

**THE EXPERIENCES OF READMITTED MENTAL HEALTH SERVICE USERS IN A
PRIVATE IN-PATIENT TREATMENT FACILITY IN GAUTENG**

by

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**A mini-dissertation
submitted in partial fulfilment of the requirements for the degree
Master's of Social Work in Healthcare
MSW (HEALTHCARE)**

in the

**DEPARTMENT OF SOCIAL WORK AND CRIMINOLOGY
FACULTY OF HUMANITIES**

at the

UNIVERSITY OF PRETORIA

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June 2019

DECLARATION OF ORIGINALITY

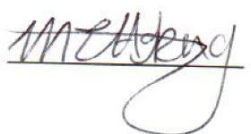
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ACKNOWLEDGEMENTS

A project such as this is never a one-woman job. I share my pride and joy with many people now that I've completed this challenge. Firstly, to my family and Sean – thank you for your constant encouragement, for being proud of me at all times, and for never giving up on me. Thank you for hanging in there through the frustrations and triumphs.

Secondly, to Dr C.L. Carbonatto, my research supervisor: thank you for the support, the direction, and all the knowledge shared. It is a privilege to learn from you.

Thirdly, to Sandy, for believing in this project with your whole heart and the possibilities it holds. I couldn't ask for a better mentor, and I am so grateful for all the love and patience you always give.

As with everything, this would not have been possible without God, who fills me with strength and courage and who is always with me.

And finally, thank you to all the study participants for sharing your world with me. Your openness and insight made this project what it is.

ABSTRACT

THE EXPERIENCES OF READMITTED MENTAL HEALTH SERVICE USERS IN A PRIVATE IN-PATIENT TREATMENT FACILITY IN GAUTENG

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DEGREE: MSW (Healthcare)

DEPARTMENT: Social Work and Criminology

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Relapse and readmission in mental health is relatively common and occurs as a result of various factors. Acknowledging the role of mental health services in preventing this readmission is vital for appropriate programmes to be developed and implemented, which will adequately address the needs of the mental health care service users. Some studies estimate that between 40% and 50% of psychiatric in-patients will be readmitted to a facility within one year of being discharged (AHRQ, 2014:1; Rieke et al., 2015:1). While the factors that contribute to readmission have been explored to some extent, knowledge about the role of mental health care services in preventing readmission is limited, particularly in South Africa.

The goal of the study was to explore and describe the experiences of readmitted mental health care service users at a private in-patient treatment facility in Gauteng. A qualitative research approach was used in this study. Applied research was conducted and an exploratory research purpose provided the researcher with the opportunity to collect data and develop a deeper understanding of a concept that had not been explored previously (Fouché & De Vos, 2011:95; Rubin & Babbie, 2010:41). A descriptive research purpose was also relevant. The research design that was utilised in this study was the phenomenological research design. Semi-structured one-on-one interviews were used.

The findings relate to the following possible factors that contribute to readmission: experiences of readmitted mental health service users, including experiencing events as a set-back; the role of psychiatric medication in relapse and recovery; and a lack of support. Participants also indicated that commitment to their recovery is an important part of their experience and poor use of their time is a possible contributor to readmission. In addition, the

participants shared their feelings about readmission as a normal part of recovery, but also shared negative emotions, such as shame. The role of programmes and mental health care facilities and how they can assist the patients was also explored.

Following interpretation of the reported experiences, recommendations were made for networks to be established, for ongoing treatment plans post-discharge to be implemented being required, and for increased promotion of mental health. Recommendations were also made for policies to be more inclusive of ongoing care and treatment in the mental health space.

The goal and the objectives of the research study were met, but continued research is needed in terms of the design and implementation of programmes for readmitted service users, the follow-up needs of discharged patients, and the experiences of those in public mental health services.

Key words:

Readmission

Mental health

Psychiatric

In-patient treatment

Private health care

Social Work

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CHAPTER ONE

GENERAL INTRODUCTION

1.1. INTRODUCTION AND CONTEXTUALISATION

The purpose of this research study was to explore and describe the readmission experiences of mental health service users in a private in-patient treatment facility in Gauteng. Relapse and readmission is relatively common in mental health treatment and care, and occurs as a result of various factors (Agency for Healthcare Research and Quality [AHRQ], 2015:1; Mark, Smoyer Tomic, Kowlessar, Chul Chu, Vandivort-Warren & Smith, 2013:208; Rieke, McGeary, Schmid & Watanable-Galloway, 2015:1). Acknowledging the role of mental health services in preventing readmission is vital if appropriate programmes are to be developed and implemented that will address the needs of the mental health care service users adequately.

While factors contributing to readmission have been explored to some extent, knowledge about the role of mental health care services in preventing readmission is limited, particularly in South Africa. There has also been limited exploration of the experiences of readmitted service users in private facilities in South Africa, as evidenced by the lack of available country-specific research on this topic. Most research and statistics are from higher-income countries, such as the United States, Canada, and the United Kingdom (Vigod, Kurdyak, Dennis, Leszcz, Taylor, Blumberger & Setiz, 2013:187).

The key concepts of this research are as follows:

- **Mental health care provider:** The *Mental Health Care Act 17 of 2002* Section 1 (xviii) defines a mental health care provider as “a person providing mental health care services to mental health care users and includes mental health care practitioners”.
- **Mental health care services:** For the purpose of this research, mental health services are any and all services rendered to individuals, groups, or communities that address mental health, such as the “promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders” (Capital & Coast District Health Board, 2016).
- **Readmission:** Readmission is defined as repeated use of in-patient mental health services, following previous discharge (Sengupta, [sa]:1).
- **Mental health service users:** Any person “receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status” of the person, is a mental health service user (*Mental Health Care Act 17 of 2002*, Section 1, xix). In the context of this study, mental health service users are those

who make use of mental health services at a private in-patient treatment facility in Gauteng.

- **Private in-patient treatment facility:** In-patient treatment can be defined as “the most intensive level of psychiatric care”. Therefore, a private in-patient treatment facility is a facility that provides this level of care through multi-disciplinary interventions at a “24-hour secure and protected, medically staffed and psychiatrically supervised treatment environment” (ValueOptions, 2006), and which is not owned or managed by the state.

1.2. THEORETICAL FRAMEWORK

The theoretical framework that was used in this study was the biopsychosocial approach. The biopsychosocial model was developed by Engel (1977:132) as a “dynamic, interactional, but dualistic view of human experience in which there is mutual influence of mind and body” (Borrell-Carrió, Suchman & Epstein, 2004:581). Through this model, Engel attempted to incorporate the psychological experiences of the patient with their social context, in order to understand illness and health more thoroughly (Hatala, 2012:52), and as a way of understanding not only whether the person seeking help was ill or not, but also why they might be ill, what they were experiencing, and how their health could be restored and maintained. By considering the influence of these various aspects, helpful medical interventions could be designed, and ongoing assessment, diagnosis and understanding becomes possible (Kaplan & Coogan, 2005:19; Miller, 2002:68).

The biopsychosocial model is based on the General Systems Theory. It was developed to fill the gaps in the biomedical approach, which viewed the mind and body as separate from each other and functioning mutually exclusively (Álvarez, Pagani & Meucci, 2012:173; Dilts, Jr, 2012:16; Heszen, 2009:11). As such, the biomedical model was not able to sufficiently explain many health and illness phenomena in general practice, which is one of its major criticisms (Álvarez et al., 2012:173; Heszen, 2009:12). The biopsychosocial model aims to “bring the care of the whole person together” (Álvarez et al., 2012:174).

Heszen (2009:12) summarises the biopsychosocial model as one that explains how a “human being acts as an interactive system in which biological factors interact with psychological and social factors within the social context of human activity and existence”. The biopsychosocial model consists of three main components namely biological, psychological, and social, and the different relationships and interactions between these components within the shifting nature of human experience (Dilts, Jr, 2012:17; Heszen, 2009:12). It is largely considered to be one of the more holistic models, as it views the mind and body as connected - something that is not supported by a number of other models (Engel, 1977:132; Heszen, 2009:12).

When applying this model, it is understood that illness appears when the “process of inner ... and/or outer ... activity fails to maintain a state of equilibrium” (Heszen, 2009:12). Today, it is widely acknowledged and accepted that both health and illness are a consequence of relationships between biological, psychological, and social factors (Álvarez et al., 2012:175). Borrell-Carrió et al. (2004:576) explain that, in order to respond sufficiently and appropriately to the challenges and discomfort experienced by patients, it is necessary to pay attention to the biological, psychological, and social aspects of their illness. This also assists in understanding the patient’s condition (Borrell-Carrió et al., 2014:576).

According to this model, there is an extensive list of possible risk factors for illness, as it includes psychological, social, and biological variables (Heszen, 2009:13). For example, situational factors such as every-day problems, life events, and extreme stressors are all considered possible contributors to illness, according to this model (Heszen, 2009:15; Skeen, Kleintjes, Lund, Petersen, Bhana, Flischer and the Mental Health and Poverty Research Consortium, 2010:611). In terms of patient experience, the biopsychosocial model recognises an ethical component in which “there are no good or bad patients, nor are there interesting and boring diseases”. Rather, patients should not feel as though they have to legitimise their suffering or experience in any way, in an attempt to make the professional feel more comfortable or confident through the disease description (Borrell-Carrió et al., 2014:580).

Coppock and Dunn (2010:17) and Patel, Chisholm, Parikh, Charlson, Degenhardt, Dua, Ferrari, Hyman, Laxminarayan, Levin, Lund, Medina Mora, Peterson, Scott, Shidhaye, Vijayakumar, Thornicroft and Whiteford (2016:1673) indicate the following as social determinants of illness: demographic factors (such as age); socio-economic factors (such as poverty and unemployment); neighbourhood factors; environmental events (such as natural disasters); and social change. Life events such as violence, bereavement and loss are also possible triggers for mental distress (Coppock & Dunn, 2010:17). The main theme that runs through all these issues is “powerlessness, inequality, and oppression” (Coppock & Dunn, 2010:17). All of the aspects need to be considered and integrated into an assessment and treatment plan and are given equal weight and importance (Álvarez et al., 2012:174; Dilts, Jr, 2012:19; Smith, Fortin, Dwamena, & Frankel, 2013:266).

The biopsychosocial model provides an alternative, and more holistic, response than the medical model (Borrell-Carrió et al., 2014:576; Kaplan & Coogan, 2005:19). Hatala (2012:51) describes the biopsychosocial model in the following way:

“Underlying this multifarious collection of research within health psychology is the position that biological (e.g. genetic predisposition), psychological or behavioural (e.g. lifestyle, explanatory styles, health beliefs), and social factors (e.g. family

relationships, socioeconomic status, social support) are all implications in the various stages of pathogenesis and health etiology.”

The model encourages the use of open-ended questions and discussion led by the service user to assist in identifying the social and psychological elements of what would otherwise only be biological reporting in non-patient-centred care (Smith et al., 2013:266). These scientifically-based methods encourage the service user to report and discover relevant social and psychological information which helps to provide the human context of the illness (Smith et al., 2013:268).

The biggest criticisms of this model have been that it is not testable and that there is no method to it (Álvarez et al., 2012:176; Smith et al., 2013:266). Álvarez et al. (2012:177) highlight challenges experienced with practical application of this model for many health professionals, particularly in mental health, and the incorporation of all aspects in treatment plans. Instruments such as the INTERMED interview and the International Classification of Functioning, Disability, and Health (ICF) are two tools that have been developed and which are available for use (Álvarez et al., 2012:177). The model is also criticised for being too general and vague in its conceptualisation (Álvarez et al., 2012:178), and as requiring “virtually all biopsychosocial patient information” (Smith et al., 2013:266).

The model has been supported by a number of mental health disciplines (Miller, 2002:47) and its benefits are evident, particularly in the social work field. It can assist with continual formulation and checking of interpretations, subsequent reformulation of interpretations, as well as the explanations of the patient’s experiences of mental illness (Miller, 2002:48-49).

In this study, the model assisted in the interpretation of the findings, as the experience of the readmitted patients covered multiple aspects of their lives. Biological (such as possible reaction to medication, health issues or other psychiatric illnesses), psychological (for example, experience of a traumatic event or experience) and social factors (including family environment, social group, and economic status) contributed to their relapse and subsequent readmission. Therefore, none of these aspects could be overlooked. By gaining an understanding of the experiences of those who have relapsed, it is possible to recommend ways to improve the mental health services on offer, by addressing the role that mental health services play in relapse and readmission.

Mental health is a vast and evolving field of practice. Aside from the practice of it, the impact of both mental health and the effects of mental illness are clear in terms of both society and the lives of individuals diagnosed with, or affected by, a psychiatric disorder or challenge. The range of possible impacts allows for numerous interventions and positive management of

disorders and symptoms that would increase the likelihood of recovery and a return to effective functioning for the individual.

1.3. RATIONALE AND PROBLEM STATEMENT

The rationale for this research was that if the experiences of mental health care service users who have been readmitted to treatment are understood, then programmes that address these experiences could be developed and implemented by the mental health care services. This could assist in increasing the likelihood of successful recovery and reintegration of service users, while preventing the readmission of these service users in future.

While research is available about readmission to mental health services, research on the experiences of readmitted mental health service users – particularly in South Africa – is limited, as was found when a search was conducted on EBSCOhost. Thus, the problem statement was that the experiences of readmitted mental health service users were unknown and needed to be explored, in order to decrease the readmission rate of service users. Only once such experiences are understood, can the possible role of mental health services in preventing readmission be identified, and readmission prevention programmes developed and implemented. Consideration of readmission was important, as there are multiple effects on society if the readmission rate is high, including increased cost and financial impact on society, on the family, and on the mental health care user. Readmission also places more pressure on already-strained service providers (AHRQ, 2015:1; Mark et al., 2013:208; Van der Merwe, 2015).

Due to the qualitative nature of the research and the intended exploration into the experiences of the service users, a research question was formulated, as valuable research always begins with a “good question” (Drisko, 2013:9). The research question was as follows: “What are the experiences of mental health care service users with regard to readmission to a private in-patient treatment facility in Gauteng?” The research aimed to provide an answer to this question.

1.4. GOAL AND OBJECTIVES

The goal of the study was to explore and describe the experiences of readmitted mental health care service users in a private in-patient treatment facility in Gauteng.

There were six objectives that had to be reached, in order to achieve the goal of the study:

- To contextualise mental health, mental health care, mental health care users and mental health care services in South Africa.
- To explore and describe the possible effects of readmission on mental health care users.

- To explore and describe the perceptions of readmission by mental health care service users.
- To explore and describe possible factors that contribute to readmission of mental health care service users.
- To identify the role of mental health professionals and services in preventing readmission.
- To make recommendations to mental health services for possible programmes, interventions, and initiatives that are aimed at preventing readmission of mental health users.

1.5. OVERVIEW OF RESEARCH METHOD

The research approach considered most appropriate for this study was the qualitative research approach. During this study, applied research was conducted and an exploratory research purpose provided the researcher with an opportunity to collect data and develop a deeper understanding of a concept that had not been explored previously (Fouché & De Vos, 2011:95; Rubin & Babbie, 2010:41). A descriptive research purpose was also relevant. The research design that was utilised in this study was the phenomenological research design.

In order to conduct qualitative research, specific research methods must be followed. The population that was the focus of this study was mental health service users who had previously made use of such services, and who had been discharged from a previous treatment in an in-patient facility, and then readmitted.

Non-probability sampling was most appropriate and this research made use of purposive sampling, which entailed the selection of specific cases that were relevant to the study (Greeff, 2011:392). The first ten individuals who met the following criteria were recruited and became the research participants:

- Individuals who were receiving in-patient mental health services and treatment at a private in-patient treatment facility in Gauteng.
- Individuals who had been readmitted for in-patient mental health services.
- Individuals whose last treatment was less than one year before readmission.
- Individuals who were above the age of 18 years.
- Individuals who had the mental capacity to participate in the research study.
- Individuals who were not, or had not previously been, on the researcher's caseload.
- Individuals who were conversant in English.

Data were collected through semi-structured interviews, and the researcher made use of a broad open-ended question when interviewing the participants, but also included other open-ended questions, so as to ensure that the necessary topics were addressed. When analysing

the data that were collected, the researcher identified topics and themes through analysis of the interview transcriptions (Schurink, Fouché & De Vos, 2011:402). The process of thematic analysis was used to analyse the responses obtained during the interviews that were done for this study. The thematic analysis process utilised in this study is that proposed by Braun and Clarke (2013:202), namely: transcription, reading and familiarisation, coding, searching for themes, reviewing themes, defining and naming themes, and writing the research report.

A number of criteria and techniques were applied to the qualitative research, to ensure that it is at the appropriate standard. Trustworthiness was ensured through credibility, transferability, dependability, and confirmability. The researcher also avoided researcher bias.

A pilot study was conducted with one user, at a different private in-patient treatment facility within the clinic group, to ensure the appropriateness of the data collection method. This pilot study was done prior to conducting the main research, and the responses were not included in the results. The pilot study tested the interview schedule, as well as the recording device, type of venue and duration of the interview. It also provided an opportunity for the participant to provide feedback. No changes had to be made to the process, following the pilot study.

The researcher also considered many ethical aspects when conducting the research (Edwards & Mauthner, 2012:14), including avoidance of harm, voluntary participation and informed consent (see Appendix C), confidentiality, debriefing of participants, publication of findings, and actions and competence of the researcher. Ethical clearance for this study was received from the Research Ethics Committee of the Faculty of Humanities, University of Pretoria (see Appendix A).

The research methods are discussed in further detail in Chapter 3, Section 3.6.

1.6. CONTENTS OF THE RESEARCH REPORT

The remainder of this research report and what each chapter covers, is as follows:

CHAPTER TWO: MENTAL HEALTH AND READMISSION

This chapter focuses on the historical context of mental health in South Africa, and the legislation and policies in place. It also discusses the impact of mental health issues on those experiencing them, and on the people around them. Diagnosis and treatment in mental health is covered, before the process of recovery is explored. Readmission as a phenomenon and its prevalence in South Africa are also dealt with.

CHAPTER THREE: RESEARCH METHODOLOGY, EMPIRICAL FINDINGS AND INTERPRETATION

This chapter discusses the research methodology used. The ethical considerations and the empirical findings are also discussed and interpreted.

CHAPTER FOUR: CONCLUSIONS AND RECOMMENDATIONS

In the final chapter, achievement of the goal and objectives of the study is discussed, as well as the key findings of the research. Conclusions are drawn from the study and recommendations are made for mental health service providers, mental health programmes and further research.

The next chapter contains the literature review, which focuses on mental health and readmission, in order to provide the context and a deeper understanding of the research.

CHAPTER TWO

MENTAL HEALTH AND READMISSION

2.1. INTRODUCTION

In order to understand the experiences of readmitted mental health service users in a private in-patient treatment facility, one must begin to understand mental health services and readmitted service users as a population group. This will enable the identification of the possible causes of readmission. The historical context of mental health in South Africa is reviewed, as are the currently implemented legislation and policies. The impact of mental health and mental illness on the individual, families and society is considered, and the diagnostic process and treatment options explored. Readmission as a concept and its prevalence in South Africa is understood. Finally, the theoretical framework is explained and applied in the context of readmitted mental health service users.

2.2. HISTORICAL CONTEXT OF MENTAL HEALTH IN SOUTH AFRICA

The history and context of mental health services in South Africa needs to be understood as being closely related to social and scientific development in the country and in the world, as the field of psychiatry has always been largely influenced by these views among others (Fawn Jones, 2012:11; Uys, 2010:3). This historical context is necessary as a foundation, as it places the current South African mental health system and service provision in context. Over time, views and beliefs regarding mental health have changed significantly, which has had a direct effect on the services available to those with mental health issues. Historically, mental health issues were thought to be a result of supernatural occurrences (Kent, 2003:16; Uys, 2010:3); therefore, treatment was based on physical and religious foundations, while the family was expected to be primarily responsible for the care and support of a mentally ill person – beliefs that still extend to the traditional treatment of mental illness in many ways in South Africa, even today (Fawn Jones, 2012:21; Uys, 2010:3). This supernatural-causation belief continued for a number of years, with the focus moving more specifically to the possession of a person by demons as the cause for mental distress and symptoms during the middle ages (Kent, 2003:18; Uys, 2010:4). The responsibility of care eventually shifted largely to the state, in the belief that those with mental illness should be isolated from normal society, the development of institutions gained momentum (Fawn Jones, 2012:20; Uys, 2010:4).

In colonial-era South Africa, the wealthy were often cared for at home while the poor were placed with families who were supported and reimbursed by the church for their service (Uys, 2010:4). Around this time, mentally ill individuals began to be admitted to general hospitals as required. By the 19th century, the number of institutions for the mentally ill increased, with Robben Island becoming one of the first psychiatric hospitals (rather than general hospitals

admitting psychiatric patients), admitting patients from 1846 (Uys, 2010:5). In the years to follow, a number of “lunatic asylums” opened their doors (Uys, 2010:4), including what are today known as Weskoppies Psychiatric Hospital, Sterkfontein Hospital, and Tara Hospital – some of the currently available state-managed facilities. Throughout the 20th century, psychiatric care proceeded to be a poorly-regulated and stigmatised field with overpopulation being common and patient management techniques focusing more on isolation and restraint (Uys, 2010:6). However, with the development of medication options, particularly sedatives, the possibility of discharge from hospital facilities increased, as did the “transfer of treatment to the community” (Uys, 2010:6). The focus of care and treatment began to shift towards more social and therapeutic environments (Uys, 2010:6).

Regulation of mental health services improved with a committee established in 1913 to oversee and protect the interests of the intellectually disabled and mentally ill; this would later be known as the South African Federation for Mental Health (NGO Pulse, 2016; Uys, 2010:7). Psychiatric hospitals came to fall under the jurisdiction of the Department of Health [DoH] and provincial administrations, a previous separation that isolated mental health care from “the mainstream of medical development” and contributed to stagnation of service delivery and development (Uys, 2010:7).

The implementation of services in South Africa, particularly in the public sector, remains problematic, with the services often not effectively accessible at a grassroots level and leaving service users without the necessary care (McCrea, 2010:4; South African College of Applied Psychology [SACAP], 2013; Van der Merwe, 2015). Van der Merwe (2015) highlights that part of the challenge is insufficient service providers – in the private sector, the ratio of patients to private psychiatrists is approximately 33 000:1, with the number of patients per psychiatrist being even higher in the public sector. Once a characteristic of the apartheid-era, the considerable difference in quality of services to various population groups remains, as does a historical neglect for mental health and mental health services (McCrea, 2010:1; Skeen et al., 2014:115; Uys, 2010:10).

Throughout the field of mental health, various definitions of important terms exist. Much of this terminology is grounded in the understandings of the group using the terminology (Coppock & Dunn, 2010:8) which can lead to confusion, misinterpretation and misunderstanding. As more research is conducted and more advances are made in the mental health field, the terminology continues to change, as understanding changes and develops (Coppock & Dunn, 2010:8). The field of mental health is highly dynamic and, as such, is often contested (Coppock & Dunn, 2010:8).

Mental health distress and mental disorders are, statistically, a common experience, but the experiences vary significantly between individuals (Coppock & Dunn, 2010:10; Fawcett, Weber & Wilson, 2012:89). While these experiences of distress may be an occurrence in everyday life for many, society often wants to be distanced from such experiences, which indicates there is stigma attached to it, and fear of experiencing and discussing such issues (Ben-Zeev, Young & Corrigan, 2010:319; Coppock & Dunn, 2010:10). The attitude of the public towards mental illness and those with a mental illness is found to be largely negative, despite policy frameworks that try to be inclusive (DoH, 2013:14; SACAP, 2013; Van der Merwe, 2015).

Additionally, mental health is still not made a priority in South Africa (Van der Merwe, 2015). Funding is a big problem for the services, as are sufficient resources (DoH, 2013:9). Mental health in South Africa is an area that needs to be invested in on a great scale and needs to move to greater inter-sectoral involvement (Skeen et al., 2010:613; Van der Merwe, 2015). Mental health care in South Africa has evolved over time and has certainly become more effective and patient-centred, but issues still remain. To address mental health issues and to provide and manage care and treatment, legislation and other guiding policies are put in place.

2.3. LEGISLATION AND POLICIES

Mental health and mental health care in South Africa is governed by the *Mental Health Care Act 17 of 2002*. Dennill (2012:201) describes this Act as providing “a legal framework for the management of mental health in the Republic. It outlines both admission and discharge criteria for patients who are mentally ill”. The *Mental Health Care Act 17 of 2002* is created to support an approach to mental health care that is more comprehensive with services available at all levels (Madelá-Mntla, 2010:104; McCrea, 2010:2). Additionally, it aims to assist with anti-stigma measures through the use of terminology (Madelá-Mntla, 2010:104). Protection from discrimination is also a key focus point as outlined in Section 10 of the *Mental Health Care Act 17 of 2002* (McCrea, 2010:2). According to the *Mental Health Care Act 17 of 2002*, mental illness is defined as “a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis”. Beyond this, Section (8) (1) of the *Mental Health Care Act 17 of 2002*, explains that services provided for mental health should improve the service user’s capacity to develop their full potential and should also assist in facilitating their reintegration back into community life.

Service users must give valid legal consent to receive treatment and they have the right to refuse psychiatric treatment if they wish (Coppock & Dunn, 2010:89). As per Section 9 (1) (a)

of the *Mental Health Care Act 17 of 2002*, a facility may only provide care if this consent for services or admission has been received. Section 25 states that an individual seeking voluntary care and treatment is required to receive such treatment or a referral to alternative appropriate services (McCrea, 2010:2). While involuntary care is an option in specific circumstances - where a person is legally compelled to receive psychiatric intervention - most private treatment facilities provide only voluntary care. The consent for such care needs to be given free of pressure and service users also have the right to information about what they can expect from the treatment and why the treatment is being given (Coppock & Dunn, 2010:89). Any possible side effects of the treatment need to be disclosed to the service user as well (Coppock & Dunn, 2010:89).

While the *Mental Health Care Act 17 of 2002* provides the legal framework, there are also two main guiding policies that support standards of care and services required for mental health. The World Health Organization (WHO) implemented the *Mental Health Action Plan 2013-2020*, which focuses on the action needed to achieve targets, such as: effective leadership; providing community-based services, promotion and prevention strategies; and strengthening research (Stein, 2014:115), in order to guide national policies. In line with this, South Africa has the *National Mental Health Policy Framework and Strategic Plan 2013-2020* (DoH, 2013:19). Some objectives of this plan are to empower local communities for increased participation in mental wellbeing and recovery promotion, to ensure evidence-based planning and provision of services for mental health, and to promote the mental health of the South African population as a whole. The *National Mental Health Policy Framework and Strategic Plan 2013-2020* (DoH, 2013:24) also highlights the “provision of in-patient and limited out-patient mental health services” (DoH, 2013:24) by specialised psychiatric hospitals.

Legislation and policies are put in place as one method of managing not only the services and interventions provided, but in assisting to lessen the impact of mental health issues on society - an impact that is far-reaching and impacts not only many different sectors, but the functioning of society as well.

2.4. THE IMPACT OF MENTAL HEALTH ISSUES

The trigger for seeking assistance with a mental health issue is often another person noticing a change in behaviour or mood, or developing a concern about the person’s wellbeing (Coppock & Dunn, 2010:18). This indicates that there is a noticeable negative effect on the person’s life in some way (Fawcett et al., 2012:90). Some of these impacts include relationship difficulties, work challenges that lead to higher levels of unemployment, and personal challenges (Fawcett et al., 2012:90). Due to the relationship difficulties, people with a “diagnosed mental disorder are more likely to live by themselves” (Fawcett et al., 2012:90).

When looking at gender differences in impact, women – particularly single mothers working full-time – are found to have a higher vulnerability to stress and poorer overall mental health (Fawcett et al., 2012:100). Women are also found to be at an increased risk for depression and anxiety disorders (DoH, 2013:11; Fawcett et al., 2012:89). Other differences and inequalities, such as race and class, can also contribute to mental distress and impact the way in which individuals respond to circumstances, which also influences their mental health (Fawcett et al., 2012:99). The inequalities are found to have a greater impact if they begin in childhood, as this can then carry through to adulthood (Fawcett et al., 2012:100).

Tromp, Dolley, Laganparsad and Govender (2014) note that one-third of South Africans have a mental illness, with depression, substance abuse, anxiety, bipolar disorder and schizophrenia being the most common. Over 11% of South Africans are thought to experience substance use problems, and up to a third of the population experience a mental illness during the course of their lives (Van der Merwe, 2015). Common mental health disorders, for example depression and anxiety, can lead to losses in not only health, but also in functioning (WHO, 2017:13).

Despite the high prevalence of mental illness, less than 25% will get help for their mental illness (Van der Merwe, 2015; WHO, 2013:8). The WHO (2010:1; 2013:08) sees even less than this number of people with mental health issues receiving services; they note that four out of five people in need of services for “mental, neurological and substance use conditions” are not receiving them in low- and middle- income countries. Even when available, some of the interventions are not evidence-based or of high quality (WHO, 2010:1). As a result, many service users choose to receive treatment through private institutions, rather than those managed by the state (Tromp et al., 2014). South Africa also sees a shortage of mental health services and funding for these services (Tromp et al., 2014; WHO, 2017:12; 26).

Psychiatric disorders have been ranked as the third highest contributor to disease in South Africa, and also contribute significantly to the causes of health disability (DoH, 2013:11; Van der Merwe, 2015). Mental health issues are costing more than double the cost of treatment as a result of the impact on the economy when left untreated - an indirect cost that largely outweighs that of the direct cost of healthcare provision (DoH, 2013:14; Van der Merwe, 2015). This indirect cost includes reduction in productivity at work, something that is costing South Africa over three billion rand a year (Business Tech, 2012; Convey, 2015:8; South African Depression and Anxiety Group [SADAG], 2017). Despite these visible workplace impacts, SADAG (2017) found that 56% of employees had taken time off work in the previous 12 months due to mental illness, and 16% do not have a formal diagnosis. The impact of mental illness is seen for those experiencing it and those around them and includes many aspects of

daily life and functioning. Diagnosis, and the intended understanding of the diagnosis, is often the first step to identifying how to lessen the impact on the individual.

2.5. DIAGNOSIS

There are three main criteria that determine if behaviour is considered abnormal, namely “distress, dysfunction and deviance” (Passer, Smith, Holt, Bremner, Sutherland & Vliek, 2009:780). All mental health assessments are dependent on theories that determine what is “normal” in terms of thoughts, feelings, and behaviours (Coppock & Dunn, 2010:17). Passer et al. (2009:780) explain that “classification is a necessary first step towards introducing order into discussions of the nature, causes and treatment of psychological disorders”. In order for a classification system to be appropriate and useful, it needs to be both reliable and valid (Passer et al., 2009:780).

The medical model is an approach that has had a profound impact on the diagnostic process. Diagnosis, in terms of the medical model, is the “accurate name of an objective disease process” (Coppock & Dunn, 2010:15). The Diagnostic and Statistical Manual (DSM) of Mental Disorders and the WHO International Classification of Diseases (ICD) are the two major classification systems which are acknowledged. They are used in the field of mental health to assist with diagnosis through the use of set lists of criteria (Burns, 2014:66; Coppock & Dunn, 2010:15; Kendell, 2009:43; Passer et al., 2009:781). Coppock and Dunn (2010:16) explain that one of the challenges with diagnosis as a form of measurement, however, is that it can cause practitioners to perhaps overlook the individual information and aspects of each patient’s case and, as a result, lead to a lack of understanding of the real reason behind their mental distress. Personalisation and individuality is key for effective treatment in mental health (Uys, 2010:52).

The first formal stage of possible mental disorder assessment and diagnosis is that of the mental state examination (Coppock & Dunn, 2010:18). A medical doctor, often a psychiatrist, uses standardised tools to gain more insight into the symptoms experienced by the service user (Coppock & Dunn, 2010:18; Leach, 2009:9). As physical tests are often not useful in the diagnosing of a mental disorder, the examination takes place through a series of questions and observations by the doctor (Leach, 2009:9; WHO, 2010:6). The patient’s psychiatric and social history often also forms part of this examination, with information provided by the individual, and their family and friends. A multi-disciplinary team may be useful here (Coppock & Dunn, 2010:18; WHO, 2010:6). While the psychosocial professionals and team may be involved, the role of making the diagnosis is that of the psychiatrist or medical doctor (Leach, 2009:10). The practitioner should always be aware of the possibility of their beliefs influencing the diagnostic process, which should be an objective one (Coppock & Dunn, 2010:15).

Through this process of identifying any disordered thoughts, feelings and behaviours, and possible symptoms experienced, the practitioner is often able to define whether or not the service user is presenting with the clusters of symptoms in the classification symptoms, and whether or not a diagnosis is possible (Coppock & Dunn, 2010:17; Leach, 2009:9). In the diagnostic phase, understanding the service user's severity of symptoms is important, particularly with things like suicidal risk (Allers, 2015:11; Korb, 2015:31). In cases where not all criteria are met, Johnson (2002:377) notes that rather than mental "illness", a possible mental "problem" is identified. This could be relevant where the exhibited symptoms are still concerning to the person, the family, or the professional, but are not considered sufficient in number or type to meet the formal diagnostic criteria (Burns, 2014:66; Coppock & Dunn, 2010:16).

Much like physical medicine, the medical approach to mental health begins with diagnosis of the issue being experienced and an understanding of the symptoms. Only with this knowledge is a course of treatment prescribed (Allers, 2015:11; Leach, 2009:9). However, the treatment needs to extend beyond only the diagnosis.

2.6. TREATMENT

Treatment approaches in mental health develop as understandings of mental health, mental distress and mental disorders develop (Coppock & Dunn, 2010:88). With the development of psychiatry as a body of knowledge, responsibility for the clinical management of service users, as well as legal responsibility, emerged too (Coppock & Dunn, 2010:88).

Traditionally, the attitude and behaviour of health and social care professionals has been that of superiority – believing that they, as the professionals, are best in the position to determine the needs of the patient and what help will be effective, as well as that the only solution is through the professional (McKnight 1995 in Coppock & Dunn, 2010:97). The service user was also traditionally viewed as the "problem", with both the problems and solutions presented in language that was not clear to understand (McKnight 1995 in Coppock & Dunn, 2010:97), thus making the diagnostic, treatment and recovery process very user-unfriendly. Providing treatment from such a needs-focused perspective, especially based on assumptions, removes the focus from the service user and can leave them disempowered (Coppock & Dunn, 2010:97).

A better and more person-centred approach is to create and use policies, tools, and activities that recognise and empower people to develop their skills, abilities, and capacity to manage their illness or diagnosis (Coppock & Dunn, 2010:97; Drake, Deegan & Rapp, 2010:7). As each person's recovery journey is individual and unique, various factors need to be taken into

consideration when developing a treatment plan (Deegan, 2009:63; Uys, 2010:52). Communication needs to be clear and in simple language, and needs to be sensitive to differences between the practitioner and the service user (WHO, 2010:6). One must consider treatment duration, the various types of treatment available, as well as the role and value of professionals in the treatment field, to better understand treatment in mental health.

2.6.1. Treatment duration

While “some studies show that a longer duration of treatment may be more beneficial due to the continued improvement of patients during therapy”, there is evidence that suggests that brief therapies are effective (Boerema, Cuijpers, Beekman, Hellenthal, Voorrips & Van Straten, 2016:1495-1496). The treatment duration is often related strongly to the service user’s characteristics and diagnosis (Boerema et al., 2016:1496; Leichsenring & Rabung, 2011:15). Another consideration for treatment duration is the continued and increasing pressure on service providers to provide therapies which are cost effective and high quality, but of shorter duration than therapies were traditionally (Boerema et al., 2016:1495).

While those with more severe symptoms may require a longer duration of treatment, they may in fact receive briefer therapy, due to the higher risk for dropout from treatment programmes, as a result of the symptoms (Boerema et al., 2016:1496). One concern with this approach, and with brief therapy in general, is that service users may begin to show improvement in some aspects of their recovery, but do not fully recover during that time (Boerema et al., 2016:1496). Boerema et al. (2016:1496) explain that “residual symptoms are strongly associated with recurrence”; therefore, relapse is possible, as is eventual readmission to the mental health care services. Deegan (2009:63) defines a programme as “fail-proof” when the service users are “always able to come back, pick up where they left off, and try again”. The most effective mental health rehabilitation services are those where a service user can feel “welcomed, valued, and wanted” (Deegan, 2009:63).

It is necessary to provide options for recovery programmes to service users. This is because each person’s recovery is unique (Deegan, 2009:63; Uys, 2010:52). Some of the options that are suggested include social clubs, networks for self-help, skills training and workshops, and other support programmes (Deegan, 2009:63). It is the creation of these programmes and resources, as well as the connection with existing resources, which is one of the biggest challenges in recovery (Deegan, 2009:63). Puntis (2016:1633) describes continuity of care as the “process of delivering care to an individual patient over time which is perceived by both the patient and care providers as comprehensive, consistent and connected”.

Deegan (2009:63) explains that traditional values of “competition, individual achievement, independence, and self-sufficiency” can be oppressive for some people with mental distress, disorder or disability. This means that programmes that focus on these elements as the central component could contribute to recovery failure for these individuals (Deegan, 2009:63). While content of treatment programmes is important, the types of treatment used to implement these programmes are of significant importance in mental health too.

2.6.2. Types of treatment

2.6.2.1. Biological treatment

The medical model of mental health compares mental health issues to those of physical issues; therefore, according to this model, technological solutions through biological treatments should have a positive impact in treatment (Coppock & Dunn, 2010:89). This includes options such as electroconvulsive therapy (ECT) and medication/ drug therapy and treatments.

The typical frontline response to mental illness and distress since the 1950's has been prescription and administration of psychoactive drugs (Coppock & Dunn, 2010:91; Leach, 2009:10). The four main categories of psychiatric drugs are anti-anxiety, anti-depressant, anti-psychotic and mood-stabilising drugs (Coppock & Dunn, 2010:91). However, drug treatments have been shown to assist with symptoms of mental illness, as well as with some of the functioning implications, but not in actually treating the cause or curing such illness (Coppock & Dunn, 2010:92). This is partly because, despite much biologically-focused research, physical causes are rarely found in mental illness (Coppock & Dunn, 2010:92).

With the recommendation of drug treatments, communication becomes necessary about adherence, possible side effects, and the effects of such drugs (Coppock & Dunn, 2010:93; Leach, 2009:10; Liebenberg, 2015:7). A successful outcome of any medication is determined by the service user's adherence to the medication course (Liebenberg, 2015:7). Up to 15% of patients would see an improvement while on anti-depressants, for example, within the first few weeks (Allers, 2015:11). Despite this improvement, Allers (2015:12) recommends continued use of the medication for up to a year or more, depending on the number of depressive episodes experienced. Where additional medications, such as mood stabilisers, are required it is advisable for this to be prescribed by a specialist (Allers, 2015:12). Medication that interferes with other aspects of the person's functioning, particularly with action that they engage in that they feel supports their recovery, is more likely to be stopped (Macdonald-Wilson, Deegan, Hutchison, Parrotta & Schuster, 2013:259).

Service users also need to understand the interaction of psychiatric drugs with any other medication (Liebenberg, 2015:7). Each person may react differently to medications, and any changes to medication use should be supervised by a medical professional. However, the medical approach does tend to ignore the potential impact of life events, which is one of its main criticisms (Leach, 2009:10).

2.6.2.2. Psychological treatment

Psychological treatment, as described by Dilts, Jr (2012:12) holds that “mental states of one kind influence later mental states”. There are many types of psychological treatment and therapies. Some therapies include psychodynamic therapy, cognitive/ behaviour therapy, and person-centred therapy (Coppock & Dunn, 2010:93; Korb, 2015:32). The term “therapy” covers a variety of different activities, but can be understood as the process of treating a disease or disorder (Coppock & Dunn, 2010:93). Some therapies can take place under little specialisation - usually in the form of “brief supportive discussions” - while the more formal practice is that of intensive intervention with a trained professional such as a psychologist or social worker (Coppock & Dunn, 2010:93). These interventions can take place over a time period of months to years, depending on the individual’s needs and goals for the intervention. Leichsenring and Rabung (2011:15) define short-term psychotherapy as “treatment of up to 25 sessions”. In service users with acute distress, recovery after short-term therapy is seen in approximately 70% of patients, but slightly less in those with chronic distress (Leichsenring & Rabung, 2011:15).

Although there is evidence that psychological treatment and therapies are effective, particularly for disorders such as anxiety and depression, there is debate regarding the extent of the treatment as alternatives to biological treatments (Coppock & Dunn, 2010:95). For this reason, most programmes will make use of both treatment options, along with social treatment, as the effective option (Allers, 2015:11; Korb, 2015:32; Patel et al., 2016:1676).

2.6.2.3. Social treatment

Social treatment options aim to address the illness as believed to be contributed to by dysfunctional personal interactions (Dilts, Jr, 2012:12). These social treatment options provide an additional manner of assessment and understanding of the person’s experience and context (Coppock & Dunn, 2010:96; Leach, 2009:11). They provide a professional response that is supportive of the person’s recovery, but also aims to actively address the social issues contributing to their distress, such as neighbourhood factors, social change and socio-economic factors (Coppock & Dunn, 2010:97; Patel et al., 2016:1673).

Over time, social factors may contribute to vulnerability to mental distress, particularly if in the presence of biological predisposition (Coppock & Dunn, 2010:96). This is the central belief of social treatment and intervention - that mental distress is possibly understood as “a meaningful response to problematic life experiences” (Coppock & Dunn, 2010:97).

2.6.2.4. Other treatments

While biological, psychological, and social treatments are found more frequently in formal practice settings, it is vital to also consider alternative treatments, particularly in the African context, as many service users will choose to pursue traditional or cultural assistance for issues. Many African service users, in particular, will see a traditional healer in conjunction with a more western approach to treating their issues (Chabalala, 2015:17; Fawn Jones, 2012:14). Chabalala (2015:17) notes that over 60% of African patients will also then seek the final assistance of a traditional healer after discharge from hospital.

Many traditional healers do not specialise in treating mental health disorders due to stigma, possible dangers, and competence, as well as other reasons (Chabalala, 2015:17). The method of treatment frequently results in reassurance that the person’s health can be restored (Chabalala, 2015:17). The core focus of the traditional African treatment approach is to try to understand the root cause of the illness (Chabalala, 2015:18).

Interventions of the above nature, particularly the biological, psychological, and social interventions, are recommended to be facilitated by a professional trained appropriately in such interventions. Professionals are an aspect of treatment that cannot be ignored in the recovery experience for this reason.

2.6.3. Professionals

The complexity of mental health care, as well as the unique needs and challenges of each service user, requires professional competence. Not only is cultural competence of paramount importance in practice, but expressions and language that are person-centred are also essential to providing care (Johnson, 2002:369-370). Professionals should be responsive to diversity between their clients and between the client and themselves, such as race, age, and gender, and the accompanying beliefs, values, and norms (Coppock & Dunn, 2010:95; Johnson, 2002:369).

The professional therapeutic relationship, regardless of the profession or intervention in question, is a central part of the recovery process (Leach, 2009:10). Coppock and Dunn (2010:95) note that there are times when these relationships are abused, and also when they are subject to bias and discrimination.

If treatment is to be effective for the person and family, it needs to be sustainable and be implemented in various aspects of one's life. It also needs to be based on unique needs and facilitated by someone who can promote recovery. When implementing programmes for recovery and the promotion of mental health, it is not only designated mental health services that are required, but a range of other services as well, such as legal services, financial services, and other health services (Johnson, 2002:372-373). When these proactive supports are in place, recovery becomes a much more attainable possibility for many (Johnson, 2002:374).

2.7. RECOVERY

Deegan (2009:58) defines recovery as “the real or lived experience of persons as they accept and overcome the challenge” of the issues that they face. This belief, and the goal of living productively and experiencing a high quality of life, regardless of issues, is the foundation of rehabilitation (Deegan, 2009:58; Johnson, 2002:373).

A variety of treatment options and programmes exist within the mental health services industry. Brodsky (2012:8) and Korb (2015:31) identify in-patient treatment (hospitalisation), partial hospitalisation programmes, intensive out-patient programmes and out-patient treatment, and residential or longer-term treatment programmes. These various options see the service user involved in therapeutic activities for varying periods of time, and also working with one or multiple professionals, depending on the options available. While the most suitable option would vary from person to person, in-patient treatment is often beneficial as it is the higher level of psychiatric care and provides a safe environment for recovery to begin (Brodsky, 2012:8; Korb, 2015:31; Tzoneva, 2014:47). In South Africa treatment is mainly in-patient or out-patient.

Research has found that treatment options that correspond with the normal lives of service users, and which include multiple practical aspects, are more highly valued than those that do not address their needs and priorities (Biringer, Davidson, Sundfør, Lier & Borg, 2016:23; Coppock & Dunn, 2010:17). Many individuals explain that they would prefer to not admit to receiving psychiatric treatment (Coppock & Dunn, 2010:10), which indicates that there is still a feeling of stigma attached to a mental illness, diagnosis, and recovery. The stigma can be either public stigma - society acting against those with mental illness as a result of belief of stereotypes - or self-stigma where the individual internalises the public stigma (Ben-Zeev et al., 2010:319). This can influence the recovery of a person negatively and may lead to readmission.

For recovery to be possible, participants need to take responsibility for their role in their recovery and actively engage in the process (Biringier et al., 2016:26; Deegan, 2009:58; Uys, 2010:52). Active engagement and shared decision-making also leads to more satisfaction with care and overall better health and functioning (Drake et al., 2010:7; Macdonald-Wilson et al., 2013:258). Achievable goals, such as measurable improvement in functioning, should be identified by the service user and the professional (Johnson, 2002:374), to ensure that there is active buy-in from the person and that the treatment plan is set up to assist in achieving these goals.

This is an ongoing and comprehensive process (Biringier et al., 2016:23) and service users must be willing to “try and fail, and try again” (Deegan, 2009:62). Due to the nature of the recovery process in mental health and the many factors contributing to ongoing recovery and relapse, many people do find themselves requiring a readmission to in-patient services.

2.8. READMISSION AND MENTAL HEALTH

Relapse and possible readmission in mental health is possible through a number of different factors and influences. These factors, as well as the prevalence of readmission in South Africa, assist in highlighting the severity of this phenomenon and also the importance of continued research in this field and will be discussed here.

2.8.1. Contributing factors

The AHRQ (2015:1) states clearly that “repeated hospitalisations on a psychiatric unit, affecting primarily the seriously mentally ill, are a substantial problem”. Readmission to a hospital is often seen to represent a negative clinical outcome for the service users (Heslin & Wiess, 2015:1; Rieke et al., 2015:1; Vigod et al., 2013:187). This is particularly true for early readmissions; that is, readmission within 30 days of discharge (Vigod et al., 2013:187). Readmissions are also costly to society as time and resources are needed to provide the necessary services (AHRQ, 2015:1; Mark et al., 2013:208).

A number of factors are thought to contribute to relapse and the subsequent readmission to in-patient mental health services. Kohn, Saxena, Levav and Saraceno (2004:859), Liebenberg (2015:7) and Vigod et al. (2013:192) emphasise that the side-effects of treatment and treatment that does not completely address symptoms (or are perceived to not be effective), increase the risk of relapse and readmission for these service users if unaddressed.

Other factors that may contribute to relapse and readmission include poor and limited access to adequate community-based aftercare and resources (AHRQ, 2014:1; Heslin & Weiss, 2015:1; Vigod et al., 2013:192), difficulties with caring for the self both physically and

emotionally (Heslin & Weiss, 2015:2; Vigod et al., 2013:192), as well as lack of or difficulty with adherence to prescribed psychiatric medication and treatment (Heslin & Weiss, 2015:2; Sajatovic, Velligan, Weiden, Valenstein & Ogedegbe, 2010:591; Vigod et al., 2013:192). Sajatovic et al. (2010:591) highlight that up to 60% of patients prescribed anti-depressants stop taking them within three months - which can lead to a decreased response to future interventions. Non-adherence to prescribed treatment is highest in those with schizophrenia (more than 60%), and up to 60% in bipolar patients too (Sajatovic et al. 2010:591). A diagnosis of either mood disorder, substance use disorder, or schizophrenia (Heslin & Weiss, 2015:2; Mark et al., 2013:219) is also found to increase the risk of relapse and readmission.

Readmission is thought to increase the risk of social stigma for the service user, as well as exclusion from society (Coppock & Dunn, 2010:12; Rieke et al., 2015:1). This stigma is not only from society, but is at times also seen from health care professionals (Coppock & Dunn, 2010:13-14). It can also be highly disruptive to the personal and professional lives of the person, as well as those of their families (Rieke et al., 2015:1). Heslin and Weiss (2015:2) explain that the readmission from mood disorders and schizophrenia is representative of the “chronic, relapsing course of these conditions”. Similarly, Rieke et al. (2015:1) note how the psychiatric population is susceptible to the “revolving door phenomenon of readmission to inpatient and residential settings”, a phenomenon that the DoH (2013:16) suggests is due to insufficient community-based services, despite rapid deinstitutionalisation.

Mark et al. (2013:209) found that readmission risk could possibly be reduced through mental health visits within a specific time period after the service user has been discharged – this time period is usually 30 days. However, Puntis (2016:1639) is of the view that more frequent face-to-face contacts increase the possibility of readmission, with 60-day gaps being the recommended length of time between follow-ups. The AHRQ (2014:1) also mention the possibility of day programmes, hospitals, crisis intervention units, supported housing options, and community-based treatment services, as options for preventing readmission by providing support for psychiatric crises as they arise. A multi-dimensional approach to treatment - that is, seeing different professions for intervention - can increase the time before a readmission (Puntis, 2016:1639).

2.8.2. Prevalence of mental health issues and readmission

The number of adults experiencing mental illness and issues related to mental health has risen (Fawcett et al., 2012:89). Coppock and Dunn (2010:10) note that one in every six individuals may experience a mental health issue during the course of their life. In the United States in 2012, Heslin and Weiss (2015:1) estimated this statistic to be even higher, with one in four adults experiencing either a mental or substance use disorder. Linked with this, the

hospitalisation rate for mental disorders was also seen to increase faster than any other type of hospitalisation (Heslin & Weiss, 2015:1). An Australian study found that women are almost 1.5 times more likely than men to make use of mental health services (Fawcett et al., 2012:90).

Thirty percent of South Africans experience a mental illness or disorder in their lifetime (Herman, Stein, Seedat, Heeringa, Moomal & Williams, 2009:339). Anxiety disorders, substance use disorders, and mood disorders are found to have the highest prevalence of lifetime disorders. Herman et al. (2009:343) note that South Africa has a “relatively high 12-month prevalence of anxiety and mood disorders” when compared with a number of other countries. Specifically, in South Africa, 4.60% of the population is seen to have a depressive disorder and 3.40% has an anxiety disorder (WHO, 2017:17).

The African region experiences more cases of depressive disorder, with a percentage prevalence that is higher than that of the world average (WHO, 2017:9). Worldwide, females experience the highest levels of depressive disorder between the ages of 60-64 years, while the males' highest level is between the ages of 55-79 years (WHO, 2017:9). Throughout the African region, there are 29.19 million cases of depressive disorder recorded (WHO, 2017:8). The WHO (2017:5) describes that “the number of persons with common mental disorders globally is going up, particularly in lower-income countries”, but this is largely due to the population growing and the age of the population increasing (Patel et al., 2016:1673; WHO, 2017:5). In other words, more people are now living to the age where depression and anxiety is most common. The number of anxiety disorder cases is slightly less, with 25.91 million reported in the African region. Compared to the world, the prevalence amongst males is similar to worldwide averages, while females are experiencing less prevalence (WHO, 2017:10-11). Globally, the burden of mental health and substance use disorders, along with neurological disorders, has increased by 41% between 1990 and 2010 (Patel et al., 2016:1673).

Some studies estimate that between 40% and 50% of psychiatric in-patients will be readmitted to a facility within one year of being discharged (AHRQ, 2014:1; Rieke et al., 2015:1). Readmission data from high-income countries shows that up to 13% of psychiatric service users are readmitted shortly after discharge (Vigod et al., 2013:187). Boerema et al. (2016:1496) note that up to a quarter of patients in the Netherlands receive treatment a second time and 16% are readmitted more than three times. Service users with mood disorders as the primary diagnosis are up to 50% more likely than others to return for admission for the same principal diagnosis (Heslin & Weiss, 2015:4). This readmission rate becomes even higher when mood disorders as a secondary diagnosis are also included (Heslin & Weiss, 2015:4). Some of the most prevalent comorbid disorders in those readmitted to hospitals are

mood disorders, schizophrenia, and alcohol-related and substance-related disorders, as found in a study done in the United States of America (Heslin & Weiss, 2015:5).

These mental disorders, as well as the contributors to recovery, or relapse and readmission, are influenced by multiple factors, both internal and external for an individual and those affected. A number of theories and models aim to explain mental illness: the bio-psychosocial model is one of those.

2.9. SUMMARY

Mental health care in South Africa and the world has changed throughout history. With the development of medication, discharge from permanent hospital treatment became possible. Social and therapeutic environments became a focus of treatment and care and the treatment approach became more holistic. Experiences of mental health and mental illness are unique and vary between individuals. Despite mental health issues being a common experience, stigma is still experienced by many.

Mental health and mental health care in South Africa is governed by the *Mental Health Care Act 17 of 2002*, the *WHO Mental Health Action Plan 2013-2020*, and the *National Mental Health Policy Framework and Strategic Plan 2013-2020*. The focus of the legislation and the plans is monitoring services and protecting service user rights; the stated aim of empowering local communities; promotion and prevention strategies; and ensuring evidence-based planning and provision of mental health services. The policies and treatment seek to address the wide impact of mental illness, including relationship difficulties, work challenges, and personal challenges.

Despite psychiatric disorders being ranked as the third highest contributor to disease in South Africa, less than 25% will get help for their mental illness. For those that do seek help, diagnosis and treatment is the often-followed course. Using policies and activities that recognise and empower people, allows for treatment that is more person-centred. As each person's recovery journey is unique, a number of factors need to be taken into consideration when developing a treatment plan, including biological and medical treatment options, psychological approaches, and social and other treatments. The biopsychosocial model was suggested by Engel in 1977, as a way of understanding whether a person is ill and why, but also how their health can be restored and maintained. It is used as the theoretical framework for this research.

A number of different aspects contribute to possible relapse and readmission to in-patient mental health services, including side effects of medication and ineffective treatment plans.

Between 40% and 50% of psychiatric in-patients could be readmitted within one year of being discharged.

The next chapter explores the research methodology used in the study, and describes the findings of the research and the interpretation thereof.

CHAPTER THREE

RESEARCH METHODOLOGY AND EMPIRICAL FINDINGS

3.1. INTRODUCTION

The goal of this research was exploring and understanding the experiences of readmitted mental health service users at a private in-patient treatment centre in Gauteng. The objectives focussed on in this chapter include:

- To explore and describe the possible effects of readmission on mental health care users.
- To explore and describe the perceptions of readmission by mental health care service users.
- To explore and describe possible factors that contribute to readmission of mental health care service users.

This research study was based on the research question: What are the experiences of mental health care service users with regard to readmission to a private in-patient treatment facility in Gauteng? This chapter outlines the research methodology, focussing on the research approach, the type of research and the research design. The research methods, including population and sampling, data collection and analysis methods, data quality and the pilot study are discussed, followed by the ethical considerations taken into account during the research. The findings of the study are then discussed in the form of a thematic analysis, with quotes from the interview and literature substantiation.

3.2. RESEARCH APPROACH

The research approach that was most appropriate for this study was the qualitative research approach. It is used with research that focuses on the meaning, experience, and perceptions that participants have about a particular phenomenon, rather than the meaning that the researcher or other writers bring to the research (Creswell, 2013:47; Fouché & Delpont, 2011:65). These perspectives are not singular and can provide a diverse view on the topic at hand (Creswell, 2013:47). It is for this reason that themes developed from the data should “reflect multiple perspectives of the participants in the study” (Creswell, 2013:47).

Drisko (2013a:3) explains that qualitative research is widely accepted as a valuable approach to research within the field of social work and related disciplines. As this type of research is useful to try to understand phenomena from the perspective of the participant, it often allows the researcher the opportunity to gain a more detailed understanding of a complex issue or situation (Creswell, 2013:48; Fouché & Delpont, 2011:64). The phenomena in the research study was understood and described from this qualitative perspective (Fouché & Delpont,

2011:64). One of the key characteristics of qualitative research is that “participants’ natural language is used in order to come to a genuine understanding of their world” (Fouché & Delport, 2011:66). The understanding of the participants’ world that the research tried to reach was the participants’ experience of readmission.

Therefore, the qualitative research approach allowed for the experiences of the mental health care users to be explored by the researcher, while being explained and presented as naturally as possible by the participants. These experiences were shared from their own perspective and provided an accurate description of their experiences, including all the aspects of their readmission.

3.3. TYPE OF RESEARCH

During this study, applied research was conducted. Applied research is useful when looking to solve problems in practice (De Vos & Strydom, 2011:42). In this case, the problem was the lack of understanding about the experiences of readmitted service users and the role of mental health services in preventing readmission. Applied research was also valuable for the “scientific planning of induced change in a troublesome situation” (Fouché & De Vos, 2011:94). This understanding is important for the improvement and development of relapse-prevention and readmission-prevention programmes offered by the mental health services, which could be done if the role of the services and experiences of those who have been readmitted were known.

Thus, an exploratory research purpose provided the researcher with the opportunity to collect data and develop a deeper understanding of a concept that had not been explored previously (Fouché & De Vos, 2011:95; Rubin & Babbie, 2010:41), as the experiences of readmitted service users to in-patient treatment were not yet known.

A descriptive research purpose was also relevant, as this allowed for the “intensive examination of phenomena” and the accurate and specific details of such phenomena (Fouché & De Vos, 2011:96). Once explored, the readmission experiences of the mental health service users were described as outlined in the objectives for the study.

3.4. RESEARCH DESIGN

The research design that was utilised in this study was the phenomenological research design. Phenomenology attempts to explain the development and meaning of lived experience surrounding a particular phenomenon (Fouché & Schurink, 2011:316; Simon & Goes, 2011:1). In this study, the life experiences were the readmission experiences of the mental health service users. In phenomenology, it is important for the researcher to describe the

phenomenon accurately as experienced by the participants (Fouché & Schurink, 2011:316; Simon & Goes, 2011:1).

Readmission experiences were the daily experiences of the participants and were what they had experienced in their lives from previous admissions to the current admission. For this reason, the participants described their experiences as they were lived, and had the opportunity to include any details they found relevant, when sharing their story. This then allowed for an accurate description of the experience.

3.5. RESEARCH METHODS

In order to conduct qualitative research, there are specific research methods that need to be followed. A study population needs to be identified and the specific participants selected. The data needs to be collected and analysed, and a pilot study conducted, in order to test whether or not the methods of data collection and the research methods are appropriate. Trustworthiness also needs to be ensured.

3.5.1. Study population and sampling

The population that was focused on for this study was mental health service users who had previously made use of such services and had been readmitted after discharge from previous treatment in an in-patient facility.

As it was not possible to have a list of all readmitted service users in the Gauteng area, non-probability sampling was most appropriate, as the exact size of the population was not known and “the odds of selecting a particular individual are not known” (Greeff, 2011:391). Specifically, this research made use of purposive sampling, which entailed the selection of specific cases that were relevant to the study (Greeff, 2011:392).

The first ten individuals who met the following criteria were recruited and became the research participants. These were individuals who:

- were receiving in-patient mental health services and treatment at a private in-patient treatment facility in Gauteng;
- had been readmitted for in-patient mental health services;
- had their last in-patient treatment less than one year before readmission;
- were above the age of 18 years;
- had the mental capacity to participate in the research study;
- were not, or had not previously been, on the researcher’s case load
- were conversant in English.

To identify potential participants, the researcher introduced the research to all potential participants via the admissions team at the facility. If a patient was interested in participating, they provided their details to the team. The researcher followed-up to confirm that the patient met the criteria and to explain the study. The researcher then selected individuals who had been for in-patient treatment and received mental health services prior to their current admission at the treatment facility. However, the participant did not have to have received the prior treatment at the specific treatment facility. The researcher explained the letter of informed consent individually to each participant, in order to obtain their informed consent for participation. The researcher obtained permission to conduct the study from the management of the specific treatment facility group. The letter of permission is attached as Appendix B.

3.5.2. Data collection

For this study, the data collection method that was most appropriate was one-on-one interviews. The purpose of interviewing is for the researcher to “obtain information through direct interchange with an individual or a group that is known or expected to possess the knowledge they seek” (Greeff, 2011:342). Interviewing is particularly beneficial when the researcher wishes to learn another person’s story or experience from their point of view (Greeff, 2011:342; Postmus, 2013:241).

Researchers are warned of some challenges that may be encountered when conducting interviews in qualitative research. For example, it can be difficult for the researcher to establish rapport with the participants. It can also be difficult for the researcher to record and manage the data from the interviews, as even short interviews may yield a high quantity of data (Greeff, 2011:343). The researcher addressed these challenges by having an introductory session with each participant before beginning the interview. The interviews took place in a private consultation room at the treatment facility. The researcher recorded the interview with the permission of the participants and filed the recordings of the interviews along with the notes and transcripts from the interview session, in order to manage the data in an organised manner.

Fouché and Schurink (2011:317) explain that “naturalistic methods” are best suited for phenomenological research and that reconstructing methods of data collection, such as interviews, do not play an important role. However, many other authors discuss the use of interviews in phenomenological research – usually in-depth interviews. Creswell (2013:81) considers the work of Moustaka and explains that phenomenological interviews usually make use of two broad questions, but that other open-ended questions can also be asked. The questions need to be general to allow the participant to provide a description of their experience of the phenomenon. The two questions that are usually asked are “what have you

experienced in terms of your readmission as a mental health service user in a treatment facility?” and “what contexts or situations have typically influenced or affected your experiences of your readmission as a mental health service user in a treatment facility?” (Creswell, 2013:81). In this study, the researcher made use of a variation on these two broad open-ended questions when interviewing the participants to create one broad open-ended primary question, but also included other open-ended questions to ensure that the necessary topics were addressed. Creswell (2013:82) explains that single or multiple interviews can be used in phenomenology, but that the data must be collected from individuals who have experienced the phenomenon that is being studied.

With consideration of the above, semi-structured one-on-one interviews were used for this study. Semi-structured interviews are interviews that are “organised around areas of particular interest, while still allowing considerable flexibility in scope and depth” (Greeff, 2011:348). Postmus (2013:255) explains that a semi-structured or guided interview makes use of some predetermined questions that prompt the exploration of certain topics. The use of this type of interview allows the data to be compared, as the participants have all been asked the same questions in the interview (Greeff, 2011:348). The semi-structured one-on-one interview allows for greater flexibility in the information collection process, as it is possible for participants to give their own meanings to the questions posed, and therefore their own reason for their answers (Greeff, 2011:351). This ensured that the experiences and various aspects were explored as fully as possible, but still allowed the participants freedom to include that which they found important and relevant. These interviews took place in a private office, and were recorded and then transcribed by the researcher in a private office.

A semi-structured interview schedule was used, which consisted of one broad open-ended question with additional predetermined open-ended questions to ensure that the interview covered the topics that needed to be explored (Greeff, 2011:352). The primary question asked was: “Tell me about your experience of being a readmitted service user in a private inpatient treatment facility?” with the secondary questions being:

- Tell me about your previous admission?
- What happened between that discharge, and your current admission?
- What do you think contributed to your readmission?
- How do you think your readmission could have been prevented or the time before it extended?
- What are your views on, and feelings about, readmission in mental health?
- Would you make any recommendations for other patients to prevent readmission?

- How do you think that mental health services/private inpatient treatment facilities can help to prevent readmission?
- What recommendations would you make for such services based on your experiences?

The interview schedule is attached as Appendix D.

3.5.3. Data analysis

When analysing the data that have been collected, the researcher will “identify the different topics or themes and code those encountered by means of a line-by-line analysis of each interview transcription” (Schurink, Fouché & De Vos, 2011:402).

While there is a process for qualitative data analysis outlined by many authors, the process of thematic analysis was used to analyse the interviews for this study. In order to analyse the data that is collected and identify themes and sub-themes accurately, the researcher questioned the responses in the interviews in a critical manner (Braun & Clarke, 2013:205). The thematic analysis process that was utilised in this study was the process proposed by Braun and Clarke (2013:202), namely: transcription, reading and familiarisation, coding, searching for themes, reviewing themes, defining and naming themes, and writing the research report. Thematic analysis was appropriate for the interpretation of interview responses, as it assisted the researcher in discussing the responses in more detail and identifying similarities and differences in the participants’ responses (Creswell, 2013:75).

The first step in the process of thematic analysis is transcription. Transcription is the translation of spoken language into written language in a clear and consistent manner (Braun & Clarke, 2013:162). The written language transcription clearly identifies who is speaking and what is said, as well as the inclusion of non-semantic sounds that may be made by those involved (Braun & Clarke, 2013:163). It is essential for the transcription method to be “thorough and meticulous” (Braun & Clarke, 2013:162).

The researcher read the data and became familiar with it. During this, the researcher began to notice the information that was relevant to the study (Braun & Clarke, 2013:204). The researcher recorded this information but also focused on critically analysing and understanding what the data means (Braun & Clarke, 2013:205). In this study, the latent meaning of the interview responses was explored. The latent meaning was identified through the application of the theoretical frameworks by the researcher to the responses and the interpretation of what the participants said (Berg & Lune, 2012:355; Braun & Clarke, 2013:207; Joffe & Yardley, 2004:57).

Once the researcher was familiar with the data, it had to be coded. In thematic analysis, a complete coding process is used (Braun & Clarke, 2013:202). When coding, all the information that was identified as relevant or important for the research is noted (Braun & Clarke, 2013:206, 210). The features of all the relevant data were labelled as precisely as possible. This can be done in many different ways, as it may be possible to classify one statement made by a participant under more than one of the identified themes (Braun & Clarke, 2013:207, 210). The actual coding of information can be coded electronically through comments on a document, keeping cards with the relevant text under the code or marking the codes on the "hard-copy data" (Braun & Clarke, 2013:210). In this study, manual coding will be done through notes made on the interview transcripts (Braun & Clarke, 2006:89). The process of coding and identifying patterns is essential to build a credible analysis and conclusion of the study (Drisko, 2013a:19).

Searching for themes follows the coding of the data. In this stage of the thematic analysis process the researcher actively identified common patterns found throughout the information (Braun & Clarke, 2013:223,225). The themes were made up of a combination of codes that related to each other, thus providing a broader organisation of the concepts (Braun & Clarke, 2013:224). The identified themes needed to be independent of each other, but still form part of one final analysis. This means that although the themes might be different, they still lead the researcher to draw relevant conclusions (Braun & Clarke, 2013:231).

Once the possible themes had been identified, they were reviewed. This reviewing process ensured that the identified themes were reflective of the information that was gathered (Braun & Clarke, 2013: 233). This was also an opportunity for the researcher to add any themes that may have been missed, or reject those that were not suitable (Braun & Clarke, 2013:234). When the themes had been finalised, they were named and defined in a "catchy, concise and informative" way (Braun & Clarke, 2013:258).

Finally, the analysis could be developed. The themes were written in such a way that they described the relevant information (Braun & Clarke, 2013:249). The information that was used in the final analysis represented the views of all of the participants (Braun & Clarke, 2013:252). At this point, the researcher had a number of themes highlighting and describing the experiences of readmitted service users. Throughout the writing of the analysis, it was possible to add or remove themes and sub-themes as necessary, as the reviewing process continued throughout the analysis (Braun & Clarke, 2013:254). Once the themes and corresponding information were complete, relevant literature was also included to interpret the findings from a biopsychosocial theoretical framework (Braun & Clarke, 2013:257).

There are a number of criteria and techniques that can be applied to qualitative research to ensure that it is of an appropriate standard, e.g. trustworthiness to ensure the quality of data. This will be discussed next.

3.5.4. Quality of data

Trustworthiness ensures the quality of the data and is valuable in qualitative research, as it demonstrates how well the researcher understands and represents the information compared to how it was presented by the participant (Lietz, Langer & Furman, 2006:444).

An element of qualitative research that has long been debated among critics is trustworthiness; as a result, a number of frameworks exist to ensure the soundness and quality of such research (Shenton, 2004:63; Trochim, 2006). One of the better known constructs is the seminal work of Lincoln and Guba (1985); their book, *Naturalistic Inquiry*, suggests credibility, transferability, dependability, and confirmability as the criteria for pursuing a trustworthy qualitative study – in contrast to the validity and reliability of quantitative studies (Shenton, 2004:63).

Credibility is, arguably, one of the most important factors for ensuring trustworthiness. It asks how similar the findings of the study are when compared to reality (Shenton, 2004:64). As the research explores the experience of the participants, the participants need to identify with the research and find it to be believable from their perspective, if the results are to be credible. Trochim (2006) explains that credibility can, therefore, only be accurately judged by the participants. A strategy that was used to ensure credibility was member checking, where the researcher presented the research interpretation or findings to the participants of the research (Lietz et al., 2006:453; Rubin & Babbie, 2013:282). This strategy assisted in ensuring that the participants' perceptions were accurately represented and therefore served to verify the interpretations made by the researcher (Rubin & Babbie, 2013:282). The participants also had an opportunity to correct any misrepresentations or clarify any information that may have been confusing (Lietz et al., 2006:453). Once the participant had completed their interview, the researcher verified the accuracy of the data interpretation with the participant during the debriefing. This was done immediately, as the service users reported differing treatment time spans and time spent in the facility.

Transferability questions whether the findings of the research are able to be transferred or generalised and applied to other contexts and settings (Shenton, 2004:69; Trochim, 2006). To ensure transferability, it was necessary for the researcher to explain the context of the study in detail, and to describe any assumptions that were central to the study (Trochim, 2006). Transferability is judged by how possible it is for another researcher to conduct the study

again. Record keeping is essential for this, and the researcher filed the audio recordings, transcripts, field notes taken after the interview and notes of any actions taken during the research process, in an organised manner, so that they may be accessed or used again for reference.

Dependability is the third criterion. It means that the researcher reports the processes that took place during the study in detail, to allow the study to be repeated, and to explain any changes that took place in the study context and the impact these may have had on the research (Shenton, 2004:71; Trochim, 2006).

Making use of an audit trail is one strategy to assist with dependability. An audit trail consists of the documentation relating to the study that is kept as a permanent record of the steps that the researcher took to conduct the research study (Drisko, 2013a:19; Lietz et al., 2006:449). This can include “all data, research notes, memos, and journals”, and is done for the purpose of allowing another researcher to examine the analysis done in the study (Drisko, 2013a:19). The use of an audit trail also allows the researcher to consistently follow their research procedures (Lietz et al., 2006:450). The researcher safely filed the audio recordings, transcripts, field notes and other relevant notes taken during the research process for the purposes of an audit trail.

Confirmability seeks to ensure that the findings and results are not due to the researcher’s preference, but are the result of participants’ thoughts, ideas, and experiences, and that these are accurately reflected (Shenton, 2004:72). Peer debriefing, the final strategy used for ensuring trustworthiness in this study, is where the researcher consulted with other professionals who are knowledgeable in the field being researched or in the research process being conducted (Lietz et al., 2006:451). This allowed an opportunity to minimise any discrepancies or bias possibly presented by the researcher (Lietz et al., 2006:451). In order to make use of peer debriefing, the researcher consulted with the research supervisor, as well as those working at the treatment facility, about the research methods, the findings and data interpretation. In this research, the researcher also identified one person who has experience in research and knowledge about readmission, who acted as a peer debriefer throughout the research process.

In addition, the researcher also avoided researcher bias, as she does not work at the in-patient treatment facility, and included a selection criterion that ensured that the participants were not part of the researcher’s caseload at any point. This prevented the researcher from being familiar with any of the aspects of the participants’ experiences.

Before the data could be collected and analysed, the researcher ensured that the planned methods and procedures for the research were effective – this was done by conducting a pilot study.

3.6. PILOT STUDY

A pilot study was conducted with one mental health care user, at a different private in-patient treatment facility within the hospital group, to ensure acceptability of the data collection methods. This pilot study was done prior to conducting the main research, and the response was included in the results. The use of a pilot study provided the researcher with an opportunity to identify challenges that may have arisen from the data collection methods, such as the interview schedule and voice recorder, during the main research and to address them before the main study was conducted (Fouché & Delport, 2011:73).

The pilot study tested the interview schedule with one user, as well as the recording device, type of venue and duration of the interview, where the participant was part of an interview and had the opportunity to give feedback. The necessary adjustments were then made.

3.7. ETHICAL CONSIDERATIONS

Ethical considerations are the factors that need to be considered when conducting research. These factors mostly concern the conduct of the researcher during the research study (Edwards & Mauthner, 2012:14). Some of the key ethical considerations of this study were avoidance of harm, voluntary participation and informed consent, confidentiality, debriefing of participants, publication of the findings and actions and competence of the researcher.

3.7.1. Avoidance of harm

As this study used human participants, the first ethical consideration was avoidance of harm – that is, protecting the participants from any physical or emotional harm wherever possible (Berg & Lune, 2012:61; Strydom, 2011:115). This involved informing the participants of any harm that they may have experienced before the study begins, as well as eliminating and/or reducing the potential harm (Strydom, 2011:115). The researcher should “protect participants within all possible reasonable limits from any form of physical discomfort that may emerge from the research project” (Strydom, 2011:115).

Discussing a sensitive topic such as relapse and readmission with the participants/ mental health service users, could be an emotional situation for participants, and the researcher needed to be aware of this and put measures in place to avoid harm where possible. To minimise harm, the researcher explained what the interviews would cover in the debriefing session, so that the participants were prepared for what would be discussed. Following the

interviews, the participants would have been referred to the therapeutic team at the treatment facility if they required counselling or further assistance, however this was not necessary.

3.7.2. Voluntary participation and informed consent

Voluntary participation means that the participants take part in the study by choice and are not forced to participate in any way (Strydom, 2011:116). This was clearly communicated during the process of obtaining informed consent. Informed consent requires that the participant is aware of “all possible or adequate information on the goal of the investigation; the expected duration of the participant’s involvement; the procedures which will be followed during the investigation; the possible advantages, disadvantages and dangers to which respondents may be exposed; as well as the credibility of the researcher, to be rendered to potential subjects or their legal representatives” (Strydom, 2011:117). Creswell (2013:57) explains the importance of disclosure of the purpose of the study to the potential participants. Informed consent issues are particularly relevant for social workers and it is important that the participants are informed that they will not be placed in a situation with unnecessary risk (Creswell, 2013:57; Reamer, 2013:41).

This informed consent should preferably be in written form, and needs to be given by a participant who is considered to be legally and psychologically competent to give the consent (Berg & Lune, 2012:90; Strydom, 2011:117). The way in which the researcher obtains consent from the participants must be ethical (Reamer, 2013:41). The participant should be aware that they can choose to withdraw from the study at any time with no consequence for them (Strydom, 2011:117). In this study, the participants were given a letter of informed consent that they read and signed if they voluntarily decided to participate in the study (Appendix C). The letter of informed consent explained the research study and its purpose, as well as any risks, benefits and other important information for the participant to be aware of before the study began. It also gave permission for the interview to be audio recorded, and for the data to be stored securely by the University for a period of 15 years.

3.7.3. Confidentiality

Confidentiality involves “the handling of information in a confidential manner” (Strydom, 2011:119). This means that only the researcher, the research supervisor, and the admissions team who refer the patient for the study, are aware of the identity of the participants and their willingness to participate (Strydom, 2011:119). The participants have a right to confidentiality as they are trusting the researcher with private information (Reamer, 2013:47). Confidentiality was ensured, but not anonymity, as the researcher conducted one-on-one interviews with the participants and was therefore aware of their identities (Berg & Lune, 2012:93). In order to

ensure confidentiality and to protect their identity, the researcher did not use the participants' real names in the report, but instead used a numbering system for each participant. This ensured that no data could be linked to a specific participant. The interview was also conducted in a private consultation room, to ensure there were no interruptions and that the interview was not overheard by anyone.

3.7.4. Debriefing of participants

Following the study, the participants should get the opportunity to ask questions and have any misconceptions that may be present addressed (Strydom, 2011:122). Debriefing participants is a useful learning experience that can be used to minimise any possible harm to the participants during the study, despite the precautions (Strydom, 2011:122). In the debriefing session, participants could share their feelings about the study and their experience of it, as well as its aftermath (Strydom, 2011:122). Debriefing of the participants was done by the researcher immediately after the interview session with each participant, and the researcher also checked that the information the participant relayed during the interview was understood correctly by the researcher.

3.7.5. Publication of findings

The results of the study are published in a report that is clear and contains all the necessary information (Strydom, 2011:126). Making the participants aware of the possibility of the publication of the findings was another ethical aspect that needed to be considered by the researcher. Through the publication of the findings, the researcher had the opportunity to recognise the input of the participants and maintain a positive relationship with the community that was involved (Strydom, 2011:126). The results were presented in an accurate, objective and non-biased manner (Reamer, 2013:51). The researcher ensured that the participants were aware of the possibility of the publication of the research findings by explaining this in the letter of informed consent.

3.7.6. Actions and competence of researcher

In research, it is important that the researcher is "competent, honest and adequately skilled" (Strydom, 2011:123). This is seen in the way in which the researcher presents themselves to the participants and those involved in the research, as well as in the ethical considerations that the researcher considers when planning and conducting the study (Strydom, 2011:123). In this study, the researcher's actions upheld the expected ethical standards through the application of all the above permissions and ethical considerations and through presenting herself in a professional manner at all times. Plagiarism is also an important aspect of this ethical consideration (Strydom, 2011:123); therefore, the researcher ensured that all

submitted work was her own and that the work of other authors was referenced where used. The researcher has conducted research for the BSW degree and successfully completed the Research Methodology module MWT 864, in order to be competent to conduct this study. Additionally, she was supervised throughout the study.

The research findings of this study will be discussed next.

3.8. RESEARCH FINDINGS

The research findings will be discussed in two sections, namely, the biographic profile of participants and the thematic analysis, using themes generated from the data, verbatim quotes from the interviews and literature substantiation.

3.8.1. Biographic profile of participants

Table 3.1 below provides the biographic information of the participants.

Table 3.1: Biographic information of participants

Participant	Gender	Age	Home language	Racial group
1	Female	51	English	White
2	Female	29	English	White
3	Male	24	Afrikaans	White
4	Male	50	Afrikaans	White
5	Female	32	Tswana	Black
6	Male	47	Zulu	Black
7	Female	36	Sepedi	Black
8	Female	21	Tswana	Black
9	Female	28	Sepedi	Black
10	Male	50	Tswana	Black

Table 3.1 shows that six of the participants were female and four were male. There was a wide age span, with the youngest being 21, and the oldest being 51. Many different home languages were included, i.e. Afrikaans, English, Sepedi, Tswana, and Zulu.

Table 3.2 below provides details regarding previous admissions and the diagnosis of the participants.

Table 3.2: Previous admissions and diagnoses of participants

Participant	Previous admissions	Reason for admissions(s)/ diagnosis	Funding
1	6	Depression, bipolar mood disorder, sedative use	Medical aid
2	8	Depression, bipolar mood disorder	Medical aid
3	2	Depression, substance use	Medical aid
4	3	PTSD, depression	Medical aid
5	1	Depression, substance use	Medical aid
6	2	PTSD	Medical aid
7	2	PTSD	Medical aid
8	1	Depression	Medical aid
9	5+	Bipolar mood disorder	Medical aid
10	1	PTSD	Medical aid

Table 3.2 indicates that 70% of the participants had been admitted one to three times prior to the current admission. Three participants had been admitted more than five times – one confirmed eight previous admissions, another six, but the third was not sure of the exact number of previous admissions. The participants were asked their diagnosis and/or the reason for admission. This was done because some patients did not agree with their doctor’s diagnosis, and others have had many different diagnoses over time. The most common reasons for admission were depression, post-traumatic stress disorder (PTSD) and bipolar mood disorder. Four participants acknowledged substance use of either alcohol or drugs – illegal or prescription – as contributing to their reason for admission. All participants were part of a medical scheme that covered their hospitalisation costs for the current admission. Participant 9 was the only participant who had previously been admitted to a state hospital.

3.8.2. Thematic analysis

This next section focuses on the thematic analysis of the experiences of the readmitted mental health service users in a private in-patient treatment facility in Gauteng. The themes and sub-themes that were identified from the interviews with the participants, cover personal experiences, physical issues, social support, as well the need for assistance from professionals. Areas in which programmes could be modified to assist with ongoing recovery and extending the time between readmissions, were also identified. Verbatim quotes were used to support the themes, as well as for purposes of literature substantiation. Many of the sub-themes identified are at opposite ends of the continuum – those that help with recovery and those that hinder it and could lead to earlier readmission.

Table 3.3 provides a list of the themes and sub-themes generated from the data.

Table 3.3: Themes and sub-themes

Theme	Sub-theme
1. Experienced events as setbacks	1.1. Trauma 1.2. Emotional triggers 1.3. Health issues
2. Psychiatric medication	2.1. Taking as prescribed or defaulting 2.2. Lack of effect of medication
3. Support/ lack of support	3.1. Professional support and support groups 3.2. Family, friends, and the workplace 3.3. Religion and spirituality
4. Commitment to recovery	4.1. Taking responsibility vs lack of responsibility 4.2. Active recovery or passive recovery
5. Use of time	5.1. Keeping busy 5.2. Service and helping others
6. Feelings about readmission	6.1. Negative emotion 6.2. Relapse is a normal part of recovery
7. How programmes and facilities can assist	7.1. Therapy options 7.2. Practical measures 7.3. Post-discharge

Table 3.3 outlines the themes and sub-themes that were identified in the interviews. The above themes will be discussed and supported by the participant's views, as well as relevant literature control for the themes and sub-themes.

3.8.2.1. Theme 1: Experienced events as setbacks

As mental health is part of everyday life, people will experience multiple challenges, triumphs, and events throughout their illness, recovery, and potential relapse. These experiences can have an impact on the person's physical, emotional and psychological well-being, depending on how they take place and how they are managed. The Canadian Mental Health Association (2011:2) explains that an unpleasant or stressful event can be a significant trigger for mental health relapse. These events can be the experienced after of a trauma or the time afterwards, an unpleasant or stressful situation, or an additional issue with physical health.

Sub-theme 1.1: Trauma

The *Diagnostic and Statistical Manual (DSM-5)* (American Psychiatric Association [APA], 2013:271) defines a traumatic event as "exposure to actual or threatened death, serious injury, or sexual violence" either through experiencing it directly, witnessing it happen to others or learning that it happened to a close family member or friend, or repeated or extreme exposure

to aversive details of the traumatic event – this is particularly relevant for those in the police service and first responders. The DSM-5 also notes that psychological distress following an individual's exposure to a stressful or traumatic event can vary significantly (APA, 2013:265). Many of the participants experienced traumatic events, which they felt contributed directly to their need for readmission to an in-patient treatment facility.

Participant 4, Participant 6, Participant 7, and Participant 10 experienced trauma at their place of work.

Participant 6 explained that he was: *"tortured by [my own] colleagues for almost two hours"* and that the experience *"traumatised me a lot, I think"*. He also stated that *"these things keep on coming to my mind. It's hard. It's very hard"*.

Participant 4 experienced trauma at work, and after trying to move divisions found himself being re-traumatised by *"the photos and stuff that you are still working with in the files... lead to the same triggers"*. This re-traumatisation was also a factor for Participant 10.

Participant 7 shared her experience as follows: *"Now its PTSD, trauma, an incident happened at work."* This was the event experienced that led to her being admitted for a second time. Her first admission was a result of the loss of her sister through illness.

Loss of a loved one was also a trigger for Participant 2, who said: *"... mother-in-law passed away from cancer. That was a trigger"*.

The effect of potential loss is also real – in Participant 8's case, this was the attempted suicide of her partner.

The South African Depression and Anxiety Group [SADAG] (2010) presents statistics that up to six million South Africans could suffer from posttraumatic stress disorder. With a 73.8% prevalence in South Africa of exposure to at least one potentially traumatic event (Atwoli, Stein, Williams, Mclaughlin, Petukhova, Kessler & Koenan, 2013:182), trauma is a real threat to continued mental health and recovery.

All of these losses, the exposure to violence, and the traumatic events at the workplace, contributed to the participants' need to seek further psychiatric assistance. For some, this trauma was the tipping point and the reason they were readmitted; for others, it was one of many issues experienced in the time between their admissions.

Sub-theme 1.2: Emotional triggers

Reynolds (2015) describes an emotional trigger as "something occurs, you react, and then your brain instantly concocts a reason for your reaction that seems to justify your behaviour even if the reason makes no sense". Most of the literature on relapses and emotional triggers

focus on addictions, but the theories can also be applied to mental health in many cases. During their recovery, emotional triggers and challenges were experienced by many of the participants. Some related to family issues, stress, work issues and personal issues, and some even led to violence.

When it is perceived that someone plans to take, or has taken away, something that is important to the person and a pillar of strength for them, emotions will be triggered (Reynolds, 2015). Sometimes, when there is an emotional trigger or response leading to dysregulated emotions, it can lead to acts of violence or harm towards self or others (Newhill & Mulvey, 2002:166). This is reactive violence that is described as “incidents precipitated by emotional reactions to perceived threat” (Newhill & Mulvey, 2002:162).

This was the case for Participant 2, who identified many emotional triggers for herself, stating: *“I’ve got these heavy triggers. My kids are my life, so you mess with one of them and my mind just goes”*. In her previous admission, these dysregulated emotions and the triggers, led her to stab her father because he harmed her mother. For the current admission, Participant 2 explained: *“My ex-husband took away my kids. I wanted to shoot myself and then halfway there decided why, I’m gonna [sic] shoot him now. And when I got there, the police was already there with my mother”*. Participant 2 got a divorce after she *“caught my husband with our au pair”*. She also said that she was shunned by her family.

Participant 1 experienced emotional issues in the family, with her oldest son emigrating and her *“youngest and oldest sons weren’t speaking to each other, which upset me a lot”*.

For Participant 5, these emotional issues contributed to her feeling like she was alone, and she subsequently became *“very hard on myself”*. These issues, paired with finding out that her son, whom she was pregnant with at the time, had a heart problem, caused severe emotional stress and pain. Regarding her previous admission, Participant 5 said that while the therapy she had while admitted *“made me feel like it’s my fault [the marital issues], I think that’s why it didn’t work at all”*, she emphasised that these issues were a contributing factor to her relapse and readmission.

Participants 2, 3, 5, and 8 experienced emotional triggers with regard to their relationships. Participant 3 ended his relationship with a girlfriend, and Participant 5 was experiencing marital issues.

Returning to the same emotional triggers is also a contributing factor for possible readmission.

For Participant 8, who was admitted previously for depression because of a past relationship, returning home to that same relationship hindered her recovery.

MedicineNet (2018) defines stress in a medical or biological context as “a physical, mental, or emotional factor that causes bodily or mental tension. Stresses can be external (from the environment, psychological, or social situations) or internal (illness, or from a medical procedure).”

Nhlapo (2018) reported that there has been an increase in stress-related insurance claims since 2016 and that 10.9% of professionals have taken time off work as a result of stress-related illness. These claims come in the form of a stroke or attempted suicide, and this chronic stress and suicidal thinking are not uncommon (Nhlapo, 2018). Everyday presentations of stress were identified by the participants as something impacting their recovery as they struggle to manage their stress.

Participant 3 expressed that “*stress is also my thing for me*” and Participant 8 expressed that she “*can’t cope at all, can’t cope in stressful situations*”.

Unmanaged stress can contribute to health issues, and can also be a contributor to relapse and possible readmission.

Sub-theme 1.3: Health issues

As mental health can be largely impacted by physical health (Mental Health Foundation, 2018), it is logical that health issues would have a potential impact on a person’s recovery, possible relapse, or possible readmission. Two participants highlighted the health issues that they experience, which have an impact on their mental health and ongoing recovery:

For Participant 3, this was a “*sleeping disorder and epilepsy*”.

For Participant 4, born with a heart disease, her continuous health challenges – she had four operations in 2018 – meant, “*All my life – I spend it at the hospital, and I can’t do it anymore*”. Her struggle with her physical health largely impacted her emotions, her desire to participate in ongoing recovery and even her will to live.

When there are physical health issues, these can also have an impact on the effect of psychiatric medication prescriptions and the side effects. This is the next key theme in the experiences of readmitted mental health service users.

3.8.2.2. Theme 2: Psychiatric medication

Medication, as the biological aspect of psychiatric treatment, is a core component of many interventions (Coppock & Dunn, 2010:91; Leach, 2009:10). This medication helps to stabilise mood, normalise sleep patterns, balance hormonal levels and reduce psychotic symptoms (among others), depending on the diagnosis and the patient’s needs. Adherence to medication

is described as “the extent to which a patient acts in accordance with the prescribed interval and dose of a dosing regimen” (Okpataku, Kwanashie, Ejiofor & Olisah, 2015:372). For many patients, however, choosing to take psychiatric medication can be a complicated decision, as they’re faced with questions, uncertainties and concerns about the impact on their functioning beyond minimising their symptoms (Doran, 2013:3). Chew, Hales and Yudowsky (2017:xiii) note the importance of patients being informed about their diagnoses and medication, as this leads to a greater degree of “compliance, safety, and positive treatment response”, a part of the consultation that Doran (2013:35) also highlights, but that the amount of information shared should be carefully considered so as not to overwhelm the patient.

Sub-theme 2.1: Taking as prescribed or defaulting

The use of psychiatric medication as prescribed by the healthcare professional is key for it to have the intended impact (National Institute of Mental Health [NIMH], 2016; Okpataku et al., 2015:372). The long-term management or progression of the illness is largely impacted by the adherence of the patient to prescribed medication (Okpataku et al., 2015:372). Between the participants, some emphasised the importance of staying on their medication and how this continues to help with their recovery.

For Participant 9, defaulting from her medication was the biggest contributing factor to her continued readmissions. She explained that through her years of experience with mental health services, she went between six months to two years before readmission became the only option for her. Many of her admissions were involuntary admissions because she was considered a danger to herself and unwilling to seek treatment. Her biggest challenge was “*not believing that I’m ill*” and because of not believing that she is ill, she did not believe she needed to take the medication. She would stop taking it soon after discharge or after a period of time, ultimately leading to her severe symptomatic relapse.

Denial, for example not wanting to believe a diagnosis, is one of the common reasons for non-adherence to medication (Doran, 2013:36).

For Participant 9, success in recovery is determined by “*if one gets the right medication and they stick to it*”.

This adherence to the medication is key for Participant 4 who says, one “*can’t let it go – doesn’t matter if you feel better*”.

Participant 6 said, “*the tablets given by the psychiatrist help me a lot*” and Participant 2 confirmed she stayed on her medication.

The communication from the treating psychiatrist can have an impact on the likelihood of the patient remaining on the medication. Chew et al. (2017:xiii) identify greater compliance to medication if the patient is informed about their medication.

Participant 1 experienced this directly with her psychiatrist who discussed the side effects and told her, *“You may feel like this or you may feel like that and if you do contact me immediately”*. However, even with information and compliance, abuse of prescription medication is possible. Participant 1 admitted misusing her sedatives because she wanted to *“feel better”* and felt she *“just couldn’t do it anymore”*.

Misuse of medication, or lack of compliance particularly when taking more than prescribed, could be due to the patient feeling like the medication is not working effectively for them.

Sub-theme 2.2: Lack of effect of medication

Doran (2013:14) explains, “When a diagnosis is made and appropriate medication prescribed, most patients are quite capable of increased functioning in their lives”. However, if there is an incorrect diagnosis, failure of the specific choice of medication or an incorrect dose, there may be an impact on the patient (Doran, 2013:15, Kohn et al., 2004:859; Liebenberg, 2015:7; Vigod, et al., 2013:192).

With Participant 9’s initial diagnosis, she was given anti-depressants for a diagnosis of major depression; however, her correct diagnosis was bipolar mood disorder and the lack of mood stabilisers caused a severe manic episode.

Considering errors in diagnosis and changes in the body’s reaction to medication, among other factors, continuous review and management of the medication is important.

Patient 4 was readmitted voluntarily and explained, *“Even now, I’m here for treatment in the sense of my medication – to see if it’s still right, if anything must change or if it must go up or down”*. For him, this readmission was a proactive choice and an attempt to continuously monitor his recovery and management of his posttraumatic stress disorder and depression.

The experience with psychiatric medication has been a challenging one for Patient 2. First diagnosed as a child, she mentioned that her doctor and the professionals she’d seen *“still haven’t found the meds to properly treat me ... When they find a mood stabiliser that works, it makes me drowsy or I’m allergic to it”*.

As a result, the medication balance in her ongoing treatment was not assisting with her symptoms and management of her illness.

There are many other reasons for possible non-compliance to medication, including availability of the medication (Okpataku et al., 2015:374).

While medication is one of the components of an effective treatment plan, psychological treatment options are also essential in many cases (Allers, 2015:11; Korb, 2015:32; Patel et al., 2016:1676). These psychological and social options include the support of professionals, the support of the social system and the workplace, religious support, and financial support – all of which play a part in a person’s ongoing recovery and risk of relapse and readmission.

3.8.2.3. Theme 3: Support/ lack of support

Support of an individual and their recovery can present in many different ways and will depend on the person’s needs.

Participant 4 felt that support could greatly influence *“how you are dealing with situations at the end of the day”*.

Possible sources of support include professional support – doctors, psychologists, social workers or nurses, for example – as well as emotional and social support, and practical support such as financial support (Allers, 2015:11; Korb, 2015:32; Patel, et al., 2016:1676). When levels of care and support are present, recovery becomes a more attainable goal (Johnson, 2002:374). On discharge, one of the first options for support is often found through the professionals seen in the hospital, similar professionals that can be seen on an out-patient basis, as well as through support groups.

Sub-theme 3.1: Professional support and support groups

Professional support and support groups form an integral part of ongoing recovery for many of the participants.

Mental health and recovery is an experience that Participant 6 felt: *“One cannot walk this thing alone. You need some assistance”*.

More frequent contact with a healthcare professional is recommended by the Canadian Mental Health Association (2011:9) if someone feels that they are struggling to cope and when they recognise that their illness is again affecting them negatively, as it can help to promote feelings of safety (Cruce, Öjehagen & Nordström, 2011:664). Within the first month of discharge, contact with professionals is found by many to significantly lower readmission rates (Mark et al., 2013:209; Sfetcu, Musat, Haaramo, Ciutan, Scintee, Vladescu, Wahlbeck & Katsching, 2017:8). It is key for these follow-ups to be done in the same hospital or clinic, by the same staff, for impact on readmission to be significantly reduced (AHRQ, 2015:11; Sfetcu et al., 2017:9).

These were the follow-up support plans in place for Participant 1, who planned to see her psychologist once a month and her psychiatrist every three months.

Participant 2 had a more intensive follow-up appointment schedule. She explained, *“My psychologist – I’ve been with since I was 9 years old – [I] see psychologist on a monthly basis – twice a week at first – and my psychiatrist within a week of discharge”*.

Participant 4 chose to be readmitted when he needed to see the psychiatrist.

The relationship the patient has with their treating professional is also of importance during recovery (Leach, 2009:10).

Participant 5 identified a very positive relationship as a key factor in her recovery, explaining that she was *“so open, so comfortable with someone [the psychiatrist], like she makes me say secrets”*.

This open and honest relationship is vital if a patient is to trust the professional and continue to see the person.

Grinshpoon, Lerner, Hornik-Lurie, Zilber, & Ponizovsky, (2011:265) found that up to one-third of patients who have had more than one mental health admission do not contact an out-patient clinic for follow-up within six months of discharge. Up to one-third of patients with schizophrenia or related-disorders who were readmitted within three months, missed their first follow-up appointment post-discharge (Grinshpoon et al., 2011:263). Attending scheduled follow-up appointments is often found to be a predictor for readmission – those not attending are predicted to need readmission sooner, whereas those in contact post-discharge show a longer time frame between admissions (Grinshpoon et al., 2011:265; Sfetcu et al., 2017:5). However, there is also research that finds that longer-term follow-ups (over six months) do not reduce the likelihood of a readmission (Puntis, 2016:1639; Sfetcu et al., 2017:8). None of the participants reported lack of follow-ups as a reason for their readmission.

Peer support – that is, having a peer mentor – has also been found to decrease risk of readmission and can be an option for transitional discharge services (AHRQ, 2015: 11; Sfetcu et al., 2017:10). Often, peer support is found in support groups, which can also provide solidarity and help to prevent feelings of isolation and loneliness (Cruce, Öjehagen & Nordström, 2011:664). These are often useful, as many do not entail a financial cost.

Financial implications of continued treatment were a concern for Participant 1.

Participant 3 explained that it was only when he attended meetings that he managed to remain sober, and that he appreciated and learned from the information from other addicts.

These professional and support group interventions may take up a part of the person’s day, but the rest of their time is spent with family, friends, and in the workplace – all areas that

could be potential triggers, or could potentially support the patient's recovery on an ongoing basis.

Sub-theme 3.2: Family, friends, and the workplace

Support from the family decreases the risk of rehospitalisation (Sfetcu et al., 2017:10). Many of the participants identified emotional triggers in their families as part of the reason they were readmitted.

Participant 1 attributed her relapse to *"trials and tribulations within the family, or work, socially"* prior to her readmission.

The participants reported mixed feelings of support from their families and loved ones. However, when identifying key areas for continued recovery, the consensus was the same – support is essential.

Participant 1: *"Family support, good friend support"*.

Participant 4: *"Your support, if you already have a support group or whatever you want to call it, family and friends, that's really things, that's keeping me going that helps me"*.

Many families were supportive of their loved ones during their recovery.

For Participant 2 it was her husband who supported her even on her low days. Participant 2's mother, as well as her oldest brother, were very supportive. Participants 4 and 10 identified having support.

Participant 5 said: *"... friends, kids, married. If maybe I didn't have those things in life, maybe I wouldn't be here"*. Not all participants experienced this support.

Although Participant 3 said, *"Mom still loves me. She still fully supports me; and my aunt and everyone here"*. He also said that he had lost his family's trust.

Some families *"don't understand [me] at all"*. This was the case for Participant 8. She explained that her family would *"say I'm crazy; which is painful"*.

Sfetcu et al., (2017:10) identify family stigma as contributing to increased readmission within one year, particularly for those with bipolar and psychotic disorders.

Stigma from her father was experienced by Participant 2: *"He [my dad] doesn't like this place. He thinks it's a mental facility. He keeps calling this place a crazy hospital"*. She also experienced loss of friendships, explaining that her friends *"just don't want to talk to me, because I'm moody"* and that a mental illness changes relationships.

Outside of family and friends, workplaces are where a large portion of daily time is spent (Mental Health Foundation, 2018). There is an increase in awareness for workplaces to support their employee's mental health (Agarwal, 2018; Mental Health Foundation, 2018), but this is far from implemented across the board. South Africa has seen an increase in workplace suicides (Health24, 2015) with both prominent figures and everyday people taking their own lives. Concerns about how the workplace would treat them or react to their illness or readmission were real for the participants.

Participant 7 feared *"how people are going to see me professionally, at work"*.

For Participant 2 and Participant 9, however, their supportive workplaces contributed positively to their recovery and their seeking of further help when needed.

Participant 9 explained that, after her recent suicide attempt, she *"got to work and they said 'you're not fine'. One person knows my history and he said, 'We're taking you to hospital'"*.

Participant 2 felt that her workplace understands, and that if she needs time during her working day to regulate her emotions they would allow her to do so.

Workplaces with an environment that promotes their employees' mental health and wellbeing often see increased job satisfaction and productivity (Agarwal, 2018).

For those who do not have a supportive family, friend system, or workplace:

Participant 1 recommended *"staying away from negative people. They feed off your energy"*.

In these cases, people may turn to alternate options for support.

Sub-theme 3.3: Religion and spirituality

Religion, spirituality, or having some sort of faith is often identified as important support for those in recovery – particularly if they feel like other support systems have abandoned them (Awara & Fasey, 2008:184; Slade, 2009:9). Religious beliefs have also been found to have a protective influence during potentially detrimental or distressing life events. They also have an effect on physical and mental health, and provide a feeling of hope (Awara & Fasey, 2008:189; Bhui, King, Dein & O'Connor, 2008:141; Cruce, Öjehagen & Nordström, 2011:665).

Participant 3 said he would continue to go to church on Sundays.

For Participant 5, her religion, spirituality and participation in these was her focus for her recovery going forward. When referring to her previous admissions and her

current progress, she asked God to help her through her experience. Going forward she planned: *“There are [church] services every day. If I attend these services every day, it will make me stay away from whereby [sic] I notice things that will trigger me, because if I’m in church, when I come back, I’ve already cooked, my children are there ...”*

Bhui et al. (2008:149) note that religious coping is found more in black and minority ethnic groups, but does happen in other groups as well. Attending a place of worship is one of the more effective options, with religion being used as a coping tool (Bhui et al., 2008:142). Religious coping and using spirituality in recovery is an important aspect for many, but one that is often not included during the hospitalisation (Awara & Fasey, 2008:184). It is, however, often found in research to be ineffective when compared to cognitive and social coping options (Bhui et al., 2008:142).

While an individual may have access to professional support, as well as support from their family, friends, and workplace, and they may draw on their spirituality for support, their recovery is still their own experience and responsibility. Commitment to that ongoing recovery is paramount for remaining well for as long as possible, or seeking assistance before a crisis occurs.

3.8.2.4. Theme 4: Commitment to recovery

Sub-theme 4.1: Taking responsibility vs lack of responsibility

Slade (2009:5) defines personal responsibility in personal recovery as “the ability to take personal responsibility for one’s own life”. With their readmission experience, many participants identified taking responsibility for their mental health and managing their illness as an important part of staying out of hospital going forward. Many of them also admitted that it was this lack of responsibility for recovery after previous admissions that contributed to them needing another admission.

Participant 1 noted, *“The previous ones [admissions], maybe I took for granted”*.

Participant 3 said, *“I don’t realise I’m doing this mistake over and over the whole time and I’m not doing anything about this problem”*. At times, this lack of responsibility came in the form of believing there was no control over their actions or emotions.

This was the case for Participant 5, who attributed her readmission and the likelihood of additional admissions in the future, to the fact that she gets *“triggered very easily; and I get very angry. I get very, very angry”*. Sentiments about returning to the facility, and therefore taking little responsibility for their recovery because readmission is inevitable, included *“You know, guys, we are coming back here next year”*, as shared by Participant 5.

Participant 1 noted this thought pattern too, expressing that it is those who are not *“taking it [recovery] seriously. They keep ending up here, the ones who are not serious”*. She believed that it was her focus going forward and her responsibility to *“have to do, I need to do, what I do to prevent having these terrible ups and downs”*.

Even if a person takes responsibility – a crucial component for recovery – there may come times where they slip away from actively working on managing their illness and become more passive in their recovery process.

Sub-theme 4.2: Active recovery or passive recovery

For recovery to be possible, participants need to take responsibility for their role in their recovery and actively engage in the process (Amering & Schmolke, 2009:17; Biringer et al., 2016:26; Deegan, 2009:58; Uys, 2010:52).

Participant 5 was not actively engaging in her recovery prior to readmission; she said that she just *“accepted what the doctor said”*, with no questions asked and no attempt to understand what her diagnosis meant for her life and for moving forward.

Participant 9 did not actively engage in her recovery, as she did not believe that she was ill.

For others, continuing to make choices that hindered recovery impacted their need for a readmission.

Participant 3 found himself *“hanging out with wrong friends again”* and subsequently started abusing drugs once again.

Cruce, Öjehagen & Nordström (2011:661) view recovery as a “process that takes place within the individual and in relation to a social context”. Therefore, if the social context is not conducive to recovery, the person may struggle.

An interesting point, with regard to active recovery, is the source of funding for the care.

Participant 5 noted that she was not concerned about lack of engagement leading to a readmission because: *“anyway, it’s not my money – it’s the medical aid”*.

This lack of engagement was echoed by some other participants too.

Participant 9 said, *“I’ve done this before”* and so was *“withdrawn and uninterested”* during her admissions.

Participant 4 explained active recovery as *“you have to work for it”* and, along with Participant 10, expressed the importance of working daily to try to remain

functioning as best as possible and paying close attention to when things feel like they are going wrong and then acting on them.

Commenting on her readmissions and active participation in the programmes, Participant 7 noted that this gave her an opportunity for reflection where she could see *“Okay, I was supposed to do this”*, and learn from the set-backs she experienced. She noted that these times of reflection allowed her to look at the skills she had gained and how she could have implemented them differently to assist her recovery.

Skills are a main focus of many in-patient programmes, as part of the therapeutic component, and another factor that is important in terms of recovery and readmission.

The shift between passive recovery and active recovery was summarised by Participant 1.

Participant 1 said that: *“Previous times I was worrying about the husband, what’s going on at home, is he upset with me because I’m here you know that type of thing. But this time, it’s my commitment. I have to do this. I want to do this.”*

Another component of active recovery is being aware of any warning signs that one may be heading towards a possible relapse. The Canadian Mental Health Association emphasises the importance of identifying early warning signs as an indicator that one’s health may be getting worse (2011:2). These warning signs vary from withdrawing from people, to a loss of appetite and weight, as well as self-harming thoughts and actions including suicide attempts – all of which were expressed in some way by the participants.

Participant 7 said, *“I didn’t want to talk. Not eating. Didn’t want to see anyone”*. For Participant 6, losing a lot of weight because of the stress he was experiencing was a warning sign.

Participant 9 said that she chose to remain in the programme because *“I’m scared of myself and my thoughts. I attempted to kill myself”*.

As many of these warning signs link with isolation and withdrawal, keeping busy and spending time participating in activities rather than spending all their time alone, can be helpful for many recovering from mental health issues.

3.8.2.5. Theme 5: Use of time

For many patients, not being busy or occupying their time with something constructive triggers emotional responses and behaviour that could contribute to relapse and readmission. The participants identified using their time for themselves to keep busy and using their time to help others, as possible contributors to continuing recovery.

Sub-theme 5.1: Keeping busy

Keeping busy and doing things with one's time, is one way that helps people to find meaning and purpose in their life and recovery (Amering & Schmolke, 2009:20). This was the general sentiment from participants.

Participant 3 said he needed to *"keep myself busy"*. Participant 1 also said that she *"need [sic] to be more busy"*.

The reasons for this were shared by Participant 10, as well as Participant 4, who explained that someone in recovery needs to *"get something, have something keeping you busy and not just think [sic] of your situation"*.

One of the challenges is not working. Participant 3 did not have work and said he was *"struggling to get work again"*.

For Participant 5, this lack of work was a direct contributor to her relapse: *"I also sometimes blame myself; like, maybe it's the issue of not working, of I'm just useless. If I have R30, why don't I just buy two [drinks] and sit, because that's what people who are not working do"*.

Keeping busy can also help with distancing oneself from negative influences, friends, and triggers.

During Participant's 3 recovery, it was during the times where he was not busy that he went back to his friends and relapsed, which contributed to his worsening mental health. He explained that when he is busy, he can *"stay away from friends"*.

There are a number of things that can be done to keep busy.

Participant 1 indicated that finding a hobby was one possibility, and also taking time to keep a gratitude diary.

For others, the best way for them to keep busy was to find a way to help others or engage in acts of service in their communities, workplaces or other areas.

Sub-theme 5.2: Service/ helping others

Slade (2009:7) explains that people who have experience with mental illness are often in a position to have a profound impact in the life of another person with mental health problems. Their experience can help them to contribute meaningfully to that person's recovery (Slade, 2009:7).

Participant 3 had *"thought about helping people"*.

Participant 1 wanted to volunteer somewhere when she finds *"the right kind of thing to do"*.

Participant 7 had bigger dreams on how to help others, as she *“want [sic] to start my own project to assist women and their teenagers”*.

Many people recovering from a mental health issue find the “need to give back” (Amering & Schmolke, 2009:20).

In Participant 6’s case, he identified being needed by others as a reason for still being here and not ending his life, saying that when he *“... think [sic] about taking your life but when you went through this test you see maybe there’s people who still need you in life”*.

Cruce, Öjehagen & Nordström (2011:666) explain that experiencing meaningfulness empowers people to find their capability to succeed in recovery. Helping someone to identify opportunities to give back to others can be an important element for professionals to assist with as a part of the hospitalisation and follow-up process (Slade, 2009:9).

Identifying keeping busy and use of time was something expressed by the participants for what they wanted to do in future, but few had focused on this after their previous admissions. These previous admissions bring about varying feelings for the participants.

3.8.2.6. Theme 6: Feelings about readmission

Recovery from mental illness is an ongoing and comprehensive process (Biringier et al., 2016:23). Despite this, being admitted multiple times to an in-patient treatment facility can bring about strong emotions for some individuals, although others experience readmission as a completely normal part of the recovery process.

Sub-theme 6.1: Negative emotions

Readmissions, according to the participants, evoked many emotions:

Participant 9 explained that the experience of readmissions *“evoke mixed feelings”*.

Participant 2’s experience can be different every time *“because they adjust the meds [sic] differently”*. She also felt angry at needing to be readmitted, as she said *“I don’t want to keep ending up in [hospital]. I’d like to just live a stable life”*.

Participant 5 explained being readmitted as an experience that brought her fear: *“... first I was scared – like I’m in the wrong place. It’s a hospital. I don’t belong here”*.

Participant 6 shared feelings of shame and that being a readmitted patient was *“like a secret to me. I feel, maybe, ashamed”*.

Most participants felt that the patients and staff at the hospitals did not know or treat them differently because they had been admitted before, except for:

Participant 5, who said, *“Sometimes it feels like they [the nurses] treat us like we’re mad”*.

Some of the strongest feelings shared were feeling worthless and feeling weak.

For Participant 7, this was a very real experience for her: *“I feel like I’m not a normal person, like I can’t deal with my situation, so that means I’m very weak... Because every time when I’m supposed to face the challenges I just, I can’t, so I’m worthless, I’m weak, I can’t deal with any problems”*.

Participant 1 had similar feelings about her readmissions: *“... sometimes makes me feel that I’m worthless. That I haven’t dealt properly with my previous issues. Makes me feel like a failure in a way ... you sort of think to yourself why does this keep happening? Why does it keep happening?”* However, even with this view, she also added that going forward *“I’m not saying that I’m not going to have a fall down again”* because relapse is a normal part of recovery for many people with a mental illness.

Sub-theme 6.2: Relapse is a normal part of recovery

Slade (2009:23) explains that “relapse (in the sense of going backwards) is normal. People struggling to break free from previous behaviour or emotional patterns experience setbacks”. For some, this relapse can lead to them needing to be readmitted. For successful recovery, service users must be willing to “try and fail, and try again” (Deegan, 2009:62).

Participant 1 explained that: *“I know that it’s [readmission] going to happen. It could happen once a year or once every two years. It could happen every six months... because of severe depression and anxiety. You know, it’s a chronic disease...”*

Participant 4 noted that *“if it’s a relapse, you’re not going to ask for it; it’s going to happen when it happens”* and that *“it’s a chronic thing. It came over a period of time and it’s not going to go away in like [sic] six months’ time”*.

In continuing with readmission as a normal part of the recovery process, Participant 6 said that *“being admitted is a matter of ... this thing it happens. Coming to the hospital. I think it’s better”*. He also added that he felt if he were to stay at home not feeling well for a period of time, he didn’t think he would cope.

Participant 5 said that if she *“waited longer to come here I would have been worse”*.

For some, readmission is a proactive choice, which was the case with Participant 4:

The first readmission Participant 4 had *“was a relapse. Others were more check-ups and things concerning my psychiatrist ... change some medications”*. In his

experience, *“the whole thing of going in, coming in, is working”* and allowing him to remain as well as possible.

For others, their readmission was a result of them not functioning optimally and struggling to cope, and so their perception of readmission was that it helped them to feel better again.

Participant 3 shared, *“That’s why I had to book myself in here again, for help for my problem. For more help. I need more help”*. Participant 2 found herself *“... in and out of here. I couldn’t find a balance point in my life and everything just went completely wrong”*.

The AHRQ (2015:39) supports readmissions for reasons such as these, stating that “readmission is not necessarily something to avoid”. Readmissions can, however, be an indicator of how effective the original treatment was.

Most importantly, the message from the participants was that readmission to a mental health facility is not something to see as a failure.

Participant 9 expressed the following for other readmitted service users: *“Do not lose hope. Usually with readmissions you start feeling like there’s nothing that can be done for you to get better, but recovery is a process. It may just be that you needed to be readmitted. Do not see it as failure”*.

There are also advantages to readmission, as shared by Participant 4: *“... mustn’t see readmission as a failure. It helps you to really get a fresh look of your situation and what’s happening and how it’s going and how you have improved from your previous situation”*.

Among these messages, there are words of hope for other readmitted services users.

Participant 1 emphasised: *“Be as positive as you can for as much days as you can. And we are going to have days where you fall down; but we’re going to pick ourselves up and we’re going to carry on”*.

While it is clear from these experiences that readmission can be expected with mental health care practice, there are opportunities to extend the time between readmissions and minimise the potential risk of harm to patients prior to them needing another admission. There is also an opportunity to assist patients with skills and access to care to help maintain their health for as long as possible. Many of these opportunities should begin while the person is still in the hospital through proper discharge planning.

3.8.2.7. Theme 7: How programmes and facilities can assist

Admission and the programmes offered while a patient is admitted, can have a profound impact on preparing the patient for discharge and ongoing recovery. Additionally, the facilities could offer services that may aid further in preventing readmissions soon after discharge.

Sub-theme 7.1: Therapy options

The participants identified many strengths and weaknesses in the therapeutic programmes that they had been through before, as well as what they were currently participating in, and how these could influence their recovery or risk of relapse and readmission.

In some cases, programmes may not be suitable for everyone.

This was the case for Participant 5, who said, *“There is nothing that is going to help anyone here. Everybody’s so negative”*.

In an attempt to address as many needs as possible, many in-patient programmes offered by appropriately registered in-patient facilities include both a medical and psychological component to their programmes (Allers, 2015:11; Korb, 2015:32; Patel et al., 2016:1676).

One of the core components in many programmes is group therapeutic interventions.

Participant 2 encouraged others to *“go to the classes. They do give you a lot of coping skills”*, but does not attend herself, because she *“can’t handle people”*.

Participant 4 did not attend the groups because he was readmitted only for medication review, but said that if someone is admitted for a relapse, then they should attend, because *“The things you worked on or whatever didn’t work, you must start again to go through the whole thing”*.

Participant 7 identified group therapy as providing *“solutions, how you can deal [sic]”* that can be used once discharged.

Participant 9 was the only participant who had been admitted to both a private and a public hospital. She shared her experience of the contrast between the services and programmes offered, explaining that private in-patient programmes give the person the opportunity to *“gain skills to use outside”*, as well as providing a *“level of freedom, perhaps I’m not so sick so I can go out there and continue”*.

In Participant 1’s experience, *“seeing a psychiatrist and psychologist every day while admitted”* was a positive aspect of an in-patient programme, as it allows patients to engage fully one-on-one with their treat professionals.

It was these engagements, along with the group therapies that led Participant 7 to *“feel inside myself I am relieved. I am happy. I can make people to laugh [sic]”* – qualities that she felt she had lost prior to her readmission.

Deegan (2009:63) describes the most effective mental health services as those where a service user can feel “welcomed, valued, and wanted”. There are some practical measures that facilities can put in place to foster an environment that promotes this type of atmosphere.

Sub-theme 7.2: Practical measures

An implemented programme is based on a number of different approaches, research, and the needs identified for that unique patient population. However, there are always opportunities to expand service offerings, and to tailor them to be more suitable for individual needs. One of the first aspects to consider is the staff working within a programme.

“People who are patients” are, in Participant 6’s view, essential for patient care.

Additionally, all staff should have *“proper training on how to deal with psych [sic]”*, something Participant 9 found lacking in her previous involuntary admissions.

Participant 5 felt that programmes should include *“not just theories taught in school but real life experience”* and would like to see previous patients, or those in recovery, sharing their stories; *“somebody who can stand there and explain to us it’s not easy, but if I managed ...”*

Participant 1 and Participant 4 both indicated that they would like to see a separate programme for patients who are readmitted. This includes different groups that focus on different elements, as well as *“maybe a more positive outlook”*, as suggested by Participant 4.

Deegan (2009:63) views a “fail-proof” programme as one in which service users are “always able to come back, pick up where they left off, and try again”. This is in contrast to the suggestion made by the participants.

Considering the age of the patient population, as well as the division into group therapies, is important.

Participant 6 said he *“cannot share with young people”* and feels that they would not understand his experiences. He also worries about confidentiality in a group setting.

A number of suggestions were made regarding post-discharge care and programmes that could assist with recovery and which could prevent or prolong the time between readmissions, once a programme has been completed and a patient is discharged,

Sub-theme 7.3: Post-discharge

Too often, when patients are discharged from hospital, they are left without a clear plan of what to do next.

This can be challenging, as Participant 2 explained, *“In here [the hospital], you’re enclosed and protected. Once you go out there, it’s not anymore. You now need to fend for yourself”*.

Up to 13% of psychiatric service users are readmitted shortly after discharge (Vigod et al., 2013:187), which could be due to the adjustment after discharge being challenging. Participant 2 added that applying the skills is easy when in the hospital, but far less so after being discharged.

Participant 1 made the following suggestion: “... *have a system where they could contact you and say to you, how are you doing? Once a month or six weeks. Like [medical aid scheme] sends out once you’ve had a hospital visit. Just a quick: How you doing? How you feeling?*”

She felt that this could greatly assist with focussing on recovery and preventing readmission soon after discharge. The AHRQ (2015:11) identifies aftercare services, for example weekly follow-up calls, as a possible alternative to readmission, so this is a suggestion that could have great impact.

3.9. SUMMARY

This chapter focused on the research methodology and empirical findings of the research study. The research methodology, research approach, and type of qualitative research were described. The research design, methods, population and sampling, and data collection process were discussed. The ethical considerations were also discussed. The research findings as well as the interpretation of the findings were then provided. Participants’ demographic profiles were outlined, and the themes and sub-themes from the findings were discussed, in order to answer the research question.

Chapter 4 will address the conclusions and recommendations to be made from this research.

CHAPTER FOUR

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

4.1. INTRODUCTION

This final chapter concludes the research study. The research goal and objectives are outlined with regard to how they were achieved and the limitations of the study are outlined. The key findings of the research are explored and conclusions are drawn in answer to the research question, with recommendations made. Finally, recommendations for policies and future research are also made.

4.2. SUMMARY

The research goal and objectives were achieved in this study. The following section describes how these were achieved, as well as how the research question was answered.

4.2.1. Goal

The goal of the research study was to explore and describe the experiences of readmitted mental health care service users in a private in-patient treatment facility in Gauteng.

This goal was achieved through the following objectives, the achievement of which will be discussed in the next section:

- To contextualise mental health, mental health care, mental health care users and mental health care services in South Africa.
- To explore and describe the possible effects of readmission on mental health care users.
- To explore and describe the perceptions of readmission by mental health care service users.
- To explore and describe possible factors that contribute to readmission of mental health care service users.
- To identify the role of mental health professionals and services in preventing readmission.
- To make recommendations to mental health services for possible programmes, interventions, and initiatives that are aimed at preventing readmission of mental health users.

4.2.2. Objectives

4.2.2.1. Objective 1: To contextualise mental health, mental health care, mental health care users and mental health care services in South Africa.

The contextualisation of mental health began from the introduction in Chapter 1 where the lack of research in a South African context was highlighted, noting that most research comes from higher income countries (Vigod et al., 2013:187). The key concepts defined these aspects of mental health, with perhaps the most notable being the definition for mental health care services as defined by the Capital & Coast District Health Board (2016).

The literature review in Chapter 2 provided the context for mental health and related aspects. Section 2.2 explored the historical context of mental health in South Africa and how implementation and regulation of mental health care services developed over time. The lack of prioritisation of mental health and mental health care services in South Africa was identified as a significant barrier in healthcare (Van der Merwe, 2015).

Sections 2.4 to 2.7 focused on the impact of mental health, diagnosis, treatment, and recovery – all of which work to achieve this first objective. It was found that the effects of mental health are far-reaching and impact many different sectors of society (Fawcett et al., 2012:90). Despite mental health issues being so prevalent, less than 25% of people experiencing symptoms will get help for their mental illness (Van der Merwe, 2015; WHO, 2013:8).

4.2.2.2. Objective 2: To explore and describe the possible effects of readmission on mental health care users

This second objective was achieved, in part, through the literature review (Section 2.8), which presented the theoretical findings for the effects of readmission on mental health care users. The literature showed that readmission could increase social stigma for a person, lead to exclusion from society and lead to stigma from mental health professionals (Coppock & Dunn, 2010:12-13; Rieke et al., 2015:1). There could also be an effect on the professional life of a person, as well as an impact on their families (Rieke et al., 2015:1).

The findings from the research supported this, and also presented other possible effects. Theme three in Chapter 3 discussed support and lack of support as experienced by the service user, which was a clear effect of readmission. Additionally, theme four (commitment to recovery) explored the effects of readmission on the service users' personal commitment to their mental health.

4.2.2.3. Objective 3: To explore and describe the perceptions of readmission by mental health care service users

The theory discussed in Section 2.8 outlined some of the perceptions about readmission. It was found that relapse and readmission is common in mental health care (AHRQ, 2014:1; Mark et al., 2013:208; Rieke et al., 2015:1).

The participants shared their perceptions in detail. These are discussed in theme six of Chapter 3 – feelings about readmission. They shared negative feelings, as well as feelings of readmission being a normal and expected part of mental health and recovery. It was emphasised that being a readmitted mental health service user is not something to be ashamed about.

4.2.2.4. Objective 4: To explore and describe possible factors that contribute to readmission of mental health care service users

This objective was achieved through both the literature review (section 2.8, readmission and mental health in particular), as well as through the interpretation of the results. Theme 1 identified events experienced by service users as contributors, theme 2 looked at psychiatric medication and its link to possible relapse and readmission, while theme four focused on the service users' commitment to recovery (or lack thereof). Theme five explored use of time and recovering service users not using their time effectively, as a contributor to possible readmission.

Three common factors seen in both the literature and the findings were: lack of adherence to medication; not accessing services after discharge; and difficulty looking after oneself – both physically and emotionally (AHRQ, 2014:1; Heslin & Weiss, 2015:1; Vigod et al., 2013:192).

4.2.2.5. Objective 5: To identify the role of mental health professionals and services in preventing readmission

To achieve this objective, Section 2.6.3 of the literature review focused on the importance of the professional and the relationship with the patient (Leach, 2009:10) in treatment and recovery. Additionally, the focus of services offered has an impact on recovery (Johnson, 2002:372-373).

In the research findings, theme 2 – which focused on psychiatric medication – once again highlighted the importance of the psychiatrist-patient relationship in successfully managing symptoms with medication and patient adherence to the treatment plan.

Sub-theme 3.1 explored the role of support (or lack of support) from the professionals (including doctors, psychologists, and nurses) in preventing readmission. Theme 7 presented

suggestions from the participants for how professionals and services can assist further in preventing early readmission.

4.2.2.6. Objective 6: To make recommendations to mental health services for possible programmes, interventions, and initiatives that are aimed at preventing readmission of mental health users

Section 4.5 of this chapter provides recommendations for mental health service providers and programmes to be implemented, such as: group therapies, positive focus of the programme; and possible adjustments to the programmes for readmitted service users. Once this research is finalised, the findings will be presented to the in-patient treatment facility in question, as well as summarised for the therapeutic staff. It will also be made available to other surrounding facilities and groups working with mental health service users.

Together, the achievement of these six objectives allowed for the experiences of readmitted mental health service users in a private in-patient treatment facility in Gauteng to be explored and described.

4.2.3. Research question

In this study, the following research question was asked:

What are the experiences of mental health care service users with regard to readmission to a private in-patient treatment facility in Gauteng?

Through the unstructured one-on-one interviews with the participants, a number of themes and sub-themes about the experiences of readmitted mental health service users in a private in-patient treatment facility in Gauteng were identified. Chapter 3 discussed these themes and sub-themes in detail and through this discussion answer the research question.

4.2.4. Limitations and strengths of study

The quality of the collected data may be limited by a number of factors. Due to the qualitative nature of the study, the following limitations need to be taken into consideration when interpreting the results:

- There were only ten participants in the study; therefore the results cannot be generalised to all in-patient service users in Gauteng.
- The patients were all admitted to a private facility and views do not include those of patients in a government facility, and therefore cannot be applied across mental health readmissions in general.
- Patients had different diagnoses, and responses and needs may be influenced by the diagnosis and history of treatment.

- The patients were at varying stages of their in-patient programme, which may have influenced their insight into recovery.

4.3. KEY FINDINGS AND CONCLUSIONS

The key findings and conclusions will be identified and presented in terms of the literature review. The key findings will be shared, conclusions drawn, and recommendations made about the research findings as well.

4.3.1. The literature study

While the literature review provided a base for understanding the concept of readmission, there were some findings in the literature review that were not identified in the research, and some findings in the research that were not supported in the literature. Kohn et al. (2004:859), Liebenberg (2015:7), and Vigod et al. (2013:192) identified a key issue in the need for readmission, namely treatment that does not address the symptoms, and which is seen by the patient to be ineffective. However, most of the participants reported feeling significantly better after admission and most did not attribute their readmission to an issue with the service they had received.

The literature did discuss lack of adherence to medication as a contributor to readmission (Heslin & Weiss, 2015:2; Sajatovic et al., 2010:591; Vigod et al., 2013:192), which was also found in the research. Other key findings in the literature included the contrasting views on follow-up visits, with Mark et al. (2013:209) finding that readmission risk could be reduced if the person followed up within 30 days, but Puntis (2016:1639) finding that frequent contacts could increase the risk of readmission.

Possibly the most important finding from the literature review was the prevalence of readmission in mental health - some studies estimate that between 40% and 50% of psychiatric in-patients will be readmitted to a facility within one year of being discharged (AHRQ, 2014:1; Rieke et al., 2015:1). This shows that readmission is a wide-spread occurrence and it is an important topic to explore further, considering all the factors that may contribute to it and the possible impact that readmission has on the individual, their family, and society.

4.3.2. Appropriateness of the theoretical framework

The theoretical framework utilised for this study was the biopsychosocial approach, as first suggested by Engel (1977:132). The biopsychosocial model is a way of understanding why the person might be ill and what they are experiencing, as well as how their health can be

restored and maintained, along with understanding whether the person seeking help is ill or not.

The biopsychosocial model consists of three main components, namely biological, psychological, and social, as well as the different relationships and interactions between these components. It is widely considered to be one of the more holistic models in use, as it views the mind and body as being connected (Dilts, Jr, 2012:17; Engel, 1977:132; Heszen, 2009:12). The participants shared their journey, including: their physical health issues and their mental health diagnoses (biological); treatment, including both medication (biological) and therapeutic options (social and psychological); the impact and influence of their home situation; social support; and personal issues (social and psychological) on their recovery, relapse, and readmission. All of these factors together comprised the full experience of the readmitted mental health service users. Understanding all these aspects assists in understanding the patient (Borrell-Carrió et al., 2014:576). Therefore, this model was appropriate because it assisted in the interpretation of the findings and considered the experiences of the participants in entirety, along with possible causes and possible solutions.

4.3.3. Key findings, conclusions and recommendations – research findings

The key findings and conclusions of the research findings will be discussed according to each theme identified from the interviews. Recommendations will also be made.

4.3.3.1. Theme 1: Experienced events as set-backs

Key findings

Participants experienced a range of traumatic events, emotional triggers and health issues that contributed to their need for a readmission. Trauma experienced included injuries on duty at work, trauma as a result of the work done (front line work as police officers) and torture from colleagues. Death of a loved one is also a traumatic experience that contributed to a relapse. In terms of emotional triggers, participants experienced anger, which led them to harm others or themselves, and also experienced relationship issues. Some participants also experienced health issues (such as sleeping disorders, heart conditions and epilepsy) that impacted their recovery. Mismanagement of stress is also a major factor for possible relapse.

Conclusions

Traumatic events, dysregulated emotions, unmanaged relationship issues, and physical health issues are all possible contributors to relapse of a mental illness and possible readmission. These are issues that programmes should be addressing while the patient is still in the hospital, to prepare them for managing them on discharge and preventing a crisis. Within

the biopsychosocial model, life events such as violence, bereavement and loss are all considered possible triggers for mental distress (Coppock & Dunn, 2010:17) and can include biological, psychological, and social events having an impact on the person.

Recommendation

- Networks need to be established with community resources for referrals for patients on discharge. Not all patients live in close proximity to the hospital and many do not know where to turn for help when they go home.
- Referrals to community-based mental health services are needed where possible.

4.3.3.2. Theme 2: Psychiatric medication

Key findings

Psychiatric medication is a core component of treatment for mental health disorders. The key finding for this theme is that while some experience challenges with finding the correct medication to address their symptoms, with the correct medication most participants report noticeable differences in their functioning and moods. Discontinuation of this medication, particularly when unsupervised, is a high risk factor for relapse, and could lead to immediate need for readmission, depending on the severity of the symptoms. For patient compliance to be improved, communication from the treating psychiatrist is important.

Conclusions

It is possible then, to conclude, that psychiatric medication has a significant role in ongoing recovery and minimising the chance of readmission, if correctly monitored. Psychiatric medication is considered as part of the biological aspect of the theoretical framework, as it has a possible effect on the persons' physiology, symptoms and recovery. With medication included as an element of the readmission experience, mental health recovery and possible readmission can be regarded as a multi-faceted issue, which requires it to be considered more holistically.

Recommendations

- Treating doctors and nurses should work with patients to explain the need for any prescribed medication, the effects and possible side-effects, as well as the importance of adhering to the medication as prescribed and consequences of defaulting.
- Facilities and treating professionals should identify a plan with the patient for where they will get their medication once leaving the facility. Given there may be financial constraints,

patients should be educated on how to get medication from clinics if they cannot afford to pay for it from private pharmacies.

4.3.3.3. Theme 3: Support/ lack of support

Key findings

The participants identified support as one of the most important elements of their recovery. Access to support helps patients to feel as though they are managing their illnesses better, provides them with hope, and gives them a reason to focus on their well-being. It was found that the support of family and friends is most valuable, with professional support, support groups and religious support also being accessed. When support is low, the potential for relapse increases. Workplaces can play an important role here, as well in actively supporting those with mental health users who seek treatment. If other types of support are absent, people are more likely to turn to religious coping to assist them.

Conclusions

Therefore, it is essential to consider support when planning to reduce readmissions. For this to happen, discharged patients need to be leaving the hospitals and entering spaces where they have support. The biopsychosocial model encourages discussion that assists in identifying the social and psychological elements of what would otherwise be only biologically-reported in non-patient-centred care (Smith et al., 2013:266). Support can be both a social and psychological element.

Recommendations

- Patients should have access to their treating professionals for follow-up appointments – appointments should be made on discharge, and professionals should be available for emergency appointments for discharged patients.
- Advocating for financial support and/or medical aid cover for follow-up appointments is needed – although not discussed in this research, there are financial implications to follow-up appointments.
- Family and friend support structures should be included in the programme where possible to allow for easier integration when returning home, as well as for increased understanding.

4.3.3.4. Theme 4: Commitment to recovery

Key findings

Taking responsibility for one's recovery is key. The most significant finding in this theme was that people do not take responsibility for their recovery, either in the hospital or once discharged. This includes accepting responsibility for their actions and the choices they make, and for working towards feeling better. Additionally, those who actively focus on their recovery have a deeper understanding of their needs and are able to identify warning signs for help before they enter a crisis.

Conclusions

It is only with full commitment to recovery that someone has the opportunity to extend the length of time between admissions for as long as possible, or possibly not need readmission at all. Commitment to recovery will need to encompass various aspects, including biological, social, and psychological elements. The theoretical framework assists in looking at all of these factors for holistic recovery and treatment for the person. These elements can include the factors identified by the participants, such as medication, support, consideration of traumatic events, as well as others.

Recommendation

- Programmes should be active and involve the patients in their own recovery. Inclusion of recovering patients could be beneficial.

4.3.3.5. Theme 5: Use of time

Key findings

When time during the course of the day is not spent carefully, it is possible to fall into old habits and thinking patterns, and increase the risk of relapse. Keeping busy was a factor identified by many participants that they felt would keep them from needing a readmission. Along with this, using their time for helping others and service was also something identified by many, as how they would keep feeling better and succeed in recovery.

Conclusions

Making use of time effectively and sharing recovery experiences with others could be a helpful tool in finding meaning in life, recovery and assisting patients to remain more actively engaged in their wellbeing. By doing so, the social and psychological wellbeing of the person could be enhanced (which is key), along with the biological aspects. The biopsychosocial model

stresses the importance of all these parts of the person's life coming together for the best possible outcome and understanding.

Recommendations

- Facilities could implement a volunteering programme or options for previous patients to give back to the community.
- Importance of time management and using time constructively should form part of the skills programme while in the facility.

4.3.3.6. Theme 6: Feelings about readmission

Key findings

For some of the participants, readmission evoked strong negative emotions. These included feelings of worthlessness, shame, failure, and weakness. There were questions about why they are not able to cope with their issues and move on from them, as well as why they find it so challenging to deal with their problems.

For most of the participants, however, readmission was felt to be a normal and completely acceptable part of the recovery process. This is partly due to the chronic nature of many of the illnesses, the need to access medication, and the view that experiencing mental illness develops over time and it would, therefore, take time to overcome it.

Conclusions

The essential conclusion here is that readmission is a part of the recovery process, although there are many steps and actions to take that can help to extend the period of time between readmissions. The varying factors contributing to possible readmission, as well as the feelings about readmission, need to all be considered as part of the person's recovery.

Recommendations

- Additional elements to the programmes should be included for readmitted patients – this could include more advanced skills or groups on identifying their reasons for readmission. This could encourage attendance of groups by those who have been through the programme before.
- Comprehensive discharge planning should be included in any in-patient programme. This should cover emergency plans, medication adherence, support options, and a reminder of the skills learnt in the programmes.

4.3.3.7. Theme 7: How programmes and facilities can assist

Key findings

The participants noted the importance of engaging in group therapy and individual therapy as part of the recovery process. This is particularly important when therapies include skill building and allow the group to develop tools that they can implement once they have been discharged.

In addition to the therapy programmes, adequate training for staff to manage psychiatric patients is key. Some participants expressed their desire for a tailor-made programme for those who have been readmitted that is different to the standard programme on offer at facilities and addresses their unique needs. Participants also identified the need for ongoing support through follow-ups from the hospitals, such as a follow-up call.

Conclusions

In conclusion, mental health facilities and programmes offer many opportunities to assist patients in their ongoing recovery and to prevent readmissions. A focus on programmes, quality reviews, and competent staff are some of the steps that can be taken. One of the challenges with the practical application of the biopsychosocial model in mental health is incorporating all aspects in a treatment plan (Álvarez et al. (2012:177)). However, the experiences of readmission have raised the importance of finding a way to do this to contribute to ongoing wellbeing and recovery. Through gaining an understanding of the experiences of those who have relapsed, it was possible to better address the role that the mental health services play in relapse and readmission.

Recommendations

- It is necessary to constantly promote mental health and wellbeing and to work to lessen the stigma surrounding mental health and mental health care. This includes working with workplaces to encourage supportive environments for those with mental health issues.
- Proper monitoring of mental health facilities, their registrations, and the quality of care provided should be done by the governing bodies.
- Patients who are high-risk on discharge should be identified for follow-up by the professional team. This could be done to follow-up and get feedback on how the discharge plan is working.

4.4. RECOMMENDATIONS

Recommendations with regard to policy and future research follow.

4.4.1. Recommendations for policy

The following recommendations regarding policy are made:

- Mental health policies need to consider ongoing care following primary treatment. Registration and action guidelines need to be clear, to allow for safety of the service users, but also for such facilities to offer services to those who need them.
- Referral processes from community-based mental health care to other services, and back to community-based care, need to be clearly stated so as to avoid prolonged waiting for mental health care.
- Policies directing the funding for psychiatric care, particularly care needed on an out-patient basis and longer-term care, need to be reviewed to allow for better access to such services for those who need them.
- Patient rights need to be clearly outlined in all policies relating to mental health, whether in private or public care.

4.4.2. Recommendations for future research

There is still a great need for more research surrounding relapse and readmission in mental health, particularly in South Africa. The following recommendations are made:

- Research and development of a more specific programme for readmitted patients should be implemented in-hospital.
- Further investigation into the specific needs of patients on discharge – what do they feel they are missing after the programme and still need to continue in their recovery?
- Exploration of the readmission experiences of patients in public hospitals, as well as those with involuntary admissions.
- Research into the follow-up needs of discharged patients – what type of follow-up do they need, to feel supported in their recovery?

REFERENCES

- Agarwal, P. 2018. How do we design workplaces that support mental health and well-being? *Forbes*. 24 June. Available at: <https://www.forbes.com/sites/pragyaagarwaleurope/2018/06/24/how-can-workplace-design-help-mental-health/#3f224784dc13> (Accessed 2018/11/02).
- Agency for Healthcare Research and Quality (AHRQ). 2015. *Management strategies to reduce psychiatric readmissions*. Rockville: Agency for Healthcare Research and Quality.
- Alghzawi, H.M. 2012. Psychiatric discharge process. *ISRN Psychiatry*, 2012(2012): 1-7.
- Allers, E. 2015. Is there a treatment plan for major depression? *Mental Health Matters*, 2(5): 11-12.
- Atwoli, L., Stein, D.J., Williams, D.R., Mclaughlin, K.A., Petukhova, M., Kessler, R.C., & Koenan, K.C. 2013. Trauma and posttraumatic stress disorder in South Africa: Analysis from the South African Stress and Health Study. *BMC Psychiatry*, 13(1):182.
- Álvarez, A.S., Pangani, M. & Meucci, P. 2012. The clinical application of the biopsychosocial model in mental health: A research critique. *American Journal of Physical Medicine & Rehabilitation*, 91(13): 173-180.
- American Psychiatric Association (APA). 2013. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Virginia: American Psychiatric Association.
- Amering, M. & Schmolke, M. 2009. *Recovery in mental health: reshaping scientific and clinical responsibilities*. West Sussex: John Wiley & Sons Ltd.
- Awara, M. & Fasey, C. 2008. Is spirituality worth exploring in psychiatric out-patient clinics? *Journal of Mental Health*, 17(2): 183-191.
- Ben-Zeev, D., Young, M.A., & Corrigan, P.W. 2010. DSM-V and the stigma of mental illness. *Journal of Mental Health*, 19(4): 318-327.
- Berg, B.L. & Lune, H. 2012. *Qualitative research methods for the social sciences*. 8th ed. New Jersey: Pearson Education.
- Bhui, K., King, M., Dein, S. & O'Connor, W. 2016. Ethnicity and religious coping with mental distress. *Journal of Mental Health*, 17(2): 141-151.

- Biringer, E., Davidson, L., Sundfør, B., Lier, H.Ø. & Borg, M. 2016. Coping with mental health issues: Subjective experiences of self-help and helpful contextual factors at the start of mental health treatment. *Journal of Mental Health*, 25(1): 23-27.
- Boerema, A.M., Cuijpers, P., Beekman, A.T.F., Hellenthal, A., Voorrips, L. & Van Straten, A. 2016. Is duration of psychological treatment for depression related to return into treatment? *Social Psychiatry and Psychiatric Epidemiology*, 51(11): 1495-1507.
- Borrell-Carrió, F., Suchman, A.L. & Epstein, R.M. 2004. The biopsychosocial model 25 years later: Principles, practice, and scientific inquiry. *Annals of Family Medicine*, 2(6): 576-582.
- Braun, V. & Clarke, V. 2013. *Successful qualitative research: A practical guide for beginners*. London: SAGE.
- Brodsky, M. 2012. Residential treatment – when to consider it, what to look for. *Social Work Today*, 12(2): 8.
- Burns, J.K. 2014. Social and ethical implications of psychiatric classification for low- and middle-income countries. *South African Journal of Psychiatry*, 20(3): 66-71.
- BusinessTech. 2012. *Workplace stress costs SA R3bn annually*. Available at: <https://businesstech.co.za/news/general/9473/workplace-stress-costs-sa-r3bn-annually/> (Accessed 2017/06/15).
- Canadian Mental Health Association. 2018. *Preventing relapses of mental illness*. Available at: <http://www.heretohelp.bc.ca/sites/default/files/preventing-relapse-of-mental-illnesses.pdf> (Accessed 2018/11/01).
- Capital & Coast District Health Board. 2016. *Definition*. Available at: <http://mentalhealthservices.org.nz/page/132-home+definition> (Accessed 2016/05/09).
- Chabalala, J. 2015. The role of traditional healers in the provision of mental health care. *Mental Health Matters*, 2(3): 17-19.
- Chew, R.H., Hales, R.E. & Yudofsky, S.C. 2017. *What your patients need to know about psychiatric medications*. 3rd ed. Virginia: American Psychiatric Association.
- Convey, B. 2015. Workplace wellbeing in a time of austerity. *Therapy Today*, 26(10): 8-10.
- Coppock, V. & Dunn, B. 2010. *Understanding social work practice in mental health*. California: SAGE.

Creswell, J.W. 2013. *Qualitative inquiry & research design: Choosing among five approaches*. 3rd ed. Los Angeles: SAGE.

Cruce, G., Öjehagen, A. & Nordström, M. 2011. Recovery-promoting care as experienced by persons with severe mental illness and substance misuse. *International Journal of Mental Health and Addiction*, 10(5): 660-669.

De Vos, A.S. & Strydom, H. 2011. Scientific theory and professional research. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delpont, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik.

Deegan, P.E. 2009. Recovery: The lived experience of rehabilitation. In Reynolds, J., Muston, R., Heller, T., Leach, J., McCormick, M., Wallcraft, J. & Walsh, M. (Eds.). *Mental Health Still Matters*. Hampshire: Palgrave Macmillan.

Dennill, K. 2012. The transformation of the health system in South Africa. In Dennill, K. & Rendall-Mkosi, K. *Primary Health Care in Southern Africa: A comprehensive approach*. 3rd ed. Cape Town: Oxford University Press Southern Africa.

Dennill, K. & Rendall-Mkosi, K. 2012. *Primary Health Care in Southern Africa: A comprehensive approach*. 3rd ed. Cape Town: Oxford University Press Southern Africa.

Department of Health (DoH). 2013. *National Mental Health Policy Framework and Strategic Plan 2013-2020*. Pretoria: Department of Health.

Dilts, Jr, S.L. 2012. *Models of the mind: A framework for biopsychosocial psychiatry*. New York: Routledge.

Doran, C.M. 2013. *Prescribing mental health medication: The practitioners guide*. 2nd ed. New York: Routledge.

Drake, R.E., Deegan, P.E. & Rapp, C. 2010. The promise of shared decision making in mental health. *Psychiatric Rehabilitation Journal*, 34(1): 7-13.

Drisko, J.W. 2013. Standards for qualitative studies and reports. In Fortune, A.E., Reid, W.J. & Miller Jr, R.L. (Eds.). *Qualitative research in social work*. 2nd ed. New York: Columbia University Press.

Edwards, R. & Mauthner, M. 2012. Ethics and feminist research: Theory and practice. In Miller, T., Birch, M., Mauthner, M. & Jessop, J. (Eds.). *Ethics in qualitative research*. London: SAGE.

Engel, G.L. 1977. The need for a new medical model: A challenge for biomedicine. *Science*, 196(4286): 129-136.

Fawcett, B., Weber, Z. & Wilson, S. 2012. *International perspectives on mental health: Critical issues across the lifespan*. Hampshire: Palgrave Macmillan.

Fawn Jones, T. 2012. *Psychiatry, mental institutions, and the mad in apartheid South Africa*. New York: Routledge.

Fouché, C.B. & De Vos, A.S. 2011. Formal formulations. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at grass roots: For the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik.

Fouché, C.B. & Delport, C.S.L. 2011. Introduction to the research process. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik.

Fouché, C.B. & Schurink, W. 2011. Qualitative research designs. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik.

Fortune, A.E., Reid, W.J. & Miller Jr, R.L. (Eds.). *Qualitative research in social work*. 2nd ed. New York: Columbia University Press.

Greeff, M. 2011. Information collection: Interviewing. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik.

Grinshpoon, A., Lerner, Y., Hornik-Lurie, T., Zilber, N. & Ponizovsky, A.M. 2011. Post-discharge contact with mental health clinics and psychiatric readmission: A 6-month follow-up study. *Israel Journal of Psychiatry and Related Sciences*, 48(4): 262-267.

Hatala, A.R. 2012. The status of the "biopsychosocial" model in health psychology: Towards an integrated approach and a critique of cultural conceptions. *Open Journal of Medical Psychology*, 1(4): 51-62.

Health24. Workplace suicides on the rise. *Health24*. 18 March 2015. Available at: <https://www.health24.com/News/Workplace-suicides-on-the-rise-20150318> (Accessed 2018/10/29).

Herman, A.A., Stein, D.J., Seedat, S., Heeringa, S.G., Moomal, H. & Williams, D.R. 2009. The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders. *South African Medical Journal*, 99(5): 339-344.

Heslin, K.C. & Weiss, A.J. 2015. *Hospital readmissions involving psychiatric disorders, 2012*. Available at: <http://hcup-us.ahrq.gov/reports/statbriefs/sb189-Hospital-Readmissions-Psychiatric-Disorders-2012.pdf> (Accessed 2016/03/20).

Heszen, I. 2009. The biopsychosocial model of illness and its new developments: An outline. In Janowski, K. & Steuden, S. (Eds.). *Biopsychosocial aspects of health and disease, Volume 1*. Lublin: CPPP Scientific Press.

Joffe, H. & Yardley, L. 2004. Content and thematic analysis. In Marks, D.F. & Yardley, L. (Eds.). *Research methods for clinical health psychology*. London: SAGE.

Johnson, H.C. 2002. Emerging knowledge and future trends in mental health: Implications for social work. In Bentley, K.J. (Ed.). *Social work practice in mental health: Contemporary roles, tasks, and techniques*. California: Brooks/Cole.

Kaplan, D.M. & Coogan, S.L. 2005. The next advancement in counselling: The bio-psycho-social model. In American Counselling Association. *VISTAS Online*. Available at: <https://www.counsling.org/resources/library/vistas/vistas05/Vistas05.art03.pdf> (Accessed 2016/02/06).

Kendell, R.E. 2009. The distinction between mental and physical illness. In Reynolds, J., Muston, R., Heller, T., Leach, J., McCormick, M., Wallcraft, J. & Walsh, M. *Mental Health Still Matters*. Hampshire: Palgrave Macmillan.

Kent, D. 2003. *Snake pits, talking cures, and magic bullets: A history of mental illness*. Brookfield: Twenty-first Century Books.

Kohn, R., Saxena, S., Levav, I. & Saraceno, B. 2004. The treatment gap in mental health care. *Bulletin of the World Health Organization*, 82(11): 858-866.

Korb, F.A. 2015. Essentials of suicide for the general practitioner. *Mental Health Matters*, 2(5): 28-32.

Leach, J. 2009. Diverse approaches to mental health and distress. In Reynolds, J., Muston, R., Heller, T., Leach, J., McCormick, M., Wallcraft, J. & Walsh, M. (Eds.). *Mental Health Still Matters*. New York: Palgrave Macmillan.

- Leichsenring, F. & Rabung, S. 2011. Long-term psychodynamic psychotherapy in complex mental disorders: Update of a meta-analysis. *The British Journal of Psychiatry*, 199(1): 15-22.
- Liebenberg, R. 2015. Possible side effects of psychotropic medication. *Mental Health Matters*, 2(3): 7-11.
- Lietz, C.A., Langer, C.L. & Furman, R. 2006. Establishing trustworthiness in qualitative research in social work. *Qualitative Social Work*, 5(4):441-458.
- Lincoln, Y.S. & Guba, E.G. 1985. *Naturalistic Inquiry*. London: SAGE.
- Loch, A.A. 2014. Discharged from a mental health admission ward: is it safe to go home? A review on the negative outcomes of psychiatric hospitalization. *Psychology Research and Behavior Management*, 7(1):137-145.
- Macdonald-Wilson, K.L., Deegan, P.E., Hutchison, S.L., Parrotta, N. & Schuster, J.M. 2013. Integrating personal medicine into service delivery: Empowering people in recovery. *Psychiatric Rehabilitation Journal*, 36(4): 258-263.
- Madela-Mntla, E. 2010. Legal structure. In Uys, L.R. & Middleton, L. (Eds.). *Mental health nursing: A South African perspective*. 5th ed. Cape Town: Juta and Company Ltd.
- Mark, T., Smoyer Tomic, K., Kowlessar, N., Chul Chu, B., Vandivort-Warren, R. & Smith, S. 2013. Hospital readmission amongst Medicaid patients with an Index Hospitalisation for mental and/or substance use disorders. *Journal of Behavioural Health Services and Research*, 40(2): 207-221.
- McCrea, N.L. 2010. An analysis of South Africa's mental health legislation. *The National Law Review*. Available at: www.natlawreview.com/article/analysis-south-africa-s-mental-health-legislation (Accessed 2017/06/15).
- MedicineNet. 2018. *Medical definition of stress*. Available at: <https://www.medicinenet.com/script/main/art.asp?articlekey=20104> (Accessed 2018/07/03).
- Mental Health Care Act 17 of 2002 (Published in the *Government Gazette*, (24024) Pretoria: Government Printer).
- Mental Health Foundation. 2018. *Physical health and mental health*. Available at: <https://www.mentalhealth.org.uk/a-to-z/physical-health-and-mental-health> (Accessed 2018/10/29).

Mental Health Foundation. 2018. *Support mental health at work*. Scotland: Mental Health Foundation.

Miller, J. 2002. Social workers as diagnosticians. In Bentley, K.J. (Ed). *Social work practice in mental health: Contemporary roles, tasks, and techniques*. California: Brooks/Cole.

National Institute of Mental Health (NIMH). 2016. *Mental health medications*. Available at: <https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml> (Accessed 2018/11/01).

Newhill, C.E. & Mulvey, E.P. 2002. Emotional dysregulation: The key to a treatment approach for violent mentally ill individuals. *Clinical Social Work Journal*, 30(2): 157-171.

NGO Pulse. 2016. *South African Federation for Mental Health*. Available at: <http://www.ngopulse.org/organisation/south-african-federation-mental-health> (Accessed 2017/10/04).

Nhlapo, Z. 2018. Gauteng residents are increasingly stressed, statistics reveal. *Huffington Post*. 14 May 2018. Available at: https://www.huffingtonpost.co.za/2018/05/14/gauteng-residents-are-increasingly-stressed-statistics-reveal_a_23433954/ (Accessed 2018/09/21).

Okpataku, C.I., Kwanashie, H.O., Ejifor, J.I. & Olisah, V.O. 2015. Medication compliance behaviour in psychiatric out-patients with psychoactive substance use comorbidity in a Nigerian tertiary hospital. *Nigerian Journal of Clinical Practice*, 18(3): 371-376.

Passer, M., Smith, R., Holt, N., Brember, A., Sutherland, E. & Vliek, M. 2009. *Psychology: The science of mind and behaviour*. New York: McGraw-Hill.

Patel, V., Chisholm, D., Parikh, R., Charlson, F.J., Degenhardt, L., Dua, T., Ferrari, A.J., Hyman, S., Laxminarayan, R., Levin, C., Lund, C., Medina Mora, M.E., Peterson, I., Scott, J., Shidhaye, R., Vijayakumar, L., Thornicroft, G. & Whiteford, H. 2016. Addressing the burden of mental, neurological, and substance use disorders: Key messages from Disease Control Priorities, 3rd edition. *The Lancet*, 387(10028): 1672-1685.

Postmus, J.L. 2013. Qualitative interviewing. In Fortune, A.E., Reid, W.J. & Miller Jr, R.L. (Eds.). *Qualitative research in social work*. 2nd ed. New York: Columbia University Press.

Puntis, S.R., Rugkåsa, J. & Burns, T. 2016. The association between continuity of care and readmission to hospital in patients with severe psychosis. *Social Psychiatry and Psychiatric Epidemiology*, 51(12): 1633-1643.

Reamer, F.G. 2013. Ethics in qualitative research. In Fortune, A.E., Reid, W.J. & Miller Jr, R.L. (Eds.). *Qualitative research in social work*. 2nd ed. New York: Columbia University Press.

Reynolds, M. 2015. *5 steps for managing your emotional triggers: your guide to gaining emotional freedom*. Available at: <https://www.psychologytoday.com/us/blog/wander-woman/201507/5-steps-managing-your-emotional-triggers> (Accessed 2018/11/01).

Reynolds, J., Muston, R., Heller, T., Leach, J., McCormick, M., Wallcraft, J. & Walsh, M. (Eds.). *Mental Health Still Matters*. Hampshire: Palgrave Macmillan.

Rieke, K., McGeary, C., Schmid, K.K. & Watanabe-Galloway, S. 2015. Risk factors for inpatient psychiatric readmission: Are there gender differences? Available at: <http://link.springer.com/article/10.1007%2Fs10597-015-9921-1#/page-1> (Accessed 2016/03/17).

Rubin, A. & Babbie, E. 2010. *Essential research methods for social work*. 2nd ed. California: Brooks/Cole.

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

Schurink, W., Fouché, C.B. & De Vos, A.S. 2011. Qualitative data analysis and interpretation. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik.

Sengupta, P. [sa]. *Hospital readmissions*. Available at: www.hsi.gatech.edu/rebo/images/d/d7/Pramit_Hospital_Readmission.pptx (Accessed 2016/05/09).

Sfetcu, R., Musat, S., Haaramo, P., Ciutan, M., Scintee, G., Vladescu, C., Wahlbeck, K. & Katsching, H. 2011. Overview of post-discharge predictors for psychiatric re-hospitalisations: A systematic review of the literature. *BMC Psychiatry*, 17(1): 1-15.

Shenton, A.K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, 22(2004): 63-75.

Simon, M.K. & Goes, J. 2011. *What is phenomenological research?* Available at: <http://dissertationrecipes.com/wp-content/uploads/2011/04/Phenomenological-Research.pdf> (Accessed 2015/05/06).

Skeen, S., Kleintjes, S., Lund, C., Petersen, I., Bhana, A., Flischer, A.J. & The Mental Health and Poverty Research Consortium. 2010. Mental health is everybody's business: Roles for an intersectoral approach in South Africa. *International Review of Psychiatry*, 22(6): 611-623.

Slade, M. 2009. *100 ways to support recovery: A guide for mental health professionals*. London: Rethink.

Smith, R.C., Fortin, A.H., Dwamena, F. & Frankel, R.M. 2013. An evidence-based patient-centered method makes the biopsychosocial model scientific. *Patient Education and Counselling*, 91(3): 265-270.

South African College of Applied Psychology (SACAP). 2013. *Mental health in South Africa: Whose problem is it?* Available at: <http://www.sacap.edu.za/blog/counselling/mental-health-south-africa-whose-problem-counselling/> (Accessed 2017/08/27).

South African Depression and Anxiety Group. 2010. 6 million in SA may have PTSD. *Health24*. 05 October 2010. Available at: <https://www.health24.com/Mental-Health/News/6-million-in-SA-may-have-PTSD-20120721> (Accessed 2018/10/28).

South African Depression and Anxiety Group (SADAG). 2017. *Dealing with stigma in the SA workplace: Are we making progress?* Available at: http://www.sadag.org/index.php?option=com_content&view=article&id=2897:dealing-with-stigma-in-the-sa-workplace-are-we-making-progress-8-october-2017&catid=149&Itemid=226 (Accessed 2017/11/01).

Stein, D. 2014. A new mental health policy for South Africa. *South African Medical Journal*, 104(2): 115-116.

Strydom, H. 2011. Ethical aspects of research in the social sciences and human service professions. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delpont, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik.

Trochim, W.M.K. 2006. *Qualitative Validity*. Available at: <http://www.socialresearchmethods.net/kb/qualval.php> (Accessed 2016/06/01).

Tromp, B., Dolley, C., Laganparsad, M. & Govender, S. 2014. One in three South Africans suffer from mental illness – most won't get any help. *TimesLIVE*. 07 July 2014. Available at: <http://www.timeslive.co.za/local/2014/07/07/one-in-three-south-africans-suffer-from-mental-illness---most-won-t-get-any-help> (Accessed 2016/02/10).

Tzoneva, D. 2014. Psychiatric hospitalisation: Attending to mental crises. *Mental Health Matters*, 1(2): 47-50.

Uys, L.R. 2010. The history of mental health nursing. In Uys, L.R. & Middleton, L. (Eds.). *Mental health nursing: A South African perspective*. 5th ed. Cape Town: Juta and Company Ltd.

ValueOptions. 2006. *ValueOptions Provider Handbook*. Available at: http://www.valueoptions.com/providers/Handbook/Criteria/Inpatient_Services/2.201_Acute_Inpatient_Mental_Health_Adult.pdf (Accessed 2016/09/30).

Van der Merwe, M. 2015. *Psychiatry in distress: How far has South Africa progressed in supporting mental health?* Available at: <https://www.dailymaverick.co.za/article/2015-07-15-psychiatry-in-distress-how-far-has-south-africa-progressed-in-supporting-mental-health/#.WLad71WGPIU> (Accessed 2017/07/12).

Vigod, S.N., Kurdyak, P.A., Dennis, C., Lesczc. T., Taylor, V.H., Blumberger, D.M. & Seitz, D.P. 2013. Transitional interventions to reduce early psychiatric readmissions in adults: systematic review. *The British Journal of Psychiatry*, 202(1): 187-194.

World Health Organization (WHO). 2010. *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health gap action programme, Version 1.0*. Geneva: WHO Press.

World Health Organization (WHO). 2013. *Mental Health Action Plan 2013-2020*. Geneva: WHO Press.

World Health Organization (WHO). 2017. *Depression and other common mental disorders: global health estimates*. Geneva: WHO Press.

APPENDICES

Appendix A: Ethics approval



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

31 March 2017

Dear Ms Hosking

Project: The experience of readmitted mental health service users in a private inpatient treatment facility in Gauteng
Researcher: ME Hosking
Supervisor: Dr C Carbonatto
Department: Social Work and Criminology
Reference number: 11060515(GW20170331HS)

Thank you for the application that was submitted for ethical consideration.

I am pleased to inform you that the above application was **approved** by the **Research Ethics Committee** of 30 March 2017. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

Prof Maxi Schoeman
Deputy Dean: Postgraduate Studies and Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: tracey.andrew@up.ac.za

CC:
Supervisor(s): Dr C Carbonatto
HoD: Prof A Lombard

Research Ethics Committee Members: Prof MME Schoeman (Deputy Dean); Prof KL Harris; Dr L Bheki; Dr R Fassolt; Ms KT Goehner; Dr E Johnson; Dr C Panebianco; Dr C Puttergill; Dr D Rayburn; Prof GM Spias; Prof E Tsjard; Ms B Tsebe; Dr F van der Klauwer; Mr V Sibole

Appendix B: Permission from in-patient facility to conduct research

akeso

Akeso Clinics (Pty) Ltd
Tel: +27 (0) 11 447 0268
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24 3rd Avenue
Parktown North, 2193
PostNet Suite 6178
Private Bag X31
Saxonwold, 2132

Reg. No: 2006/021291/0707
Director: Alan Apteker, Alan Sweldan

08 November 2016

To whom it may concern

PERMISSION TO CONDUCT RESEARCH AT AKESO CLINICS

I hereby grant researcher Megan Hosking permission to conduct the research entitled "The experiences of readmitted mental health service users in a private inpatient treatment facility in Gauteng" at my institution – Akeso Clinics (Pty) Limited.

The researcher may make use of any of the clinic facilities in Gauteng to conduct the research.

Yours sincerely,



Sandy Lewis
Executive: Clinical Processes and Outcomes
Akeso Clinics (Pty) Ltd.
Email: sandy.l@akeso.co.za
Tel: 011 447 0268

Appendix C: Letter of informed consent

Researcher: Megan Hosking
Contact number: 079 804 9437

Participant's identification information: _____

INFORMED CONSENT

1. **Title of the study:** The experiences of readmitted mental health service users in a private inpatient treatment facility in Gauteng.
2. **Purpose of the study:** The purpose of this study is to explore and describe the experiences of readmitted service users in a private inpatient treatment facility in Gauteng.
3. **Procedures:** I expect to participate in an interview focusing on various aspects of my readmission experience, including my previous admission(s) and the period of time between my admissions. In addition, I will provide some details on my demographics. I expect it to take about 60 minutes of my time. It will be scheduled on a time convenient for me and be held in a venue where I can feel safe. This interview will be audio recorded.
4. **Risks and discomforts:** There are no known physical harms or risks associated with this study although I might experience some emotions while talking about my readmission experience. If I experience any form of stress I will inform the researcher and give her permission to ask the therapeutic team to follow-up with me for further assistance.
5. **Benefits:** I understand that there are no known direct benefits for me participating in this study. However, the findings of this study could be used to improve mental health services and services addressing readmission of mental health service users in private inpatient treatment facilities.
6. **Participant's rights:** I may withdraw from this study at any time without any consequence.
7. **Financial compensation:** I will receive no financial compensation from the researcher for my participation in this study.
8. **Confidentiality:** I understand that the data obtained will be kept confidential unless I ask that it be released. The findings of this study will be published in the researcher's research paper and/or professional journals and/or it may be presented at professional conferences. However, neither the data nor my identity will be revealed unless required by law.
9. **Queries:** If I have any questions or concerns I can call Megan Hosking at 079 804 9437.

I understand my rights as a research participant and I voluntarily consent to participate in this study. I understand what this study is about, as well as how and why it is being done.

I give permission for the interview to be audio recorded.

I am aware that the data will be stored for 15 years in the Department of Social Work and Criminology at the University of Pretoria.

Signature of participant

Date

Signature of researcher

Date

Appendix D: Interview schedule

INTERVIEW SCHEDULE

In conducting the interviews with the participants, the following primary question will be asked, followed by secondary questions if necessary, in order to achieve the objectives and goal of the study:

Primary question

Tell me about your experience of being a readmitted service user in a private inpatient treatment facility?

Secondary questions

1. Tell me about your previous admission?
2. What happened between that discharge, and your current admission?
3. What do you think contributed to your readmission?
4. How do you think your readmission could have been prevented or the time before it extended?
5. What are your views on, and feelings about, readmission in mental health?
6. Would you make any recommendations for other patients to prevent readmission?
7. How do you think that mental health services/private inpatient treatment facilities can help to prevent readmission?
8. What recommendations would you make for such services based on your experiences?

Appendix E: Confirmation of editing

Write Skills

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30 March 2019

To whom it may concern

DOCUMENT EDITING

This serves to confirm that a formal research report was submitted for the standard English language editing service, as follows:

- Editing date: March 2019
- Title:
- Length: 90 pages; 30501 words
- Author: Ms Megan Hosking
- Number of corrections made: 2440
- Note: The standard editing service was applied. The text correction work could not be completed, however the text required the substantive editing service. The author will attend to the remaining correction work.

Juliet

Member: J C Gillis BA (Eng, Comm, Psych), ~~Postgrad Dip~~ (Marketing), BA Hon (English)