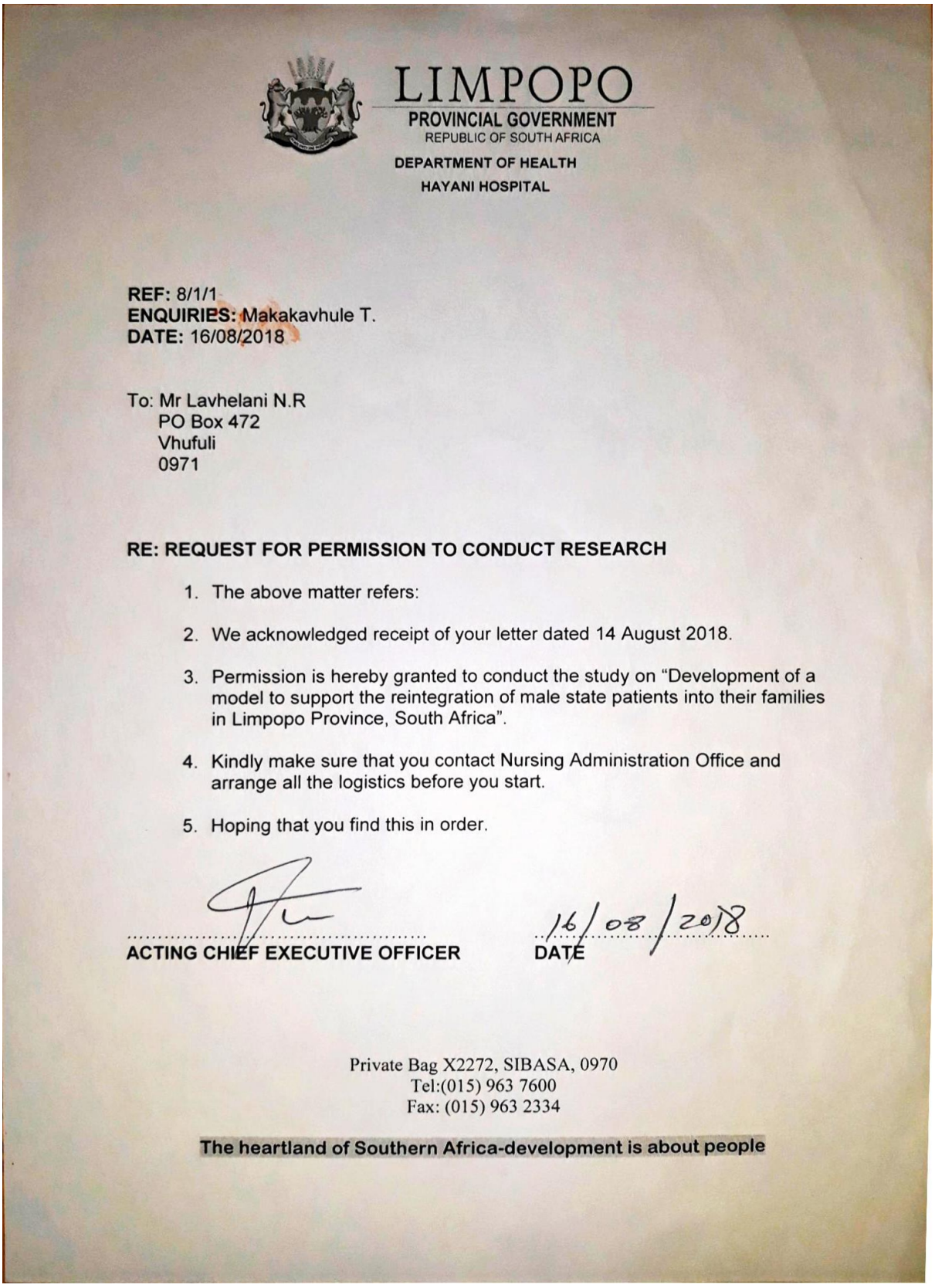
Looking forward to your positive response in this regard.

Yours faithfully,

Mr Lavhelani N.R.

## ANNEXURE E2

## APPROVAL LETTER FROM HAYANI HOSPITAL



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA
DEPARTMENT OF HEALTH
HAYANI HOSPITAL

**REF:** 8/1/1
**ENQUIRIES:** Makakavhule T.
**DATE:** 16/08/2018

To: Mr Lavhelani N.R
PO Box 472
Vhufuli
0971

**RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH**

1. The above matter refers:
2. We acknowledged receipt of your letter dated 14 August 2018.
3. Permission is hereby granted to conduct the study on "Development of a model to support the reintegration of male state patients into their families in Limpopo Province, South Africa".
4. Kindly make sure that you contact Nursing Administration Office and arrange all the logistics before you start.
5. Hoping that you find this in order.

.....
**ACTING CHIEF EXECUTIVE OFFICER**

16/08/2018
**DATE**

Private Bag X2272, SIBASA, 0970
Tel:(015) 963 7600
Fax: (015) 963 2334

**The heartland of Southern Africa-development is about people**

## ANNEXURE F

## CENTRAL QUESTIONS TO THE FAMILY MEMBERS

- As a family member of a patient who committed crime, could you please share with me your perceptions regarding reintegration of him into your family?
- What can be done to make you feel supported for reintegration of the male state patient into your family?

## MBUDZISO NGA TSHIVENDA

- Sa murado wa muta a re na mulwadze wa munna wa vhulwadze ha muhumbulo o itaho tshiwo vha nga nkovhela-vho mbonalo yavho nga ha u vhusiiwa mutani ha uyu mulwadze?.
- `Vha vhona hu tshi nga itwa mini uri pfe vho tikedziwa kha u vhuisiwa ha mulwadze wa munna wa vhulwadze ha muhumbulo mutani?

**ANNEXURE G1**

**UNIVERSITY OF VENDA**

**INFORMATION SHEET ABOUT THE PROPOSED STUDY**

Dear prospective participant,

I am Ndivhaleni Robert Lavhelani, a Doctoral student at University of Venda.

I am conducting a study entitled “Development of a model to support the reintegration of male state patients into their families in Limpopo Province, South Africa”.

**Aim of the study is** to develop a model to support reintegration of male state patients into their families in Limpopo Province, South Africa**.**

**The objectives of the study** are to:

- explore the perceptions of family members with regard to reintegration of male state patients into their family
- describe the perceptions of family members with regard to reintegration of male state patients into their family
- determine the kind of support needed by family members to reintegrate the state patients into their family
- develop a model to support reintegration of male state patients into their families

The information gathered will assist me to develop a model to support the reintegration of male state patients with their families in Limpopo Province, South Africa”. The supervisors for the research study are Dr M. Maluleke, Professor D.U. Ramathuba, and Professor M.L. Netshikweta at the University of Venda.

To complete the research study, I would like to invite you to participate in the study. The information that you will provide will be audio-taped and then transcribed for verification with the supervisors and the independent coder. These will be the only people who will have access to the tapes and transcriptions. The results from the study will only be used for the academic report. The data from the

study will be coded so that it is not linked to your name. Your identity will not be revealed while the study is being conducted, reported and published. The study data will be collected by the researcher (Robert Lavhelani). The data will be audio taped, transcribed and stored in a secure place and will be erased after five years of completing the study. Informed consent will be sought from you to participate in the study.

Participation in this research is voluntary and you have the right to withdraw at any time without penalty. Once interviews have been conducted, I will come to meet you again to confirm the information that you provided. I hope that you will participate in this research because your views are very important to me and will assist in improving mental health care services in our province.

The benefit of participating in the research study is that you have an opportunity to verbalize your needs, and there are no risks and discomforts in the study. However, if at any time during the study you experience emotional distress from disclosure you can notify me. Of importance is that there will be no remuneration in participating in the research study. Data collected from this project will be disseminated through a research report and an article in an accredited nursing journal. If you have any questions about the study and about being a participant in the study, please feel free to contact me on the following numbers: 084 467 8159 or 072 238 6106. The research committees of the University of Venda and Limpopo Province Ethics and Research Council Committee have approved the study.

I have discussed the above information with the participants. It is my opinion that they understand the risks, benefits and obligations involved in the study.

---------- ----------

Mr Lavhelani N.R, Date

Researcher

**ANNEXURE G2: INFORMATION SHEET: VENDA TRANSLATION**

**YUNIVESITHI YA VENDA**

**BAMBIRI LA U DIVHADZA MAFHUNGO NGA HA THODULUSO YA NGUDO INE YA DO ITWA**

Ha vhashelamulelenzhe vho teaho thoduluso kha ngudo,

Ndi nne Ndivhaleni Robert Lavhelani, mutshudeni wa digirii ya vhudokotela ha pfuzo ya vhuongi Yunivesithi ya Venda.

Ndi khou ita thoduluso kha ngudo ine thoho ya hone ya vha “U bveledzisa modele/mutodo une u do tikedza mirado ya mita ya vhalwadze vha muhumbulo vha vhanna vho itaho tshiwo vha tshi dovha u tanganiswa/u vhuisiwa na mita yavho Dzinguni la Limpopo, Shangoni la Afrika Tshipembe”.

Ndivho ya ngudo iyi ndi u bveledzisa modele/motodo une u do tikedza vhalwadze vha muhumbulo vha vhanna vho itaho tshiwo vha tshi dovha u tanganiswa/u vhuisiwa kha mirado ya mita yavho Dzinguni la Limpopo, Shangoni la Afrika Tshipembe.

**Zwipikwa zwa ngudo iyi ndi:**

- u wanulusa vhudzivha nga ha zwine mirado ya mita ya vhalwadze vha muhumbulo vha vhanna vho itaho zwiwo vha vhonisa zwone nga ha vhuisiwa ha vhalwadze avha mitani yavho,
- u talutshedza nga vhudalo nga ha zwine mirado ya mita wa vhalwadze vha muhumbulo vha vhanna vho itaho zwiwo vha vhonisa zwone nga ha vhuisiwa ha vhalwadze avha mitani yavho,
- u toda uri ndi ifhio thuso ine ya todiwa nga mirado ya mita ya vhalwadze vha muhumbulo vha vhanna vho itaho zwiwo nga ha vhuisiwa ha vhalwadze avha mitani yavho,
- u bveledzisa modele/mutodo une wa do tikedza mirado ya mita vha vhalwadze vha muhumbulo vha vhanna vho itaho zwiwo nga ha u vhuisiwa mitani yavho.

Mafhungo ane a do waniwa kha ngudo iyi a do thusa vhukuma kha bveledzisa modele/motodo une u do tikedza vhalwadze vha muhumbulo vha vhanna vho itaho tshiwo vha tshi dovha u tanganiswa/u vhuisiwa kha mirado ya mita yavho Dzinguni la Limpopo, Shangoni la Afrika Tshipembe

Vhalavhelesi vha ngudo iyi ya thoduluso ndi Dokotela M. Maluleke, Phurofesa D.U. Ramathuba na Phurofesa M.L. Netshikweta vha re Yunivesithi ya Venda.

U ri ndi kone u thaphudza pfunzo kha ngudo dza thoduluso iyi, ndi khou humbela nga u di tukufhadza uri vhone vha shele mulenzhe kha u disa mafhungo kha ngudo iyi. Mafhungo ane vha do a amba a do rekhodiwa nga tshidzhiamaipfi nda konaha u a nwala o tou ralo sa zwe vha a ambisa zwone u itela uri vhalavhelesi vha sedzuluse zwine nda do vha ndo nwala zwi tshi bva kha vhone. Ndi vhone vhathu fhedzi vhane vha do wana aya mafhungo kha tshidzimaipfi itsho na zwo nwalwaho. Mvelelo dza thoduluso dza ngudo iyi dzi do shumisiwa kha zwa pfunzo fhedzi. Madzina avho ha nga nwaliwi fhethu na hu thihi. Mafhungo ane vhone vha do a amba a do dzhiiwa nga nne fhedzi sa mutshudeni. Mafhungo aya a do vheiwa ho tsireledzeaho a konaha u phumuliwa nga murahu ha minwaha mitanu musi thoduluso dzo no fhela. Madzina avho na vhupo havho a zwi nga andadziwi musi mvelelo dzi tshi do andadziwa kha dzibugu dzi no do vhaliwa nga nyi na nnyi.

U shela mulenzhe kha thoduluso idzi vha tou u funa vhone vhane, a vha kombetshedziwi. Vha na pfanelo dza u di bvisa arali vha tshi pfa vha si tsha takalela  u ya phanda na u shela mulenzhe. Musi ndo no ita nyambedzano navho ndi do vhuya uri vha khwathisedze zwe vha amba. Ndi a fhulufhela uri vha do shela mulenzhe kha thoduluso idzi sa vhunga muhumbulo wavho u tshi khou dzhielwa ntha vhukuma kha thoduluso idzi. Zwe avha amba zwi do thusa vhukuma kha u thogomela vhalawadze vha muhumbulo vha vhanna vho itaho tshiwo musi vha tshi toda u vhuisiwa mitani yavho kha Dzingu la Limpopo na shango lashu lothe la Afrika Tshipembe nga u angaredza.

Vhone zwi do vha thusa vhukuma kha amba zwine vha toda u zwi vhona zwi tshi itiwa kha u vha tikedza kha u vhuisa vhalawdze avha mitani yavho. Fhedzi arali vha pfa muya wavho u fhasi musi ri kha nyambedzano vho tendelwa u amba na nne. A hu nga vhi na dzimbadelo kha nyambedzano idzi. Mawanwa a thoduluso idzi a do andadziwa kha dzibugu dzo tendelwaho nga vhalavhelesi kha sia la vhuongi. Musi vha tshi pfa vhe na mbudziso vha nga amba na nne kha nomboro

dza lutingokhwalwa dzine dza vha: 084 467 8159 or 072 238 6106. Komiti ya Thoduliso ya Yunivesithi ya Venda na Komiti ya Thoduluso ya Muhasho wa Mutakalo wa Dzingu la Limpopo vha do vha vhone vhane vha do themedela u itiwa ha thoduluso dza ngudo iyi.

Ndo ambedzana mafhungo aya na vhashelamulenzhe, zwo ralo ndi vhona uri vhashelamulenzhe vho pfesesa zwothe zwi no nga pfanelo dzavho na dzimbuelo dzothe kha u dzhelela kah thoduluso dza ngudo iyi.

---------- ----------

Mr Lavhelani N.R Duvha

Mutodulusi

**ANNEXURE H1**

**UNIVERSITY OF VENDA**

**Informed Consent / Participant's and Researcher's Statement Form**

**CONSENT FORM.**

**Title of the study:** "Development of a model to support the reintegration of male state patients into their families in Limpopo Province, South Africa."

I have read the information on the proposed study and was provided with the opportunity to ask questions and also given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me as indicated hereunder. I have not been pressurised in any way to participate in the study.

**Aim of the study is** to develop a model to support reintegration of male state patients into their families in Limpopo Province, South Africa**.**

**The objectives of the study** are to:

- explore the perceptions of family members with regard to reintegration of male state patients into their family
- describe the perceptions of family members with regard to reintegration of male state patients into their family
- determine the kind of support needed by family members to reintegrate the state patients into their family
- develop a model to support reintegration of male state patients into their families

I know that sound recordings will be taken of me. I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this, provided that my names and home are not revealed.

I understand that participation in the study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the care of my relative as a state patient.

I know that this study has been approved by the University of Venda (UNIVEN) Research Ethics Committee and the Limpopo Province Department of Health Ethics and Research Committee. I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed. I hereby give consent to participate in the study.

..... ……..

Name of family member Signature

Place…….. Date…… Witness…….

**Statement by the Researcher**

I provided verbal and/or written information regarding this study. I agree to answer any future questions concerning the study to the best of my ability.

I will adhere to the approved protocol.

..... .....…… ……

Name of Researcher Signature Date

Place……..

**ANNEXURE H2: INFORMED CONSENT: VENDA TRANSLATION**

**YUNIVESITHI YA VENDA**

**Fomo ya Thendelano i re na Ndivho**

**THOHO YA THODULUSO**

“U bveledzisa modele/mutodo une u do tikedza mirado ya mita ya vhalwadze vha muhumbulo vha vhanna vho itaho tshiwo vha tshi dovha u tanganiswa/u vhuisiwa na mita yavho Dzinguni la Limpopo, shangoni la Afrika Tshipembe”.

Ndivho ya ngudo iyi ndi u bveledzisa modele/motodo une u do tikedza vhalwadze vha muhumbulo vha vhanna vho itaho tshiwo vha tshi dovha u tanganiswa/u vhuisiwa kha mirado ya mita yavho Dzinguni la Limpopo, Shangoni la Afrika Tshipembe.

**Zwipikwa zwa ngudo iyi ndi:**

- u wanulusa vhudzivha nga ha zwine mirado ya mita ya vhalwadze vha muhumbulo vha vhanna vho itaho zwiwo vha vhonisa zwone nga ha vhuisiwa ha vhalwadze avha mitani yavho,
- u talutshedza nga vhudalo nga ha zwine mirado ya mita wa vhalwadze vha muhumbulo vha vhanna vho itaho zwiwo vha vhonisa zwone nga ha vhuisiwa ha vhalwadze avha mitani yavho,
- u toda uri ndi ifhio thuso ine ya todiwa nga mirado ya mita ya vhalwadze vha muhumbulo vha vhanna vho itaho zwiwo nga ha vhuisiwa ha vhalwadze avha mitani yavho,
- u bveledzisa modele/mutodo une wa do tikedza mirado ya mita vha vhalwadze vha muhumbulo vha vhanna vho itaho zwiwo nga ha u vhuisiwa mitani yavho.

Ndo vhala mafhungo, ndivho na zwipikwa zwine zwa khou tea u swikelelwa kha bambiri la u divhadza mafhungo maelana na thoduluso ya ngudo iyi. Ndo nekedzwa tshikhala tsha u vhudzisa mbudziso na u newa tshifhinga tsha u humbula nga ha mafhungo a thoduluso dza ngudo iyi. Ndivho na zwipikwa zwine

zwa khou toda u swikelelwa kha thoduluso ya ngudo iyi zwo talusiwa zwa vha khagala. A tho ngo kombetshedzwa u shela mulenzhe nga inwe ndila-vho.

Ndi a divha uri hu do vha na u rekhodiwa ha u amba hanga. Ndi a divha na zwa uri mvelelo dza thoduluso dza ngudo iyi dzi do andadziwa kha nyandadza mafhungo a zwa saintsi na zwa thekhinolodzhi shango lothe nga vhuphara. Ndi khou ita thendelo iyi fhedzi madzina anga na hune nda dzula hone a zwi nga divhadziwi fhethu na hu thihi. Ndi a divha tshothe uri u dzhenelela kha tsedzuluso dza ngudo iyi ndi u tou funa hanga na uri ndi nga di litsha u isa phanda na u dzhenelela tshifhinga tshinwe na tshinwe na hone ndi so ngo nea zwiitisi zwa u litsha. U litsha hanga a zwi nga itisi uri mulwadze wanga a sa wane thogomelo yavhudi.

Ndi a divha uri tsedzuluso idzi dzo newa thendelo nga Komiti ya Zwa Vhudifari ha Thoduluso ya Yunivesithi ya Venda na Komiti ya Zwa Thoduluso ya Muhasho wa Mutakalo wa Dzingu la Limpopo. Ndi a tenda u dzhenelela hanga, tenda hu tshi do vha na tsireledzo ya madzina na vhune hanga.

Ndi khou tenda u nea thendelo ya u dzhenelela kha thoduluso dza ngudo iyi

..... ……..

Dzina la shaka Tsaino

Fhethu…….. Duvha…… Thanzi…….

**Tshitatamende nga Mutodulusi**

Ndo nekedza mafhungo nga u tou amba na u nwala maelana na thoduluso dza ngudo iyi. Ndi do tenda u fhindula mbudziso dzothe tshifhinga tshidaho nga ha ngudo iyi u ya nga vhukoni hanga.

Ndi do tevhedza zwothe zwo vheiwaho nga mulayo wa u ita thoduluso.

..... ..... ……

Mutodulusi Tsaino Duvha

Fhethu……..

**ANNEXURE I**

***PRE-TESTING TRANSCRIBED INTERVIEW***

**TRANSLATED FROM TSHIVENDA TO ENGLISH ON PERCEPTION OF FAMILY MEMBERS REGARDING REINTEGRATION OF MALE STATE PATIENTS INTO THEIR FAMILIES IN LIMPOPO PROVINCE, SOUTH AFRICA**

**P: Participant** **R: Researcher**

R: Good morning

P: Nice morning

R: How are you?

P: Ok and how are you?

R: I am ok. I am Mr Robert Lavhelani. I am a student at the University of Venda. I came to you because of research, like I told you yesterday when I called you for an appointment, now I am here so that we can take our interview further as I said. I am going to ask you two questions regarding reintegration of male state patients with their families, which include your son who is in the hospital. Is that ok with you?

P: Uhmmm, ok

R: As we have been attending the meeting at your traditional council this morning with you during the campaign by Hayani Hospital regarding reunification of patients with their families. Now we are here at your place to continue with what I have said earlier on regarding the interview. Can I continue with the questions?

P: Yes.

R: The most important thing is that if you feel you need to stop the interview there is a button (pointing to it) on this audio voice recorder where you can press the stop button. This is the record button to record the interview. The buttons are indicated here “stop” and “record”. Do you understand?

P: Yes, I see the buttons

R: ***As a family member of a patient who committed crime, could you please share with me your perceptions regarding reintegrating him into your family?***

P: Myself I feel happy for him to come back home. The most important thing is for him to quit smoking and drinking alcohol. Where possible he must go to church.

R: Ok, what you mean is that you like him to be home. Is that true?

P: Yes, I like him to come home as a child. The important thing is that I had told him to quit smoking dagga and drinking alcohol so that he will live better, as when he was readmitted he was no longer taking his treatments as expected, saying he is not ill.

R: Ok, the second question is ***"What can be done to make you feel supported for reintegrating the patient who committed crime into your family?"***

P: If possible, the government should send him to school, to learn work that is done using his hands. Regarding a house, I had already built it. He is the only child.

R: So you are saying that the government should build a house for him?

P: No, I have already built it.

R: What else can be done?

P: The hospital should make home visits to check him if he is taking treatment. I also think that we should also visit him in the hospital as he has a grandmother who does not even know where Hayani Hospital is. This will assist us to see how he is being helped in the hospital.

R: You can go to the hospital after you would have talked to the social workers who will arrange your visit. But I am again saying what else you think the government could do to support you?

P: Mmmm, what can I say. Maybe the government can assist me to get his two children back from his wife who has since left to her home village with these kids.

R: Ok, the local social workers could assist you with that. If there is nothing more to say, it is ok.

P: There is nothing more to say.

R: Thank you very much, I will now play back what we had recorded so that you check what you said. Is that ok with you?

P: Yes.

R: Ok.

The researcher then played back the recorded interview to the participant.

**ANNEXURE J1**

**INTERVIEW TRANSCRIPT FROM FAMILY MEMBER: FAMILY UNIT NO. 1 (Sister)**

**TRANSLATED FROM TSHIVENDA TO ENGLISH ON PERCEPTION OF FAMILIY MEMBERS REGARDING REINTEGRATION OF MALE STATE PATIENTS INTO THEIR FAMILIES IN LIMPOPO PROVINCE, SOUTH AFRICA**

**Key: Participant: P** **Researcher: R**

Good morning

P: Nice morning

R: How are you?

P: Ok and how are you?

R. I am ok. I am Mr Robert Lavhelani. I am a student at the University of Venda. I came to you because of research, like I told you on Friday when I called you for an appointment and again I called you yesterday, and now I am here so that we could take our interview further as I said. Is that ok with you?

P: Uhmmm, ok.

R: Thank you. The research is going to look into the patients who had been admitted at Hayani Hospital because of committing criminal offences due to mental illness. I will then ask you a question like this ***"As a family member of a patient who committed crime, could you please share with me your perceptions regarding reintegrating him into your family?"***

P: I understand.

R: Now I will not speak much, you are the one to tell me more, myself I will be listening and only ask for clarification. The most important thing is that if you feel you need to stop the interview there is a button (pointing to it) on this audio voice recorder where you can press the stop button. This is the record button to record the interview. The buttons are indicated here "stop" and "record". Do you understand?

P: Yes, I see the buttons.

R: Let me restart again. “As a family member of a patient who committed crime, could you please share with me your perceptions regarding reintegrating him into your family?”

P: Myself as a sister to him I see coming back home as a good thing, but mmh, his mother is the one who seems to be having fear.

R: Can you elaborate on the fear?

P: I think the cause of fear is that my mother might be thinking that the victim’s family where he committed murder might cause fights for my mother as a way of revenge and many things could happen. The other thing is that the health professionals from the hospital had never conducted home visits to the victim’s family to see how far the family accept his coming back, including the close relatives of the same victim family.

R: Does his mother stay with you and your brother here?

P: Yes, it is just that she is still asleep.

R: Uhmmm, nodding his head. Are you saying that your mother is afraid that if he comes back the victim’s family will revolt against this?

P: Yes.

R: ***“What can be done to make you feel supported for reintegrating the patient who committed crime into your family?”***

P: Myself as his sister I feel that as a human being, he might now be tired of staying in the hospital for a long time as a mentally ill patient. I don’t know whether the victim’s family have forgiven him or what are they thinking about him, if they see him coming here at home. I really don’t know.

R: Uhmmm, nodding his head.

P: But I like him to be here at home according to me.

R: Uhmmm, What kind of support do you think family members need to reintegrate male state patients?

P: I think they should start by visiting the victim's family to find out how do they feel about reintegration of my brother as he has been in the hospital for a long time. How will they accept his coming back at home and understand their feeling about his coming back home.

R: Uhmmm, you are saying the first thing is that the hospital or its workers should visit the victim's family?

P: Yes, they should go and conduct a home visit so that they could find out whether they will be happy when he continues to be admitted or how will they feel if they see him back home. That is it.

R: What you are saying is that they should conduct a home visit to the victim's family. Is that so?

P: Yes, they will establish the victim's family's main opinion or understanding regarding his coming back. If they see him back how will they feel as he had committed murder which had affected them negatively? He had committed this murder due to mental illness and they may not be comfortable with this even when he had committed murder due to mental illness.

R: Uhmmm

P: He was mentally ill since his childhood and as such maybe they may understand that he had committed this murder due to mental illness or they may not accept him as they are highly affected by this case. Even us a family we were frightened and shocked on the day when he committed that murder. I saw my mother hiding behind the kitchen door as she was highly frightened. I understood it after some time and told my mother that these are things that are happening in other areas or countries committed by mentally ill people like my brother.

R: Uhmmm

P: The victim's family may not just accept him back due to anger of what had happened before. For us will be just to wait and see what they will say.

R: Thank you, what else besides home visits can be done regarding reintegration in terms of which the government can do to support this reintegration of your patient?

P: The hospital should talk to the chief of this village, as this person committed murder in two families. They will find out from the chief how his opinion is regarding the patient coming back home, whether the chief is accepting his coming back home or not.

R: Uhmm, you are saying they must speak to the chief about his reintegration?

P: Yes (nodding her head), and going to the victim's family.

R: Ok, besides these, is there anything that could be done to support reintegrating your brother with the family?

P: Yes, they can also talk to his mother to find out if she will be happy to accept her son if he is brought back home. I say this because I work for your Department of Health and she may think that I am supporting the department. I really know that mentally ill patients feel not being accepted if they stay for a very long time at a place which is not their home. The patient feels that it is not good that way.

R: Uhmmm, it will mean that you are saying that as a mother of your brother she should be talked to and say how she feels about his reintegration?

P: Yes, she must indicate how she feels about the whole situation really, if he said to be released from the hospital and come back home.

R: Ehh, if his mother agrees then you don't have the problem about his reintegration.

P: Yes if the mother agrees then the hospital should conduct further checking of his mind to determine if he may not pose danger to other people if he comes back.

R: In other words you are saying that health professionals should continue to assess him, whether he may be dangerous or not.

P: Yes, further they should check his mind whether he is no longer aggressive as he was during his admission. Also check if he is having records of fighting other patients. They should then determine whether his records influence his release so that the community will not fight us if all these issues are not done properly. If he repeats his aggression, the community may think that he does not trouble us as the family instead they may think that we as the family are the ones who are sending him to trouble them. They will not see that he is causing all the troubles because he is mentally ill. I do not have any other input than the ones I said above

R: Thank you. I want to summarise what you said. You said the first thing is that they should go to the victim's family through conducting a home visit and find out whether they will accept his coming back or not. Secondly, you said they should go to the chief and find out if they accept his coming back. Thirdly, you said his mother should be talked to and find out whether she accepts his coming back. Fourthly, you said one thing that should be checked is his mind by the health professionals to determine his aggressive behaviour that will show if he will be able to live with other people. Is that so?

P: Yes.

R: Is there anything that you think could be done to support the reintegration of male state patients like your brother with their families?

P: If all the above has been done, the most important thing is the intense mental status assessment of the patient whether the patient is still aggressive to such an extent that he may fight with other people. All the aggressive behaviour towards other people should really be thoroughly checked as this may cause incidents like the one committed by my brother.

R: Uhmm, you are saying that they should conduct intense mental status assessment to check whether the patient is still aggressive towards other people or not. Is this what you said?

P: Yes, it is what I said.

R: Ehh, if what you said had been done, do you have anything else that you think should be done?

P: According to me I do not see any other thing that should be done besides checking his mind or brain scan to check the extent to which his thought processes or brain is damaged that could lead to committing of serious offenses.

R: You are still saying that the brain needs to be checked including a brain scan. Is that true.

P: Yes.

R: If there is something you want to say you are still allowed to talk but if there is nothing we will then conclude our conversation.

P: I think all what I said are important rather than talking other things not related to our conversation.

R: Thank you very much for talking with you today as a sister to the patient who is admitted at Hayani Hospital. Like I said before, your names will not be revealed to anyone. All our conversation will be kept secret. Only my supervisors (Prof. Maluleke and Prof. Ramathuba) who are experienced in research will check this interview. I will then come back to validate what you said. I will also play back what you said now on this voice recorder.

P: Ok.

R: The recorded interview was played back to the participant for validation of information, who agreed to the contents of the interview.

THE END

**ANNEXURE J2**

**INTERVIEW TRANSCRIPT FROM FAMILY MEMBERS: FAMILY UNIT NO. 10 (Daughter)**

**TRANSLATED FROM TSHIVENDA TO ENGLISH ON PERCEPTION OF FAMILIY MEMBERS REGARDING REINTEGRATION OF MALE STATE PATIENTS INTO THEIR FAMILIES IN LIMPOPO PROVINCE, SOUTH AFRICA**

**P: Participant** **R: Researcher**

R: Good afternoon

P: Nice afternoon

R: How are you?

P: Ok and how are you?

R. I am ok. I am Mr Robert Lavhelani. I am a student at the University of Venda. I came to you because of research, like I told you yesterday and today this morning that I will come to visit you to get information regarding the research that I am conducting. Do you agree?

P: I again phoned you this morning when I was getting lost but nevertheless I am here now as you directed me well to your place. You can direct a person well to your home.

P: Thank you. I did that because I realised that you may have problems of finding my home.

R: Ok, today's weather is good and is not muddy on the road.

P: But few days ago it was muddy.

R: I am here so that we could take our interview further as I said. Today I am here at your place to interview you regarding the research that I am conducting as a student from the University of Venda. I am going to ask you two questions regarding reintegration of male state patients with their families. Are you agreeing to interview you as I said during our telephonic conversation?

P: Yes, I am agreeing.

R: My research is about patients who are at Hayani Hospital when they need to be released to go home. The research seeks to solicit information from relatives of these patients regarding reintegrating of them with you as family members. I will ask you two questions that you will answer. I have a voice recorder with me to record this interview. The most important thing is that if you feel you need to stop the interview there is a button (pointing to it) on this audio voice recorder where you can press the stop button. This is the record button to record the interview. The buttons are indicated here "stop" and "record". Your name and that of the patient will not be revealed. Do you understand?

P: Yes, I see the buttons.

R: My first question is ***"As a family member of a patient who committed crime, could you please share with me your perceptions regarding reintegrating him into your family?"***

P: Me I see that patients from Hayani Hospital should be released back to their homes. Like my father sometimes comes here at home and when we see that things are not well with him then goes back to the hospital.

R: Ok, when he is here at home, how is he?

P: I accept him as my father and the other family members also accept him.

R: Ok, thank you, let us go to the second question which is ***"What can be done to make you feel supported for reintegrating the patient who committed crime into your family?"***

P: What I see is that if nurses at the hospital see that the patient is now better than on the day of admission, they should go to the relatives where the patient stays and tell them in such a way that they can understand that the patient in the hospital is in a state in which he can come home.

R: Ok, continue.

P: Even when these patients are at home some of them refuse to take treatment that they have been given when they were released from the hospital and as such I

see that those nurses from the hospital should come and visit the patient once per week or twice per month to check on how the patient is doing.

R: Ok, if I can repeat what you are saying, you are saying that when nurses in the hospital see that the patient is better than on admission, they should allow the patient to come back home. Is that so?

P: Eeh (nodding her head).

R: Secondly you said that nurses from the hospital should come and visit the patient once per week or twice per month to check on how the patient is doing. Is that so?

P: Eeh (nodding her head).

R: Is there anything that the hospital or government could do to support you beside what you indicated above?

P: No.

R: If there is nothing more, I again thank you for giving me this time to talk to you about the male state patients reintegrating with their families.

R: Thank you very much, I will now play back what we had recorded so that you check what you said. Is that ok with you? Your input will assist in this research.

P: Yes.

R: Ok.

The researcher then played back the recorded interview to the participant.

## ANNEXURE K1

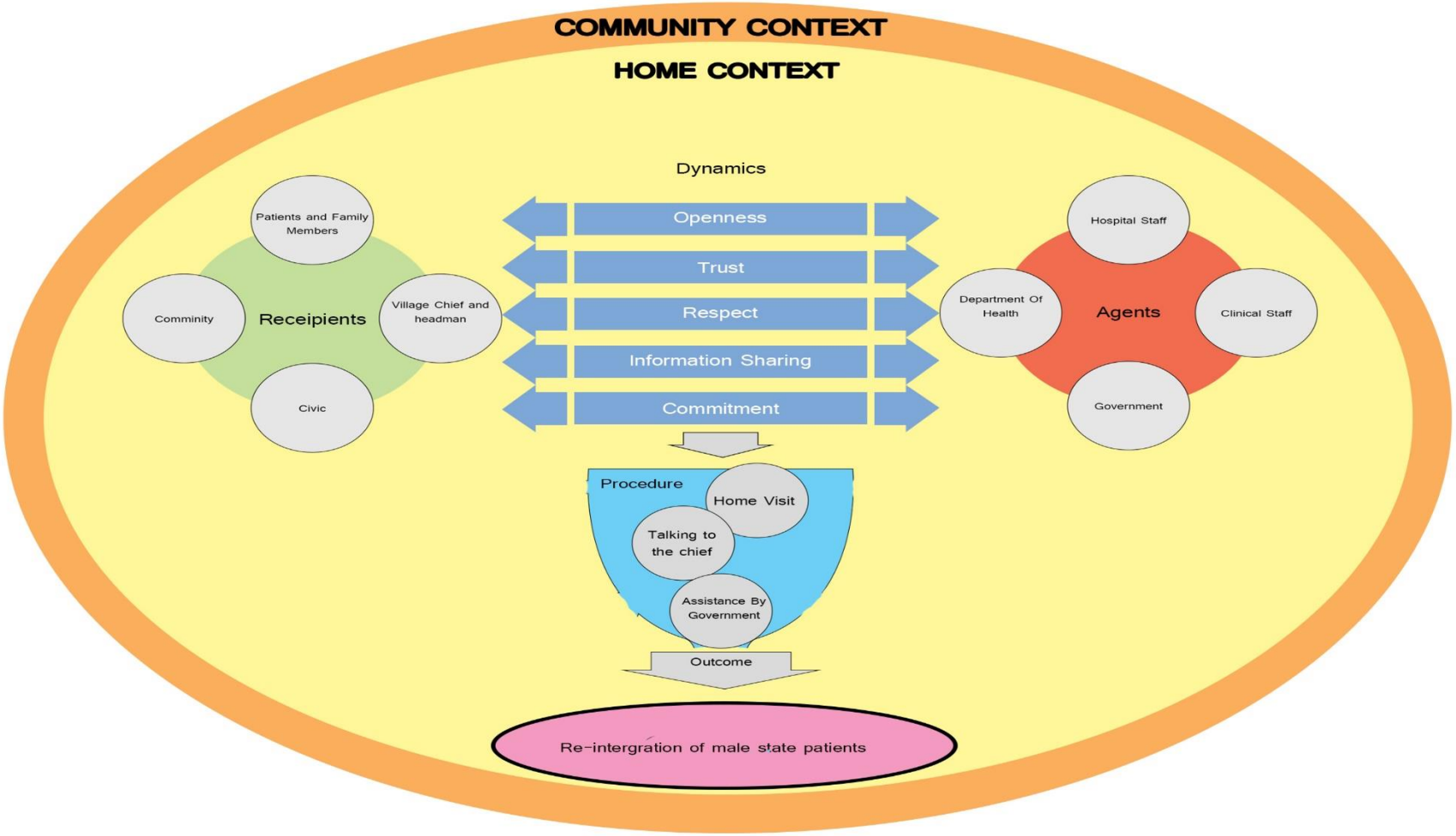
## 1ST DRAFT STRUCTURE OF THE MODEL AND COMMENTS


## COMMENTS BY THE GROUP DURING THE FIRST PRESENTATION

- How clear is the model? **Context**: The the group indicated that the "model is not so clear with regard to how the context of community, home are reflected on the model. Moreover Hayani Hospital is not appearing on the model".

However, community, home and Hayani Hospital should be oval shaped rather that circular. **Agents**: “Get one concept that will cover nurses, social workers and doctors”.

- How simple is the model? “The model is not simple as all items seem to be connected to each other. Home is indicated as separate from the context. To make the model simpler, indicate agents as health professionals, government and traditional leaders”. The **outcome** should be indicated as reintegration of male state patients into their families.
- How accessible is the model? Not much was said regarding this criterion.
- How general is the model? Not easy to comment as the model is not clear and simple.
- How important is the model? Comments will be given during the second presentation after all the corrections would have been effected.



## COMMENTS BY THE GROUP DURING THE SECOND PRESENTATION

- How clear is the model? **Context**: The group indicated that the "model is now so clear with regard to how the context of community, home are reflected on the model". **Agents**: "get one concept that will cover nurses, social workers and doctors". Use the green colour for the agents and orange colour for the **recipients.** The arrows connecting the items on the model should point upwards rather than downwards. The emphasis is that the outcome should appear at the top part of the model. For further clarity, the items on the **procedure** should be paired as follows: open communication and positive listening, mutual trust and respect, acceptance and commitment, empathy and humanity, information sharing and reflective feedback.

- How simple is the model? To make the model simpler, indicate agents as health professionals, government and traditional leaders". The **dynamics** should be rearranged from the previous presentation to give them logic and simplicity as follows: open communication and positive listening, mutual trust and respect, acceptance and commitment, empathy and humanity, information sharing and reflective feedback.The **outcome** should be indicated as reintegration of male state patients into their families.

- How accessible is the model? Not much was said regarding this criterion and was accepted as presented by the researcher.

- How general is the model? "**The procedure** can be carried out at any institution in South Africa rendering care to state patients."

- How important is the model? "The model can be used for reintegrating state patients into their families by health professionals working with these patients."

## ANNEXURE L: PROOF OF EDITING AND PROOF READING

STEVENS EDITING AND PROOFREADING
~ EDITING ~ PROOFREADING ~

BA: English; Industrial psychology (UNISA)
Sole Proprietor
*Membership*:
PEG (SA)

**2 April 2019**

**THIS IS TO CERTIFY THAT:**

I have language edited a PhD thesis for Mr Ndivhaleni Robert Lavhelani. The title of the thesis is 'DEVELOPMENT OF A MODEL TO SUPPORT REINTEGRATION OF MALE STATE PATIENTS INTO THEIR FAMILIES IN LIMPOPO PROVINCE, SOUTH AFRICA. Mr Lavhelani is a PhD candidate in the Department of Advanced Nursing Science at the University of Venda, South Africa. Email: ndivhaleni.lavhelani@dhsd.limpopo.gov.za.

The scope of my editing comprised:

- Spelling
- Vocabulary
- Word usage
- Checking of referencing style
- Tense
- Punctuation
- Language and sentence structure

It was a pleasure editing a well-written and researched thesis on a very relevant matter. My best wishes accompany Mr Lavhelani and I wish him great success in his endeavours and future career.

Yours faithfully,
Charlotte Stevens (Ms)
***Stevens Editing and Proofreading***
**e: ajc.stevens@gmail.com**
**[Note: Signature withheld for security purposes.]**