The experiences of ex-offenders living with a mental disorder within three to twelve months following discharge from psychiatric prison care in Zimbabwe: A qualitative study

By

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Abstract

Background. There are significant challenges in many countries to effectively manage the service needs of prisoners with a mental disorder, and Zimbabwe is no exception. Ex-offenders from correctional psychiatric institutions face a range of social, economic and personal challenges once released, which often hampers their ability to live adaptive crime-free lifestyles. Although there is extensive literature on the experiences of offenders within the criminal justice system from high income countries, few studies have explored the experiences ex- offenders with a mental disorder in low income country prison and their mental health service needs and barriers to re-integration. This study addresses this gap.

Methods. Chikurubi Maximum Security Prison is the largest prison in Zimbabwe and house 17 000 prisoners. A dedicated psychiatric facility integrated in Chikurubi Maximum Security Prison is funded externally through Médecins Sans Frontières (MSF). Thirteen ex-offenders with a severe mental disorder who were discharged from Chikurubi Maximum Security Prison participated in the study. All participants were from Harare Metropolitan Province, discharged within a period of three to twelve months, were over eighteen (18) years of age, and provided informed consent. The research participants were interviewed using a qualitative interview schedule exploring the experiences and needs of ex-offenders living with a severe mental disorder, key drivers and barriers to community re-integration following discharge, and access to community mental health services. Interviews were transcribed verbatim and analysed using the framework approach to identify themes.

Results. Three main themes emerged from the analysis. The first highlighted how the prison infrastructure and environment negatively impacted on their mental health. This included dilapidated buildings, no running water, electricity shortages, poor ventilation in cells and overcrowding. The second focused on the perceived benefits of the comprehensive and integrated mental health services at Chikurubi Hospital. The third theme focused at the experiences and needs upon discharge from psychiatric prison care. Participants had mixed experiences of integration depending on the severity of the crime committed and whether they were integrated back into the same community where the crime was committed. Successful reintegration was challenging given the stigma and discrimination experienced as a result of committing a crime and having a mental health illness. The lack of community based mental health services providing recovery focused interventions was also highlighted as a challenge.

Discussion. Chikurubi Psychiatric Hospital provided comprehensive quality services through external funding. Participants experienced several challenges to re-integration including re-engaging in employment due to having a criminal record, stigma, and discrimination. Upon discharge, community mental health services focused primarily on clinical recovery in the form of the provision of medication. The availability of limited community mental health services focusing on personal recovery impacted on the mental health of the participants as they re-integrated into the community.

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Dedication

This work is dedicated to my late parents Maria Mtasa and Sylava Mhishi. It is hard not to remember you in such moments, with a wish in mind of course. To the late uncle Antony Mtasa, I am very much indebted to you for nurturing me and believing in my academic prowess; I am now striving for excellence as per your word. May your soul rest in eternal peace. To my wife Francisca and children Theophilus, Kudzaiishe, Mutsawashe and Mazvita thank you for your unwavering support and putting up with my absence when you needed me most; you kept me going.

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1.0 Introduction

There are significant challenges in many countries to effectively manage service needs of prisoners living with a mental disorder. Mental health services for prisoners with a mental disorder remain in dire shortage in most parts of the world due to high prison populations and inadequate resources (Beck & Maruschak, 2001; Dissel, 2008). Additionally, dedicated psychiatric prison units worldwide continue to be overwhelmed by the high demand for psychiatric services which are not always in tandem with available staff and resources (Wolff, 2005; World Health Organization, 2011).

There is evidence to suggest that the proportion of prisoners living with a mental disorder is much greater than among the general population. Mental disorder such as schizophrenia, bipolar disorders, major depression, psychosis and post-traumatic stress disorder are approximately two to four times more prevalent in prison populations as compared to the general population (Andreoli et al., 2014; Binswanger et al., 2011). It is also reported that in 2016, the prevalence of mental disorder in prison inmates globally was approximately between 11% - 17% for depression, anxiety and schizophrenia altogether (Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016; Krau, 2019). A literature review that included studies across 24 countries found that the pooled prevalence of major depression in prisoners was approximately 10 and 14% for males and females respectively (Fazel & Seewald, 2012).

Epidemiological studies on inmates in many African settings also reveal a high prevalence of mental disorders (Glaze & Bonczar, 2010; Sirdifield, 2012). For example, a study conducted in South Africa among 193 prisoners found that antisocial personality disorder (47%), substance use disorders (42%), depression (lifetime) (25%) and psychosis (lifetime) (7.3%) were prevalent (Naidoo & Mkize, 2012) whereas a study conducted in Nigeria, with 725 prisoners awaiting trial (remand prisoners) found that 56.6% met criteria for a mental disorder. The most common disorders reported were current depression (20.8%), alcohol dependence (20.6%), substance dependence (20.1%) and antisocial personality disorder (18%) (Abdulmalik, Adedokun, & Baiyewu, 2014). In Ethiopia, a number of studies have been conducted on the prevalence of mental disorders among prisoners (Dachew, Fekadu, Kisi,

Yigzaw, & Bisetegn, 2015; Dadi, Dachew, Kisi, Yigzaw, & Azale, 2016). The most recent study utilized a multistage random sampling method to explore the occurrence of mental disorders in three correctional centers (Dachew et al., 2015). Of the 727 prisoners recruited, 44% met criteria for current depression (Beyen, Dadi, Dachew, Muluneh, & Bisetegn, 2017).

In Zimbabwe, there is a gap in the available research on the prevalence of mental disorders among prisoners. However, it is widely believed to be as high as in other African countries (Naidoo & Mkize, 2012, Fory, Ashaba & Rukundo, 2019). The Ministry of Health and Child Care estimates that approximately 1,3 million people are living with a mental disorder in Zimbabwe (Ministry of Health and Child Care, 2015). Zimbabwe's public health delivery system is threatened by understaffing, as less than 30 registered psychologists and psychiatrists are expected to oversee the country's nine public mental health institutions. For a country with more than 14 million people, many Zimbabweans compete for services, and healthcare staff and medication remain in dire shortage in the country. Given the scarcity of available services for people living with a mental disorder in the country, this extends to prisoners and ex-offenders living with a mental disorder who may be experiencing additional challenges. Médecins Sans Frontières (MSF) or "Doctors without borders" (2015) suggest from their experience that in Zimbabwe, offenders with a mental disorder who have committed minor crimes are often sent to prison for longer periods than required particularly if their families cannot support them (Médecins Sans Frontières, 2015).

Apart from high prison populations which often are not accompanied by available resources, it is also reported that ex-offenders from correctional psychiatric institutions face a range of social, economic and personal challenges once released, which often hamper their ability to live adaptive crime-free lifestyles (Hopkin, Evans-Lacko, Forrester, Shaw, & Thornicroft, 2018). This is partly due to ex-prisoners remaining socially excluded (Burgess-Allen, Langlois, & Whittaker, 2006; Eshareturi, 2016). Additionally, research has shown that the transition from prison following incarceration may adversely affect the mental health of ex-offenders living with a mental disorder (Burgess-Allen et al., 2006; Eshareturi, 2016). Effective reintegration programmes for ex-offenders with a mental disorder from psychiatric prison care to community-based care might be considered as a prime opportunity to break the cycle of recidivism as well as socializing them back into society as productive citizens. Recidivism is defined as ex-offenders reverting to criminal activity and is generally measured by a prisoner being rearrested for a new offense (McDonald, 2003; McKean & Ransford, 2004). Re-entry

into prison is known to have a particularly adverse effect on all offenders and not merely for those with mental disorders (McKean & Ransford, 2004).

Although there is extensive literature on the experiences of offenders within the criminal justice system, few studies have explored the experiences ex- offenders with a mental disorder in a low-income country prison and their mental health service needs and barriers to re-integration. Unfortunately, the mental health service provided at Chikurubi psychiatric hospital were not sustained given that MSF project withdrawal in 2017. This has severe implications for prisoners with mental health problems at this hospital. Currently, we do not know what is being provided. This study addresses this gap.

1.1 Aim

The aim of the study is to explore the experiences of ex-offenders with a mental disorder within a period of three to twelve months following discharge from psychiatric prison care.

1.2 Specific Objectives

The objectives of the study are:

- To explore the perceived impact of the prison environment at Chikurubi Hospital on the mental health of ex-offenders living with a mental disorder.
- To explore the quality of mental health services provided at Chikurubi Hospital.
- To explore the experiences and needs of ex-offenders living with a mental disorder upon discharge from psychiatric prison care.

2.0 Literature Review

This section will begin by describing prison populations globally followed by a presentation of the available literature on the prevalence of mental disorder among prison inmates. It will then explore the factors impacting on the mental health of inmates including prison related factors. The mental health services available in prisons is explored in addition to recommendations for effective mental services. The importance of clinical and personal recovery and evidence-based treatments for people living with a mental disorder is highlighted. Finally, the available literature exploring reintegration ex-offenders with mental disorders into the community is discussed.

2.1 Prison Populations Worldwide

Prisons worldwide continue to be overwhelmed by high inmate populations (Wolff, 2005). It is reported that there are over 10 million inmates in prison globally at any particular time with more than 30 million circulating annually (Fazel, Hayes, Bartellas, Clerici, & R. Trestman, 2016). Twenty percent of the world's prison population are detained in only three countries namely the USA, China and the Federation of Russia (Byrne, Pattavina, & Taxman, 2015). However, prison populations continue to grow in all the five continents due to factors such as income inquality, poverty and poor economic development (Walmsley, 2015). An ever-increasing gap between the poor and the rich affect admissions by increasing crime rates among low income individuals thereby increasing chances of arrest and imprisonment. Additionally, poor economic development correlates with high numbers of imprisonment because of meagre economic opportunities. From 2015 to 2018, the worlds general population increased by 3.0 %, the known prison population globally increased by 386,500 (3.7 %) (Walmsley, 2015, 2016, 2018). Thus, the world prison population rate (prisoners per 100,000 of the general population) has remained quite stable, rising from 144 to 145 per 100 000.

Prison population figures range widely over world regions and across countries (Byrne et al., 2015; Walmsley, 2015, 2018). This is attributed to factors such as law enforcement, prosecutorial decision making, scale of prison admission, length of time served in prison and other means of social control in a society (Byrne et al., 2015; Walmsley, 2009, 2015, 2018). Law enforcement and prosecutorial decision making may increase or decrease prison population figures through decisions made at police charge offices and courts respectively. Prosecutors are the attorneys who represent the state in criminal cases and decide whether to

charge or not charge following arrest hence the scale of prison admission hinges on prosecutorial decision. Other factors like length of time served in prison makes prison population fluctuate between high and low owing to the rate of admission against discharge. In the Americas the most substantial changes in prison population rates have been in Nicaragua (rise of 61%) and Ecuador (rise of 37%) (Walmsley, 2018). Other large rises occurred in El Salvador (23%), Argentina (16%) and Peru (12%). A large fall in prison population rates (of 23%) was recorded in Mexico. In Asia the most substantial changes have been in Cambodia (rise of 68%), Philippines (rise of 48%) and Indonesia (rise of 45%). Other large rises occurred in Jordan (31%), Myanmar (28%), Bangladesh (23%), Saudi Arabia (22%) and Thailand (14%). Large falls were recorded in Kazakhstan (21%), Japan (15%) and Vietnam (11%) (Walmsley, 2018).

Walmsley (2018) also notes that in Europe the most substantial changes have been rises in Turkey (31%), Belarus (19%) and Italy (14%), and falls in Romania (22%), Ukraine (19%) and the Russian Federation (10%). Finally, in Oceania the prison population rate in Australia rose by 14%. (In the next largest country in Oceania, New Zealand, the rate rose by 10%. (Walmsley, 2015, 2018). In Iran, it is reported that the prison population increased from about 100 000 in 1993 to approximately 160 000 in the year 2002, with a rate of 229 inmates per 100 000 of the general population. The Iranian correctional system is reported to have several features in common with other low and middle-income countries (LMICs), such as inmate overcrowding and inadequacy of health care services. More recently, Walmsley (2018) reports that in Africa the most substantial changes have been in Egypt, where the prison population rate has risen by 53%, and Cote d'Ivoire (rise of 27%). Other large rises occurred in Nigeria (19%), Zambia (17%) and Uganda (12%). The Zimbabwean prison population currently stands at 19 521 presenting an incarceration rate of 120 per 100 000 which translate to 23, 5% (Walmsley, 2015, 2016).

The unprecedented increases and decreases in prison population rates discussed above in various countries is credited to progressively penal political climate contained by each country's criminal justice policy (Ryan, 2013). Relationships between prison population rate and incarceration, crime, sentence policies and several other variables influencing the growth or decrease of incarceration are complex though they change across time and place (Durlauf & Nagin, 2011).

2.2 The prevalence of mental disorders among prison populations

The global prevalence of mental disorders among inmates has been a topical issue since much of the available data is found in studies carried out in western countries. In a large scale systematic review of serious mental disorder among 23 000 inmates in European countries, it is reported that one in seven prisoners had either a psychotic illness or major depression (Fazel & Danesh, 2002). The pooled prevalence of psychosis was around 4%, with 10-12 % of prisoners having major depression and 40-70 % being diagnosed with a personality disorder (Fazel & Danesh, 2002).

Mental disorders among prisoners is widely viewed as an international challenge. Systematic reviews suggest that mental disorders are more prevalent in prison populations than the general population of the same country. Generally, the prevalence is thought to be between 5 and 10 % higher among prisoners than the general population (Sirdifield, 2012). For example, community surveys of mental disorders conducted in England and Wales have reported rates of severe mental disorders among women in the general population at approximately 5.8 % and 12% respectively, which is between three and five times lower than amongst prisoners (Singleton, Meltzer, Gatward, Coid, & Deasy, 1998). Similarly, the prevalence of psychosis in prisons is substantially higher than in the general population (Jenkins et al., 2005). Studies carried out in USA showed that, approximately 0.4% of the general population have probable functional psychosis (Meltzer & Okayli, 1995), compared to 7-14 % of the prison population (Singleton et al., 1998). Other epidemiological studies carried out in various countries in Europe have shown high prevalence of mental disorders in prisons (Baillargeon, Hoge, & Penn, 2010). It is estimated that approximately 16% of inmates have at least one disorder that requires treatment (Kopp et al., 2009). Rates of mental disorder including severe mental disorders such as schizophrenia/psychosis, major depression, bipolar disorder and posttraumatic stress disorder are approximately two to four times greater in the prison population as compared to general population (Binswanger et al., 2011).

Studies have also shown that gender differences exist among prison populations. In a study in Brazil among approximately 1800 prisoners found that lifetime and 12-month prevalence of any mental disorder was, respectively, 68.9% and 39.2% among women, and 56.1% and 22.1% among men (Andreoli et al., 2014). Lifetime and 12 month prevalence of anxious-phobic disorders was, respectively, 50% and 27.7% among women and 35.3% and 13.6% among men, of affective disorders was 40% and 21% among women and 20.8% and 9.9% among men, and of drug-related disorders was 25.2% and 1.6% among women and 26.5% and 1.3% among

men. For severe mental disorders (psychotic, bipolar disorders, and severe depression), the lifetime and 12-month prevalence rates were, respectively, 25.8% and 14.7% among women, and 12.3% and 6.3% among men (Andreoli et al., 2014). These differences were evident across all individual disorders with significant gender differences present for males as compared to women. The rates of these conditions are higher in women than men in the non-prison population due to factors like emotional advantages and disadvantages of marital status, employment status, number of children and parenthood (Riecher-Rossler, 2017).

In psychopathology; severe mental health disorder is believed to constitute mental and psychological problems that disturb the proper functioning of an individual (Comer, 2010). Other scholars believe that, severe mental health disorder is diagnosable mental, behavioural or emotional disorder that causes serious functional damage that greatly interferes with or limit one or more major life activities. There is limited literature on the prevalence of mental disorders in inmates in African or other LMIC countries. A systematic and meta-analysis on the prevalence of psychiatric disorders in LMICs exposed significantly higher rates of severe mental disorder and substance use disorders than in the general populations (Baranyi et al., 2019). For example, a study which aimed to determine the prevalence and sociodemographic correlates for mental disorder among inmates at Mukobeko Maximum Security Prison in Zambia revealed that 29.2% of prisoners had a mental disorder (Mweene & Siziya, 2016). In Lusaka Central prison 63.1% had mental disorder from a sample size of about 227 inmates (Nseluke & Siziya, 2011). LMICs have been understood to possess high prevalence rate of psychosis at 5.5%, which is higher than high-income countries (Mundt et al., 2013). However, this review of the seven penal institutions throughout Chile exposed methodological shortcomings, in the sense that studies were selective and carried in small samples hence making generalizability very difficult (Mundt et al., 2013). Furthermore, prevalence rates of prison population versus the general population haven't been systematically compared in Chile. The methodological shortcomings shows the big yawning gap on the need of sound studies on prevalence rates for mental disorders LMICs, hence the need for more researches.

The higher prevalence of mental disorders among prisoners has been attributed to several factors. This includes past traumatic events in a prisoner's life (S. Fazel et al., 2016), past associations with violent crime (Fazel, Gulati, Linsell, Geddes, & Grann, 2009), or the presence pre-existing mental disorders (Fazel et al., 2016). Additionally, those with a severe mental disorder may have a higher likelihood of imprisonment as some researchers have suggested that there is an association between mental disorder and criminal conduct given the higher

arrest rates of offenders with mental disorder particularly in the case of violent offending (Hodgins, Mednick, Brennan, Schulsinger, & Engberg, 1996; Kondrat, Rowe, & Sosinski, 2012; Large, Smith, & Nielssen, 2009).

It has been proposed that the relationship between mental disorders and violent offending is not a result of simply having a mental disorder itself but rather having a mental disorder with current symptoms (National Institute of Justice Research Preview, 1996 as cited in the Sentencing Project 2002). However other researchers have found no difference in offence rate of offenders with serious mental disorder versus offenders without mental disorder (Harris, Hek, & Condon, 2007). These discrepancies in findings could be due to methodological factors (Bonta, Law, & Hanson, 1998). Methodological factors like selecting the field site and acquiring access, sample selection and participants' recruitment usually have a bearing on findings. A systematic review and meta-analysis conducted by Large et al. (2009) found the number of homicides committed by individuals with schizophrenia to be comparable to homicides by those without a mental disorder in a geographic area. The authors suggested there appears to be a relationship between schizophrenia and homicide; however, they posited that the relationship does not appear to be causative and more likely due to social factors that influence violence in general, including substance abuse and low socio-economic status which may be disproportionately affect individuals with a mental disorder.

Whilst there have been several large surveys to establish the prevalence of mental disorders among prisoners (Brooke, Taylor, Gunn, & Maden, 1996; Fazel & Danesh, 2002; Singleton et al., 1998), there is less evidence regarding the impact of imprisonment on the course of mental disorders, although factors have been identified. There are a number of prison-related factors associated with mental disorders and with worsening of symptoms in this vulnerable population. Evidence on prison-related factors associated with mental disorders among inmates is described in the following section.

2.3 Factors associated with the mental health of prisoners

Whilst some prisoners enter the prison system with a pre-existing mental disorder, others develop symptoms while imprisoned and many with pre-existing mental health disorders experience deteriorations due to prevailing conditions in prisons. Many factors have been associated with the onset and deterioration of mental health problems of prisoners (Farrell et al., 2006). These include the prison environment itself, violence and victimization within

prisons, problematic substance use and the lack of available mental healthcare services. These factors are discussed below.

First, the prison setting with its procedures and systems, has been found to have damaging effects on the well-being of some inmates (Haney, 2003). In many settings, prisons are considered harsh environments where boredom, overcrowding, poor quality food, lack of enough blankets, spread of diseases such as TB and bullying are common (Fellner, 2006; Scott, 2004). Many prisons in Africa function against the background of severe infrastructural limitations, under prioritization of mental health services, poor prison conditions and poverty (Jefferson & Martin, 2016). Prisoners who are kept in African correctional institutions face a myriad of challenges ranging from many years of incarceration in often overcrowded and filthy rooms, inadequate food provisions, poor sanitation, little or no clothing and other services (Jefferson & Martin, 2016; Walmsley, 2003). It is also noted that these conditions differ across many facilities in the African continent (Jefferson & Martin, 2016). Additionally, African prisons are often thought to be influenced by corruption, unlawful violence and outsourcing of authority to influential prisoners (Jefferson & Martin, 2016).

Second, violence, torture and victimisation within prison have been shown to increase risk of mental disorders (Fazel et al., 2016). While violence is common among prisons inmates, little information is available on how often it occurs. Some studies have projected the rates of physical assault as 13 to 27 times higher than the rate in the general population (Blitz, Wolff, & Shi, 2008; Teplin, McClelland, Abram, & Weiner, 2005). Violence has been associated with gang activity, and is more common among larger prison populations were monitoring is very difficult due to large numbers of inmates (Campbell, French, & Gendreau, 2009). It is believed that some prisoner reform programmes which include punishment and ill treatment of inmates leads to some inmates being more prone to using force in order to resolve conflict. It has also been suggested that inmates may use violence to demonstrate toughness and earn respect from other prisoners (Edgar, O'Donnell, Martin, & Martin, 2003).

Third, there are higher rates of drug and alcohol misuse among prison populations (MacAskill et al., 2011; Montanari et al., 2014). In a systematic review and meta-analysis including 24 studies with 18 388 prisoners in 10 countries in Europe and USA, it is reported that the prevalence of alcohol abuse and dependence fluctuated from 18% to 30% and 10% to 24% in male and female prisoners respectively (Fazel, Yoon, & Hayes, 2017). The prevalence estimates of drug abuse and dependence in the same study varied from 10% to 48% in male

prisoners and 30 % to 60 % in female prisoners (Fazel et al., 2009). Another systematic review of studies assessing the frequency of drug and alcohol misuse, as well as addiction in prisoners, reflected substantial difference in the prevalence of substance use problems (Fazel et al., 2009). Recent research has demonstrated high rates of comorbidity between mental disorders and substance abuse (Butler, Indig, Allnutt, & Mamoon, 2011). This comorbidity has been found to worsen the prognosis of the individual and has been shown to increase repeat offending and premature mortality following release.

Finally, within prisons there is often a failure to provide treatment and care for those inmates living with mental disorders, compounded by the lack of, or poor access to mental health services for prisoners (Brinded, Simpson, Laidlaw, Fairley, & Malcolm, 2001; Jenkins et al., 2005). There is often a failure to identify mental disorders on prison entry as well as a failure to divert prisoners appropriately from the prison environment to hospital (Fazel, Khosla, Doll, & Geddes, 2008).

2.4 Mental health services in prisons

In discussing mental health services in prisons, it is pertinent to note the rationale or factors that led to the establishment of mental health services in some prisons in some countries. It has been noted that in the UK, primary care services were developed within prisons with the goal to improve health care provision in general that also included mental health care (Condon, Gill, & Harris, 2007; Harris et al., 2007). The same scenario exists in Norway and France where health care in correctional centers is overseen by a national public health department. It has also been reported that countries like Cyprus, Wales, Ireland and England have followed suit in merging mental health for prisoners with departments of public health (Goff, Rose, Rose, & Purves, 2007).

Despite the above inroads made in establishing treatment services, mental health delivery to prison inmates is challenging, and many prison inmates do not receive adequate mental healthcare (Baillargeon et al., 2010). Despite some prisons including mental health care services these are rare and in many cases services specifically designs for prisoners are absent. For example, in a study conducted among USA prisoners reported that only a quarter (25%) of prisoners with severe mental problems were receiving treatment (Wilper et al., 2009). In LMICs, the lack of resources for comprehensive prevention and treatment of inmates presents an added challenge and is likely linked to an even greater treatment gap. In Zimbabwe, there are only two major mental health institutions under the Zimbabwe prisons and correctional

service namely Mlondolozi at Khami Prisons and Chikurubi Psychiatric unit at Chikurubi Maximum Security Prison were mental health care services are offered. These two special institutions are gazetted in terms of the laws of the country (Dube, 2014).

Healthcare workers in prisons who provide services for inmates face a number of challenges. For example, balancing the individual's clinical needs with the need to maintain discipline and control (Becker & Drake, 2003). This may lead to ethical dilemmas for health care professionals whose instinct is to treat people as autonomous individuals capable and empowered to make choices about their lives, rather than as disempowered prisoners who must submit to the greater power of the institution itself (Norman & Parrish, 1999). Practicing in this context can complicate the development of interpersonal relationships. Even when prescribing medication, healthcare workers need to be aware that certain types of medication (eg. Benzodiazepines) can become currency in prisons (Ghodse, 2002; Johnston, 1987). Thus prison doctors have been described as being positioned in a triangular relationship with patients and prison facing pressure from each when making clinical decisions (Council of Europe. European Population Committee, 1998; Pollahne, 2013).

There is substantial evidence on the effectiveness and potential impact of the treatment of mental disorders in forensic psychiatric settings. The current interventions been implemented in developed countries especially in the USA and European countries have yielded positive outcomes through uptake of evidence-based interventions and prevention programmes (Herrman & Jané-Llopis, 2012; Jané-Llopis, Barry, Hosman, & Patel, 2005). Although a number of evidence-based treatments have been evaluated among prison inmates, very few randomized controlled trials have been conducted (Fazel et al., 2016). Researchers found that delivering quality health care to inmates is a multifaceted undertaking due to constraints such as the prison environment which is often viewed as anti-therapeutic and hampers the provision of effective treatment (Sarkin, 2008).

2.4.1 Recommendations for effective mental health care in prisons

The American Psychiatric Association (APA) has outlined guidelines for mental health service provision in prisons. First, the APA recommended treatment be varied in the approaches used and consistent with current mental health practices. Additionally, it is recommended that the following components be available: crisis intervention, acute care, outpatient treatment services and discharge or transfer planning (NIC, 2004). Researchers have identified six elements that should be in place for mental health treatment in prisons (Chaiken & Shull, 2007). These include a systematic programme for screening and evaluating inmates to identify those

who require mental health treatment; treatment which must entail more than inmate segregation; a sufficient number of trained mental health professionals to provide individualised treatment; maintenance of accurate and complete mental health records; supervision and periodic evaluation of prescription medications; and the ability to identify, treat and supervise inmates with suicidal tendencies (Chaiken & Shull, 2007).

In trying to address some of the problems like inmate overcrowding, some researchers have noted a need for specialised housing for offenders with a mental disorder. In a review of the use of mental health treatment units within correctional institutions it was found that many correctional facilities have developed specialized units within the facilities to cater for offenders with a mental disorder, though they are used temporarily just for stabilizing purposes (Fagan & Ax, 2003). However, there are often insufficient number of beds to house all offenders with mental disorder who are in need (Lovell, Allen, Johnson, & Jemelka, 2001). The lack of long term care units, often means inmates with serious mental disorder who cannot safely remain in the general prison population are placed in punitive institutions or settings such as isolation, segregation or in confinement which can cause further psychological distress (Lovell et al., 2001).

However, evidence does suggest that the segregation of inmates with mental disorders can be harmful and possibly cause more harm than good. Inmates in segregation have reduced access to other activities that are beneficial to holistic rehabilitation including, "social, recreational and vocational programmes" (Chaiken & Shull, 2007). The authors describe multiple levels of care that would improve the treatment of inmates with a mental disorder who are in segregated units including walk -in and in crisis intervention services. Others like case management services can assist in facilitating care and outpatient mental health treatment can assist inmates in dealing with adjustment and mood disorders (Abram & Teplin, 1991).

For those with more severe mental disorders and functional impairment, full day treatment services or programmes may be necessary to provide intensive interventions and inpatient acute care should be provided to inmates who are in danger to themselves or others, which can be provided outside of correctional facilities (Anthony, 1993). The use of interdisciplinary teams and behavioural incentive programs can be beneficial and have shown appropriate skill mix, supportive team climate, quality and outcomes of care (Chaiken & Shull, 2007; Israel, Schulz, Parker, & Becker, 1998).

The longstanding indifference of inmates with mental health conditions incarcerated in low and middle income countries (LMICs) is worrying. Researchers have proposed some recommendations for prison mental health in LMICs and these encompasses stronger global governance, clear national health mental policies that gives autonomy to health services and improved funding towards mental health budget (Jack, 2018).

2.5 Clinical and personal recovery

Diagnosis and psychiatric treatment focussed on clinical recovery is a necessary step in the treatment of mental disorders. Clinical recovery or the management of severe mental disorder and its symptoms primarily with the provision of medication is believed to facilitate recovery (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). There is ample research evidence that underscores the need for continuity of medication or people with severe mental health illness (Burns & Santos, 1995; Lave, Frank, Schulberg, & Kamlet, 1998). Adherence to prescribed mediation has been found to protect against relapse, and is a key predictor of recovery (Beck & Maruschak, 2001; Draine, Solomon, & Meyerson, 1994; Monahan et al., 2001; Ventura, Cassel, Jacoby, & Huang, 1998).

Although clinical recovery and the provision of medication is important, it is not sufficient to ensure the personal recovery of an indvidual. Personal recovery is the process of buliding a meaningful and satisfying life in a community of choice with or without the presence of mental health issues (Leamy et al., 2011; Slade, 2009). However there is no single definition to recovery because it differs according to individuals. Despite having variations in the definition, the key tenets of recovery for people living with severe mental illness are hope, willpower, discovery of meaning in life and being answerable for recovery (Nxumalo Ngubane, McAndrew, & Collier, 2019; Onken, Craig, Ridgway, Ralph, & Cook, 2007). For people living with severe mental health disorder, recovery should be incorporated into mental health care system from primary care settings in communities (Drake & Whitley, 2014).

According to review on recovery-oriented services (ROS) (Bejerholm & Roe, 2018), in addition to psychopharmacology, several interventions have been highlighted in the literature to facilitate personal recovery. Psychiatric rehabilitation includes numerous social, educational services and supportive community interventions to help inmates improve their functioning to greater levels of independence. These include: (i) Assertive Community Treatment (ACT), (ii) illness self management and recovery, (iii) integrated mental health and substance treatment, (iv) supported employment; and (v) family psychoeducation (Prins & Draper, 2009).

These evidence based interventions are considered to facilitate recovery following discharge from psychiatric prison care (Mueser, Bartels, Santos, Pratt, & Riera, 2012; Muntingh, 2005; Prins & Draper, 2009).

Assertive Community Treatment (ACT) is worth highlighting specifically as this model that has been used for several decades for facilaiting recovery among people living with severe mental illness in the community. It emphasises a long term wrap round approach that seeks to maximise continuity of care by concentrating all services within the interdisplinary team (Angell, Matthews, Barrenger, Watson, & Draine, 2014). A wrap round approach is when a team of professionals for example mental health workers and key figures in the persons life generate, implement and monitor a plan of support for people or individual with complex needs (Walker, Bruns, Conlan, & LaForce, 2011). ACT programmes generally consist of treatment teams that are made up of staff from different disciplines such as psychiatrists or psychiatric nurses, social workers, counselors and psychologists (Morrissey, Meyer, & Cuddeback, 2007a, 2007b). The teams provide assistance with psychotropic medications, mental health counselling, crisis intervention and support with living and social skills, housing and finances. ACT was originally desiged to be as intensive and lengthy as needed to meet the needs of (non-offending) individuals with severe mental disorder and assist in the community intergration and avoid frequent hospitalisations. ACT has been cited as a best practice in working with individuals with serious severe mental health disorder. However, after significant proliferation of both national and international ACT programmes, fidelity to the original model suffered and led to decreased effectiveness of the programmes (Morrissey et al., 2007a, 2007b)

One of the other major facilitators of recovery for people living with a severe mental disorder particulary in LMICs highlighted in the literature is the role of family (Gopal, Mohan, John, & Raghavan, 2020). Family may provide warmth, belonging and emotional support to people living with severe mental health disorder hence its essential. Research suggests that recovery requires long-term relational and emotional support provided by family and friends (de Wet, Swartz, & Chiliza, 2015; Gopal et al., 2020; Piat, Sabetti, Fleury, Boyer, & Lesage, 2011). Given the limited availability of mental health resources in LMICs, families carry the bulk of caregiving responbilities impacting on the recovery of their relative living with a severe mental disorder (Mall et al., 2017).

2.6 The reintegration ex-offenders with mental disorders into the community

A few studies have investigated the reintegration of ex-offenders into the community. Studies have been conducted in South Africa (Chanakira, 2013) and Kenya (Papa, 2015) respectively. The studies explored the experiences of adult ex-offenders when reintegrating into mainstream society as well as factors influencing rehabilitation programmes performance and recidivism of male inmates (Chanakira, 2013; Papa, 2015). The study conducted in South Africa had 15 ex- offenders and 5 key informants having knowledge on offender rehabilitation and reintegration participated in the study. Using thematic analysis a number of key themes emerged from the data including: poor psychosocial support from family and community, lack of employment opportunities due to criminal record, poor self-esteem and stagnation in life due to long period of time in prison, difficulties in adjusting to new environment following discharge and lack of proper after care services (Chikadzi, 2017). The study also found that ex-offenders battle to adjust because of fragmented domestic systems and poor public relations, unemployment and lack of effective after care services (Chikadzi, 2017).

Another study was done in Kenya with 130 participants on determinants influencing rehabilitation programmes perfomance reported that the efficacy of rehabilitation programes on recidivism. The key issues reported from the study centered around spiritual,religious trainings and social welfare programmes, positive psychosocial support from relatives, level of education, skills training and envionmental factors (Papa, 2015). Spiritual, religious trainings and social welfare programmes were said to be influential in correcting prisoners behaviour to become law abiding citizens. In addtion to that positive psychosocial support from relatives whilst inside the prison prepared prisoners pathway on discharge because they were warmly received following dischage. The study also found that lack of enough resources affected rehabilitation programmes as high rates of recidivism were recorded.

The available research suggests that effective post release care plays a pivotal role in reducing recidivism and facilitating community reintegration for ex-offenders living with a mental disorder (Chin & Dandurand, 2012). Strategies include proper discharge planning to support an individual discharged from a psychiatric facility who has severe mental disorder in order to preserve the gains attained throughout the sequence of management that clients have had in the inpatient psychiatric care (Alghzawi, 2012). This planning should include identifying psychosocial support networks which is an essential component in the community upkeep of ex- offenders with severe mental disorder (Alghzawi, 2012). The benefits of discharge planning

for ex- offenders with severe mental illnes may include connecting clients to suitable subsequent resources based on their needs in a way which reduces relapse and homelessness. Against this background, reintegration of ex-offenders with mental disorder from psychiatric prison care to community should be considered a prime opportunity to break the cycle of recidivism.

In their review on programmes that improve outcomes for offenders with mental disorder to facilitate re-integration into the community, Prins and Draper (2009) noted the dearth of studies investigating effective strategies for this group. They described the characteristics of treatment programmes and interventions that have been found to be effective in reducing recidivism of non mentally ill prisoners. These programs and interventions generally included the following elements; focus on dynamic criminogenic needs, use of cognitive behavioural programmes and drug treatment programmes (Prins & Draper, 2009). However research into the efficacy of practices and programmes in reducing recidivism of offenders with mental disorder has not been advanced in the same fashion. Prins and Draper (2009) also reported some evidence based programmes and interventions that improve the mental health outcomes of individuals with serious mental health illnesses. While little evidence exists regarding specific programmes, there are some aspects of post-release care for this group that show some benefit.

In providing effective post release care, it is vital to consider individual differences in needs and challenges to facilitate an effective response to ex-offenders with a mental disorder returning to the community from prison; reintergration investments should be applied to reflect these differences (Wolff, 2005).

2.7 Barriers and facilitators to effective community reintegration of ex-offenders living with a severe mental disorder

Studies have shown that, community re-entry from prison is known to be an especially vulnerable transition of all offenders not merely those with mental disorders (Angell et al., 2014). As a result, the transition from prison to community poses a great risk for the ex-offenders' health and safety. Many ex-offenders turn to shelters and settle in environments with poor sanitation compounding their health risk (Council, 2011). For ex-offenders with a mental disorder who are poorly connected to mental health service providers following the transition, the risk of suicide, reoffending and re-hospitalization can be much higher than their counterparts without mental disorder (Angell et al., 2014).

Ex-offenders with a mental disorder are likely to experience countless problems in gaining access to services than any other groups and are one of the most socially omitted groups within the society as they experience greater stigma and discrimination (Binswanger et al., 2011; Fazel et al., 2016). This results in psychological, structural and cultural barriers to early identification of mental health needs and appropriate intervention (Walsh, Scaife, Notley, Dodsworth, & Schofield, 2011). Research suggests that understanding earlier life experiences of social exclusion is important in this population (Hopkin et al., 2018). Poor psychosocial support from caregivers coupled with delays in identifying mental health problems for ex-offenders with a mental disorder means that they are often not diverted into more appropriate mental health provision and support, leading to relapse and recidivism.

Low educational attainment is a major barrier to employment for many ex-offenders. Education gives individuals basic skills to enter the job market (McKean & Ransford, 2004). It also develops a sense of self efficacy and accomplishment for ex-offenders. The effects of education makes it fundamental tool for reducing recidivism. Educational programmes are among the basic rehabilitative programmes that a prison can offer. Most prisons have less educational programs ranging from course work to vocational training (Bozick, Steele, Davis & Turner, 2018). This makes it difficult to reduce recidivism in prison.

A number of facilitators to the community reintegration of ex-offenders have been highlighted in the literature. First, rehabilitation programmes coupled with pharmacotherapy offered for offenders and ex-offenders with a mental disorder provide opportunities for this group to change their behaviours associated with criminal activities and can lead to more positive and productive lifestyles. Success of rehabilitation programmes can be translated into improvements in public safety and successful reintegration of ex-offenders into their families, community, schools, religious organisations and even labour force (Dissel, 2008). However due to budgetary constraints in the criminal justice system, most programs are discontinued altogether thereby exposing the offenders and ex-offenders to high chances of reoffending following discharge (Binswanger et al., 2011). A range of programs inside and outside are necessary to prepare offenders for release, to make referrals, provision of services when they return to community and offer support to them in their efforts to retain and find employment and attain self-sufficiency. This coordinated approach geared towards building and supporting self-sufficiency is necessary in reducing the likelihood of ex-offenders becoming involved in criminal activity.

It has been suggested that work programs should be administered whilst inmates or offenders are still in prisons to equip them with essential skills to increase their employability upon discharge. In the USA work programmes are implemented for a variety of reasons that is earning revenue for the prison, occupying and pacifying inmates (Roman & Travis, 2006; Solomon, 2004). In Zimbabwe, offenders with mental health disorders are excluded from general programmes for all prisoners as this group is thought not to be capable enough to perform any task (Médecins Sans Frontières, 2015).

Without income ex-offenders are likely to turn to crime for economic support and wellbeing. However, employment is essential for many reasons beyond the basic need of income as it provides stabilizing routine, occupies time and keeps individuals responsive to employers' needs or demands always. Being incarcerated is associated with stigmatization and it comes with increased reluctance among employers to hire ex-offenders worse with mental disorder. In a study on delinquency and stigmatization done in 1971, it was found that employers turned down employment opportunities to job applications containing information about conviction status to the job applicants with past convictions (Buikhuisen & Dijksterhuis, 1971). Most offenders leave prison without savings, no immediate entitlement to employment prospects disposing them to broader economic implications. In Zimbabwe, a clean criminal record and medical examination is required for employment in the public sector thus to employ ex-offenders with a mental disorder or even those without this condition following discharge is very difficult to do so (highest form of stigma and discrimination). Yet, ex-offenders need employment to attain self- sufficiency and be better able to avoid involvement in criminal activity.

Time in prison is time away from workforce were valuable skills and experience can be obtained (Abadinsky & Abidinsky, 1987; Butterfield, 2004). In Zimbabwe many prisoners do not have access to work opportunities whilst in prison as they are feared to escape from lawful custody and this is worse for offenders with a mental disorder. Studies conducted in USA have shown that job training and placement plays a significant role in reducing recidivism after discharge from prison because most ex-offenders will have been empowered with various skills and will automatically be employed in various sectors of industry by occupying themselves as well as having income to sustain themselves (Bushway & Apel, 2012). Success for employment programs that places ex-offenders into jobs as soon as they leave prison is often dependent on the prison developing strong relationships with employers who will be willing to hire ex-offenders with both mental disorder and criminal backgrounds (Bushway & Apel, 2012).

Follow up employment services with released inmates increases the chances of potential employers to be more comfortable in hiring people with criminal records (Cooke, 2004). In Zimbabwe there are no such programmes, hence there might be a need to have a comprehensive employment programmes for ex-offenders post discharge.

2.7.1 Implications on poor community reintegration

In studies carried out in the USA, investigators found that two thirds of released inmates are re-incarcerated within three years (Fazel et al., 2016). High rates of recidivism result in tremendous costs both in public safety and tax payers' money, which is spent on arresting, prosecuting and incarcerating re-offenders (Baillargeon et al., 2010). Additionally, high rates of recidivism lead to devastating social costs to the communities, families of offenders and personal costs to offenders themselves (Morenoff & Harding, 2014).

Rates of recidivism reflect the degree to which released offenders have been rehabilitated and the role of correctional facilities in reintegrating offenders back into the society (McKean & Ransford, 2004; Morenoff & Harding, 2014). Mental disorders often occurs in conjunction with substance abuse which compounds the barriers to employment and reintegration into society faced by ex-offenders (Gunnison & Helfgott, 2011). Both these conditions are directly related to recidivism. Therefore, although rehabilitation and therapeutic programmes in correctional facilities yield desirable social outcomes in that they educate, treat prisoners or assist in recovery from severe mental disorders and substance abuse, another potential important benefit of the programmes initiated whilst in prison or psychiatric prison care is the reduction of recidivism.

2.8 The study's contribution to new knowledge

The study contributes to mental health research and practice in a number of ways. First; in most developing countries (resource poor countries like Zimbabwe, Kenya, Malawi and Tanzania), mental health care services have been initiated and remain underdeveloped (World Health Organization, 2011). Coupled with this, not much is known about access to mental health services by ex-offenders with a mental disorder. Secondly, epidemiological studies conducted among prisoners in many African countries have shown a high prevalence of mental disorders and the degree of severe mental disorders is assumed to be five to ten times higher among prisoners as compared to general population (Andreoli et al., 2014; Beyen et al., 2017; Glaze & Bonczar, 2010; Sirdifield, 2012). The study expands on the available literature by exploring the perceived impact of the prison environment at Chikurubi Hospital on the mental

health of ex-offenders with a mental disorder, exploring the quality of mental health services provided at Chikurubi Hospital and exploring the experiences and needs of ex-offenders living with a mental disorder upon discharge from psychiatric prison care.

3.0 Methods

3.1 Introduction

This section describes the study's research design, setting, population, inclusion and exclusion criteria, study procedure, analysis strategy and ethical considerations.

3.2 Research Design and Sample Selection

This study was an exploratory case study, making use of key informant semi-structured interviews. A non-probability, purposive sampling technique was used to select participants to include in the sample. Non-probability sampling suggests that not all elements of the population has a chance to be incorporated in the sample (Creswell & Creswell, 2017; Creswell, Plano Clark, Gutmann, & Hanson, 2003). Purposive sampling, also known as selective or judgmental sampling technique, involves choosing a sample that appropriately addresses the information needs of the study. These techniques were used because the study focused on the lived experiences of ex-offenders with a mental health disorders post discharge. The vulnerable population made it most appropriate to use these techniques due to limited number of primary data sources for the study. Finally, the sampling methods are the most cost-effective and time-effective methods for this group of population.

3.3 Setting

The study was carried out in Harare metropolitan province. The city of Harare is situated in the north-eastern part of Zimbabwe, and has an estimated population of between 1 606 000 and 2 800 000 in its metropolitan area. It is the capital city of Zimbabwe with more than 15 suburbs.

Chikurubi Maximum Security Prison is the largest prison and correctional facility in Zimbabwe and is located on the outskirts of Harare (about 18 km from Harare). It houses about 17000 male and female prisoners. The psychiatric wing in the prison has a population of approximately 300 offenders with a mental disorder undergoing pharmacological treatment as well as psychotherapy. Ideally, offenders are admitted into psychiatric care after undergoing a mental health assessment that is executed by qualified personnel as part of the entrance process. Prisoners with a mental disorder who are discharged from the psychiatric wing upon serving their sentences return to their various communities in and around Harare where their caregivers

are expected to monitor them. There are no monitoring and evaluation teams that follow up with these ex-offenders.

Médecins Sans Frontières, (MSF) in Zimbabwe provides mental health diagnostic and treatment services to prisoners at Chikurubi psychiatric hospital supported by psychiatrists, clinical psychologists, occupational therapists, nurses and clinical social workers (Médecins Sans Frontières, 2015). MSF has also trained mental health service providers, health workers, prison officers from the general duties section, and prison administrators on mental health issues and the management of prisoners with mental disorder (Médecins Sans Frontières, 2015). The training aimed to enhance staff members' understanding of mental disorders and of human rights issues relevant for prisoners, educate staff members on stigmatizing approaches practiced in the prison services and encourage the advancement of mental health services for both inmates and prison staff (Médecins Sans Frontières, 2015). The superintendent of the psychiatric wing reported that through this training, the prison health workers acquired more specialised skills in identifying and managing mental disorders, and this made a positive impact within the prison community, particularly on changing lives of the inmates within the prison institution for better. There was also improvement of psychotropic medication availability and positive psychosocial support for the treatment of mental disorders (Personal communication with the Superintendent of the institution)

3.4 Participants

Participants were ex-offenders with a severe mental disorder who were discharged within a period of three to twelve months prior to the study from psychiatric prison care at Chikurubi Maximum Security Prison and released into the community. All ex-offenders were over eighteen years of age and they participated in the study willingly and provided informed consent. Only those based in Harare Metropolitan Province were included.

3.4.1 Inclusion criteria

- ❖ Ex-offenders with any type of severe mental disorder who were released from psychiatric prison care within a period of three to twelve months following discharge.
- ❖ Ex-offender with a severe mental disorder regardless of type of offence and length of stay in psychiatric prison care.
- ❖ Ex-offenders who are eighteen years or older.
- ❖ Ex-offenders who were willing to provide informed consent.

3.4.2 Exclusion criteria

- Participants who were in visible distress or experiencing an episode of psychosis.
- Participants who were younger than 18 years.
- Participants who did not have the capacity to provide informed consent.

3.5 Participant recruitment

Participants were identified using client data at the Chikurubi psychiatric hospital. The researcher was assisted by the social workers employed at the psychiatric hospital. Due to factors of expense and time to conduct data collection interviews, a list of ex-offenders who had been discharged in the past three to twelve months was created. Those ex-offender patients under eighteen years were removed from the list. The social workers who had previous interaction with the discharged patients and their caregivers contacted the individuals identified on the list. The social workers obtained verbal permission for the researcher and his team to contact the patient directly. A snowballing technique was then used where some of the research informants willingly referred or recommended ex-offenders for inclusion in the present study. Sampling continued until data saturation.

3.6 Study Procedure

In this study, two research assistants were recruited to assist the researcher. The research assistants were qualified health care workers. Research assistants received training on the research questions, how to conduct key informant interviews, data collection, and management of data. The researcher and his two research assistants contacted the potential participants by phone to determine willingness to participate in the study. An agreed time, date and location where the interviews were to take place was negotiated. The interviews took place in community facilities.

Following greetings, introductions and establishment of rapport, the researcher explained the purpose of the study in full to the participants, along with potential risks of the study and their rights as research participants. Potential participants were given an information sheet which explained the aim of the study, how data is collected, used and what mechanisms were put in place to ensure their anonymity, privacy and confidentiality. Participants were given the opportunity to carefully review the written agreement form and ask questions regarding the study prior to signing. Participants who were unable to sign their name, marked the space with an “X” and a witness co-signed on their behalf. A witness was included to ensure that all the

information within the consent form had been explained to the participant. Participants' right to participate or to withdraw from the study without fear of repercussions was respected.

An explanation and demonstration of the use of the audio recorder was also given and consent was obtained (see Appendix A). At least two hours were allocated per interview, in order to assess comfort and willingness to participate, and allow for questions and answers. The researcher was the questioner and he collected all the data though he was always accompanied by his research assistants for safety purposes. The researcher anticipated danger from the participants hence being accompanied always by the assistants though nothing sinister happened though out the process of data collection. The interview itself did not take more than one hour. Participants were interviewed using an interview schedule (see Appendix B and C) which inquired about their experiences, challenges and needs upon discharge from psychiatric prison care, key drivers and barriers to community re-integration following discharge from psychiatric prison care and access to mental health services available to them in the community. All interviews were tape-recorded with participants' permission and were carried out in Shona or English as preferred by the participants. Participants were asked to choose a name other than their own to protect their identity. The interviews were audio recorded and the questioner took notes. Participants received a snack box to the value of USD$5.

3.7 Data analysis

Interviews were translated from Shona to English and then transcribed verbatim. Qualitative data were analysed utilizing a framework approach. The framework approach is suitable in identifying commonalities and differences in qualitative data before concentrating on relationships among different parts of the data. The approach involves five key stages (Pope et al., 2000). The stages comprise of (1) Familiarisation – where the researcher reads the data to gain a thorough understanding of and engage with the data set; (2) Coding – a methodical procedure of classifying and cataloguing applicable features of data in relation to the research question; (3) Indexing – the data that materialises are indexed and used to create thematic matrix which in turn is labelled and numbered; (4) Charting – diverse themes are organised into charts where by each participants answer is prearranged beneath correct graphic representation; and (5) Mapping and interpretation- creating connections with data in order to produce a wider understanding of data. To ensure validity of the categories, a second researcher coded the interviews independently. Both coders met regularly to review the codes for

consensus. To facilitate analysis of data, the qualitative analysis computer software NVivo 11 was utilised.

3.8 Ethical considerations

Ethical approval was granted by the University of Cape Town Human Research Ethics Committee (HREC) in South Africa. The Joint Research Ethics Committee for University of Zimbabwe College of Health Sciences and Parirenyatwa Group of hospitals (JREC) and Medical Research Council of Zimbabwe (MRCZ) approved the use of client's records at the psychiatric hospital and conducting the study, as well as the institutional head of Zimbabwe Prisons and Correctional Service, the Commissioner General. This was confirmed by letters of permission from the ethical committees to conduct the study. Written as well as verbal consent statements was sought from the participants.

The ethical principles of autonomy, maleficence, justice and beneficence guided the research. As most of the participants were suffering from severe mental disorder, they were considered vulnerable group by virtue of their condition and were treated with particular sensitivity around the provision of information and voluntary consent to participate in the study. All costs related to the research was the responsibility of the researcher and participants were not inconvenienced in any way.

3.8.1 Privacy and Confidentiality

Initial communication with ex-offenders with a mental disorder was done by social workers, who work at Chikurubi psychiatric hospital. These social workers were the point of communication and introduction of the research officer to potential participants. Once they had introduced potential participants to the researcher, there was no further involvement and they did not know who consented and who was chosen to do the interviews.

Privacy and confidentiality of participants was ensured in the following ways: by conducting interviews in secluded space with only the most necessary people present; by not discussing them with any person besides the professional staff directly involved with their mental healthcare if the need arose; by assigning each participant with a unique identifier to link the study information to consent forms, and by using pseudonyms in research reports and in the dissemination of findings. The consent forms included information regarding compulsory disclosure if the researcher observed or the participant disclosed physical or sexual abuse of themselves or others.

3.8.2 Storage of study records

The audio data was stored electronically on a password protected hard drive that, only the researchers have access to. Consent forms were stored in a locked cupboard. Data will be kept for five years, after which it will be destroyed. Apart from consent forms, dataset did not contain participants' names or any identifying information

3.8.3 Potential risks and discomfort

The risks involved in the present study were thought to be minimal. Some of the questions may have been sensitive or upsetting, and participants may have felt uncomfortable answering these, or may have been reluctant to share their feelings with the researcher. Risk of fatigue during data collection was minimised by offering breaks and refreshments to participants. For the participants who showed signs of mental or emotional distress or discomfort during the interview; the interview was immediately stopped. Amongst the participants interviewed, three referrals were made to the nearest health center for further management of their conditions because of their underlying condition that was not being managed optimally.

3.8.4 Potential benefits of the study

Through their involvement, the participants helped the researchers learn how they view recovery and how this in turn can inform future recovery focused interventions. Since the research was aimed at inquiring about experiences, challenges and needs of ex-offenders with severe mental disorders upon discharge from psychiatric prison care, key drivers and barriers to community re-integration of ex-offenders with a mental disorder following discharge from psychiatric prison care and access to mental health services available in the community were explored. The researcher aims to meet ethical principle of justice by ensuring that the study findings will be disseminated to policy planners and service providers. By conducting this study, the researcher had a responsibility to share the findings with stakeholders' health and other sectors.

4.0 Results

Results are presented according to the three major themes that emerged from interviews with participants namely: 1) The prison environment at Chikurubi Hospital; 2) Mental health services at Chikurubi Hospital and 3) The experiences and needs upon discharge from psychiatric prison care.

4.1 Socio-Demographic Characteristics of Participants

In total thirteen participants took part in the study, of which twelve were male and one female. Participants were aged between twenty-one years and forty-five years with a mean age of 29.7 (SD= 6, 9). Six (46%) indicated that they had attained the Zimbabwe Junior Certificate (nine years of learning) whilst five (38%) had a Zimbabwe General Certificate of Education at Ordinary Level (eleven years of learning). Only one participant had advanced level (thirteen years of learning) and one had tertiary education. Participants had various types of a mental disorders and the participants' diagnosis was based on clinical records from the hospital. Amongst the participants studied five participants had a diagnosis of schizophrenia, three participants were detected of bi-polar, three participants presented substance induced psychosis and two participants had a diagnosis of temporary lobe epilepsy.

4.2 Theme 1: The prison environment at Chikurubi Hospital

For many respondents, the prison environment itself emerged as a contributor to mental health status. Participants reported that they believed the prison environment negatively impacted on their mental health whilst inside Chikurubi Hospital. Many participants described their experience as "not easy" and "very difficult to adjust to the prison environment". Reports of dilapidated buildings, no running water, electricity shortages and poor ventilation were common experiences among inmates at Chikurubi Hospital. This was expressed through the following quotes:

> *"…There was no running water, buildings were old with poor aeration circulating in the yard so as cells. Power cuts were the order of the day"* (P2)

> *"…The prison psychiatric hospital had no running tap water and poor ventilation in cells"* (P12)

Another feature of prison life highlighted by most participants was the quality of food provided. The majority of participants reported displeasure with the type of food that they were eating. For instance, lack of meat in prison was described as an issue for some, while others spoke

about the lack of flavor of the prison food as well as food being poorly cooked. Participants described the food as being very different to the meals they were used to in their homes as one participant reflected:

> *"…It was a difficult period being inside the psychiatric hospital since it was my first time, worse being in psychiatric hospital inside prison looking at the type of food we were eating differed very much from what I was used to home as it wasn't properly cooked most of the time." (P4)*

Many described the food as unhealthy and one participant reflected on the need to be eating healthy food, given they were also taking psychiatric medication:

> *"… We need wholesome meals because tablets need wholesome meals."* (P7)

In addition to the food, participants also expressed their dissatisfaction with the prison issued uniforms. Some described the fabric as uncomfortable, whilst others disliked the color. Many stated they would have preferred to wear their own regular clothes. Participants had a lot of misgivings towards the uniform they were given whilst in psychiatric prison care impacting on their mental health:

> *"It was difficult time for me being inside the prison hospital, the living conditions and putting on their uniforms. It wasn't easy I felt uncomfortable in prison uniform worse the colour made me feel low always, since I had committed offence I had no option." P 5*

Another issue impacting on the mental health of the participants was complaints of overcrowding of the prison. Many participants described how the high numbers of inmates in the institution impacted significantly on sleeping quality as there were not only too many inmates in one cell, but some slept on the floor during their entire sentence as one participant reflected:

> "*There are no beds and so we had to sleep on mats spread out over the crowded cell floor"* (P5)

The one aspect of prison that was conducive to promoting the mental health of inmates was emphasis on individual responsibility and self-care. Participants highlighted the usefulness of health promotion in improving their health care. Whilst in prison hospital, staff put much

emphasis on activities of daily living (ADLs) such as brushing teeth, bathing, washing their uniforms just to mention a few. In addition, the inmates were provided with basic amenities such as reflected by this participant:

> *"…In prison we were treated well and we were even taught to be responsible that is to clean where we would have eaten, where we sleep we would fold our blankets and sweep and also check if we had bathed on a daily basis. Sometimes we got soap from the prison and those who visited us thus getting more time to bath. Hence we got good treatment."* (P1)

Activities of daily living were conducive to good health as they were a key indicator in assessing level of care. Taken together, the food, the uniforms and the overcrowding of the prison itself was not necessarily conducive to supporting the mental health of any individual, regardless of whether they were receiving psychiatric care:

> *"…This hospital in prison is like a prison setup so as the first time to be admitted there I found it very difficult to adjust to the environment because of larger prison populations in the institution and higher security levels of the institution or proportion of high security offenders with a mental illness. In my opinion, there is nothing which can stop mental disorders to develop as a consequence of prevailing conditions. Those are some of the things I encountered."* (P9)

The unpleasant various prison conditions mentioned above created serious psychological risks for inmates with mental illness. These conditions seemed to have negative effects on mental health of inmates. For instance, it is well known that eating a balanced diet is of vital importance for maintaining good health and wellbeing hence provision of poor nutrition or bad food reduced social pleasures of life and active life. Other issues associated with poor nutrition include tooth decay, high blood pressure, cancer, obesity and other chronic diseases. Uncomfortable clothing brought loss of individuality and freedom of expression to inmates. Clothing is observed as an implicit element of punishment and stigma while the level of psychological distress and embarrassment caused by the dressing is in large part determined by the distinctive and overall design.

4.3 Theme 2: Mental health services at Chikurubi Hospital

The experiences of ex-offenders regarding the mental health services available while inside the prison environment were explored. Participants underlined benefiting from various services and programmes as it relates to the following sub themes: (1) Multidisciplinary team that provides comprehensive package of mental health services for outgoing prisoners; (2) Peer support and sharing (3) Psychoeducation; (4) Availability and monitoring medication; and (5) Rehabilitation Programmes.

4.3.1 Multidisciplinary team providing comprehensive mental health services

Most participants described receiving a comprehensive package of mental health services from a diverse multidisciplinary team which encompassed psychiatric doctors, psychiatric nurses, psychologists, social workers and occupational therapists. These professionals educated the inmates on their mental disorder more generally, the reason why they should take their medication and how to continue adhering to it when discharged from hospital. Participants received comprehensive services from multiple health professionals:

> *"…I was treated [for my] mental illness at Chikurubi Psychiatric hospital. The psychiatric doctors, psychiatric nurses, social workers and psychologists helped me a lot through treatment, psychotherapy and counselling."* (P13)

> *"…The team of nurses, psychologists, social workers, doctors and occupational therapists treated me well at Chikurubi psychiatric hospital."* (P5)

Participants spoke positively about their relationships with health professionals allowing open sharing of concerns. Given the rapport and trusted relationships, participants responded well to the psychosocial support and described how they benefitted from counselling sessions by mental health personnel at Chikurubi. Counselling and psychotherapy was instrumental in their treatment:

> *"…The mental health team at Chikurubi psychiatric helped me a lot to understand mental illness and live a normal life with the condition as they openly talked about mental illness with us whilst in the institution. I now understand that*

I have a mental health condition and it's just like any other condition like TB,HIV/AIDS, Diabetes, Cancer and it does not stop me from marrying, living a normal life or performing any other duty as long as I stick to my medication" (P11)

The hospital provided rare space of social support that is understating their condition and support of ideal behaviour. Participants also thought the services were well organized and that patients were generally treated well. Additionally, participants reported that the role of the social worker in the psychiatric prison hospital was instrumental in producing a report for evaluating psychosocial support from relatives and the community of an offender with a mental disorder. The report was important to secure the discharge of an inmate from a psychiatric hospital.

4.3.2 Peer support and sharing

In many instances' participants supported each other and constantly reminded each other when it was time for taking medication. Participants had testimonies and group discussions which they said, was supportive in accommodating new offenders in the system as well as understanding mental disorders.

"...In the prison we would remind each other when the time of medication is up and staff would remind us when its medication time." (P1)

"...I managed to learn through others in the institution though their testimonies. I heard that some had committed murder because they were not taking medication. They committed murder not because they wanted to, but because they had mental illness and couldn't differentiate wrong and right." (P12)

4.3.3 Psychoeducation

Most participant's highlighted receiving effective psychoeducation which helped in improving insight and understanding. Participants reported that psychoeducation programmes were developed specifically to meet their needs through empowerment, that is provides the tools to manage, cope and live with a mental disorder. Two sub themes emerged from psycho-education namely (i) mental health literacy (including the effect of substance use on people living with a mental disorder); and (ii) availability and monitoring adherence to taking medication.

A large number of participants credited the Chikurubi mental health team as having played a pivotal role by increasing their mental health literacy through understanding mental disorders and their treatments. Participants also highlighted enhancing help-seeking efficacy from Chikurubi mental health team. Many denied that they had a mental disorder prior to being in psychiatric hospital and some believed that witchcraft was the cause of mental disorder.

> *"…I got to know much on mental illness whilst I was in this hospital and I got treatment and medication to help cure this illness. That is the help that I got from hospital."* (P3)

> *"…I had little knowledge about mental illness but I was still in denial that I had mental illness hence I kept on leaving my medication."* (P13

Most of the participants stated that their mental disorder was a result of biological, emotional, cognitive and behavioural symptoms for prolonged periods of time. Participants described their understanding of what causes mental disorders including taking drugs, life stressors and in some instances being genetically pre-exposed.

> *"….Mental illness is when one fails to live normally with others in the community and is usually caused by smoking Marijuana and. It is something which just happened but these days I am alright. It happened way back." (P5)*

> *"….Mental illness is caused by thinking too much or stress and pressures in life. What you will be thinking will go the other way round different from what you are usually expected of. " (P3)*

Most participants highlighted that, whilst in prison, they learnt about substance abuse and its impact on mental their mental health or how it may trigger new symptoms. According to participants, they were using drugs and substances to cope with difficult emotions not knowing it was detrimental to their mental health. It was through psychoeducation and improved mental health literacy that the participants were familiarized with the dangers of taking alcohol and abusing substances; practices that would exacerbate their condition:

"….What I know is that if you take drugs 'mbanje/ marijuana' or drink different types of alcohol for example "Krango" may cause you to get ill. Smoking mbanje and failure to take medication. I had stopped taking my medication that is what caused me to be detained in the prison hospital." (P2)

According to the participants, psycho-education was highly important as it helped them in accepting reality and adapting to the illness. A few highlighted behavioural interventions particularly promotion of health activities in daily living like nutrition, lifestyle management and interaction with other members of the society.

4.3.4 Availability and monitoring of medication

Participants highlighted that they were educated on proper adherence to medication as a solution to prevent reoffending. They described the importance of following the uptake of prescribed medication. Therefore, in addition to the counselling received, participants described how healthcare personnel emphasised adherence and how it need not be a barrier to normal living:

"They were counselors who were teaching us about mental illness and the reason why we should take our medication regularly and why we should continue taking medication when discharged from hospital if you stay alone or with relatives or friends, how to take medication on time." (P2)

"I learnt a lot from the mental health team at Chikurubi Psychiatric hospital that is Nurses, Social workers, Psychologists, Doctors and Occupational therapists that if I take my medication properly without skipping it, I can survive well without being admitted in the hospital. I also learnt that this medication doesn't stop me from marrying, going to work or do anything that those who aren't suffering from mental illness can do." (P9)

Most participants underscored the benefits of taking psychotropic medication and being monitored timeously on medication during the period they were in Chikurubi psychiatric hospital. The following were some of the responses from the participants who benefited from availability of psychotropic drugs, monthly injections and constant supervision:

"...I took salbutamol and theophylline and at times I used an inhaler that I got there (Chikurubi Psychiatric Hospital) because I was already asthmatic and it got worse because of the mental illness, so I used it whilst I was in the prison hospital." (P2)

"...I took Olanzapine once a day before bed and Fluphenazine deaconate injection once a month and in hospital they monitor you to check if you are complying with your medication but at home it's up to you to take medication or not. That's the only difference." (P6)

"...I was taking CPZ 100mg in the morning and evening but now I am only taking once in the evening and the only difference is that I am now taking it on my own once in the evening. I am no longer given time to take medication, to sleep or to eat. I am doing it on my own time." (P 8)

4.3.5 Rehabilitation programmes

Most of the participants highlighted gaining a lot from rehabilitation programmes which were being rolled whilst in the psychiatric prison care. Much of the rehabilitation programmes revolved around skills training to engage in income generation, for example agricultural programmes like rabbitry and horticulture.

"....Occupational therapists also taught us to be self-employed through agricultural activities they taught us namely gardening and rabbitry. Therefore I am looking forward to engage myself in gardening planting vegetables in our rural home in Marondera if I got money to from my sisters and brothers." (P1)

"...There were also agricultural programmes like rabbitry and horticulture which we were taught though at a small scale." (P13)

Apart from learning how to engage in income generation, the participants also described partaking in recreational activities:

"….We also had time for sporting activities like chess, soccer, volleyball and netball. I still remember we played volleyball against the team that had nurses, social workers, occupational therapist and we beat them resoundingly." (P11)

Many participants reported rehabilitation programmes ranging from agricultural activities, sporting and recreational activities like chess, soccer, volleyball and netball. The respondents shared that agricultural and sporting activities as being key reintegration programmes

4.5 Theme 3: The experiences and needs upon discharge from psychiatric prison care

Participants had mixed experiences of integration after discharge from the prison, depending on the severity of the crime committed and whether or not they were integrated back into the same community where the crime was committed. For example, participants who were incarcerated for murder or violence against children reported more difficulties with the transition. The overarching and critical factor that contributed to all of the participants experience and process of integration was the support of their family and relatives. This also influenced the impact of the other barriers reported by participants. These included: 1) Discrimination; 2) Availability and access to mental health services. Participants also highlighted some recommendations to facilitate integration of ex-offenders with a mental disorder.

4.5.1 Support of family and relatives

In many instances' participants received a positive welcome from their family and relatives who helped them navigate their reintegration into the community. For some inmates returning home it was easier for those when the community did not know about the crime and even their whereabouts when they were in prison. Returning home was a challenge to those who committed the crime in the community where they were returning to, particularly if the crime was more severe. Most of the reintegration problems that these participants experienced revolved around discrimination from community members:

"…People could not understand the crime I had committed and they could also not understand as to why I had been released from prison. Some were afraid of

me including the relatives of the person I had committed the crime against and some even wanted to attack me......" (P3)

"...It was very difficult considering the offence I had committed, there was a of negatives despite receiving warm welcome from my relatives. I faced a lot of stigma and discrimination from the community. A lot of people were afraid to associate with me." (P11)

4.5.2 Discrimination

To reduce possible discrimination, advance talks with family members of the victims and community members was reported by some. The discussions were facilitated by family members of the participants or if required trained social workers. The advance talks were meant to prevent discrimination from family members and community at large. In some instances, discharge occurred through halfway homes to allow the family and community time to prepare before the participants could be fully reintegrated.

"...Social workers were talking to my relatives and my relatives were talking to the deceased's relatives and also talking to me. When I was discharged, I did not go home straight and was going home on weekly basis mostly on weekends, then I come back until I got used to the society and we are now getting along well." (P3)

"...I was discharged from Chikurubi Psychiatric Hospital via ZIMNAHM (Tirivanhu half -way house). At first people were reluctant to accept me back into the community maybe because of the offence I had committed so I had to be discharged through a half way home whilst talks were going on between my relatives and community members for me to be accepted. It was difficult and as I am speaking to you some people are not yet convinced, I am now very normal just like them." (P1)

A number of participants highlighted that having a mental illness appeared to be less of a stigma than having committed a crime, and over time facilitated re-integration into the community. When family and community members were provided with education about mental disorder and its implications on an individual behaviours and thoughts, participants reported feeling less

"blamed" for their crime. Family and relatives played a key role in educating the community about mental illness and the availability and importance of receiving treatment to get them "back to normal", as described by the following ex-offender:

> *"…My relatives helped me in talking to other members of the community through enlightening them that I was being treated for a mental illness and now that I am now of sound mind. What is only needed is for me to continue taking my medication. I sometimes wish if those who treated me would have come here and explain to the public that I am now of sound mind because I haven't been fully accepted in the community."* (P11)

Finally, a few participants reported challenges re-engaging in employment due to a label or stigma of carrying a criminal record. Participants highlighted that having a criminal record creates extensive barriers and has far reaching consequences in securing employment since employers are reluctant to hire people with criminal records.

> *"… It was very difficult for me to return to work for the organization I had worked for previously because everyone knew I was now a patient and I faced a lot of stigma and discrimination due to my mental health condition"* (P7)

4.5.3 Availability and access to mental health services

A handful of the participants indicated that they encountered no challenges in accessing their medication after release. When in need of medical supplies, the participants made use of the nearest health centers as reported by this participant:

> *"…. Yes, I was given the correct medication prescribed by the doctor. The medication lasted for two weeks and arrangements were made by the guys at Tirivanhu (Zimnamh) so that we go to nearest health centre, Parirenyatwa Annex Hospital for collection of our resupplies of medication."* (P1)

There were other advantages of accessing medication at health centers after release because at these health centers the participants could also be attended to by psychiatric doctors and psychiatric nurses. Participants reported being treated with psychotropic drugs and injections

during the period they were in psychiatric prison care, and therefore for some participants there was no difference between taking medication in and out of the prison environment:

> *"… There is no much difference. I am now taking my medication in the evening. The only difference is that the type of medication I was taking while in prison care has changed but I am taking my medication and its helping me to associate with others outside." (P2)*

A few participants experienced challenges accessing medication when they returned to the community. In some instances these challenges resulted in non-adherence. Most of those who had challenges highlighted the cost of medication as another barrier in accessing mental health services. Participants described times when they had to travel far distances to access medication. In some instances, medication was not available at clinics and they would have to travel to access at larger referral centers or purchase it from pharmacies at a high cost. This high cost of medication was another barrier to accessing treatment.

> *"…At the nearest health center there is no medication therefore I am supposed to visit a bigger hospital which is 15 km from here that Parirenyatwa Annex hospital for reviews. Due to lack of money I haven't been there."* (P3)

> *"… I attend my reviews at local referral health center Hatclife clinic but the kind of medication, I take is very scarce at the hospital therefore I am given prescription and buy it in pharmacies in town. Once every month for reviews with Doctors and resupply of medication if it's available but mostly I buy my medication from pharmacies. My medication is expensive at times I won't be having enough money to buy and they don't give you medication on credit." (P9)*

4.5.4 Recommendations to facilitate integration of ex-offenders with a mental disorder

Given the lack of rehabilitation programmes in the community post-discharge, participants made a number of recommendations that would meet their specific needs. To begin with, participants highlighted the need for prison psychiatric services to have follow-up programmes

and offer some form of continuity of services to assist with the adjustment period and oversee continued adherence to medication:

> *"...I think it would be a nice idea to have follow up programmes otherwise they might help us living well in communities and also to see whether we are still taking medication. At least we will feel being loved."* (P1)

> *"...I feel they need to make follow up so as to assess whether those discharged from the institution are complying with their medication in various communities they will be living. Professionals should be aware of our needs and the challenges we face on reentry into the community."* (P13)

Secondly, some participants recommended peer support groups as a way of supporting each other post discharge.

> "…*We should have support groups to encourage each other especially those new people with a mental illness for them to understand." (P3)*

Thirdly, most participants spoke highly of being linked with available religious support systems/ support programmes and placed a strong emphasis on religion and prayer as a source of support and comfort.

> *"...Some of the things are beyond me, though I am putting everything before the Almighty God to help me overcome these challenges."* (P13)

> *"...I am assisted with prayers but I don't have anyone to discuss with (Psychotherapy)."* (P6)

> "…*Another method is for prayers. Some churches do come for prayers on Wednesday and others who would not have gone to their churches on Sundays they also come for church service at our place."* (P3)

5.0 Discussion

This qualitative study examined the experiences of ex-offenders living with a mental disorder within three to twelve months following discharge from psychiatric prison care in Zimbabwe. With the aim to explore the experiences of these participants, their mental health service needs and barriers to re-integration, three themes emerged: 1) The perceived impact of the prison environment at Chikurubi Hospital on the mental health of ex-offenders with a mental disorder; 2) The quality of the mental health services provided at Chikurubi Hospital; and 3) The experiences and needs of ex-offenders living with a mental disorder upon discharge from psychiatric prison care. These themes are discussed in detail. Thereafter, the strengths and limitations of the study are highlighted followed by concluding remarks.

5.1 The impact of prison infrastructure or environment at Chikurubi Hospital on mental health of offenders with a mental disorder

Participants in the present study highlighted that the prison environment negatively impacted on their pre- existing mental health conditions. Participants described the dire state of physical buildings and poor ventilation which exposed them or resulted in them experiencing extreme emotional state of displeasure, embarrassment, and unease. Consistent with the available literature, prison environments themselves and the associated procedures and systems can have damaging effects on the well-being of some inmates, particularly those with pre-existing mental health conditions (Birmingham, 2003). For example a study done by Goomany and Dickinson, (2015) on the influence of prison climate on the mental health of adult prisoners highlighted that, prisoners perceive the prison environment to have a damaging effect on their mental health as the physical buildings are not therapeutic at all. However, the same study found that, some inmates had a different view and instead perceived prison as a place of relief which gave them an opportunity to access health services. The participants in this study also appreciated access to medical services and medication which was being offered freely. Despite these findings, and that physical surroundings have the potential to play a therapeutic role for offenders with a mental disorder, many scholars have maintained that prisons should always be unfriendly and uncomfortable to discourage people from reoffending (Darkwa, 2016).

There are international standards regarding prison environments. For instance, the United Nations Standard Minimum Rules for the treatment of prisoners – known as the Nelson Mandela Rules - and the Kampala declaration on prison conditions in Africa, guides the police,

the prosecuting authorities and the judiciary on human rights issues despite being incarcerated (Penal Reform International, 2001). For example, according to the minimum standards described in the Kampala declaration, the windows should be big enough to allow the offenders enough circulation of air whether or not there is artificial ventilation (Akih & Dreyer, 2017). Light is also believed to be essential in upholding physical health and mental health for prison inmates. Further, recommendations 3 and 4 of the Kampala Declaration stipulate that the prison conditions should not worsen the suffering already caused by the loss of liberty (Dissel, 2008).

However, the physical conditions of most prisons in Africa, including those at Chikurubi prison hospital do not appear to meet international standards or protocols (Mhlanga-Dube & Kewley, 2020). It has been argued that one of the main reasons for not meeting international standards, is the physical structure of the buildings themselves (Dissel, 2008), with description of the infrastructure of most African prisons described as debilitated and dire (Sarkin, 2008). In Zimbabwe, prisons including Chikurubi Psychiatric Hospital, were constructed during the colonial era and have not been updated or renovated. These prisons therefore lag behind in meeting international standards. It seems the prisons and psychiatric hospitals remain places of punishment as opposed to rehabilitation and treatment. This view was shared by the International Committee of the Red Cross (1996).

According to the Commissioner General of prisons in Zimbabwe, “the majority of the country's 43 prisons were outdated and lacked basic amenities.” He went further to say that, “One of the major problems we have is that most of our big prisons, like Chikurubi Maximum Security Prison, Harare Central Prison, Harare remand Prison and Masvingo Prison, were built a very long time ago…” “they were built without proper ventilation and do not have adequate washrooms ….” (Zimbabwe News, 2016, p.6).”

Overcrowding impacted negatively on mental health of offenders with mental disorders whilst at Chikurubi psychiatric hospital. Overcrowding was when Chikurubi prison cells were accommodating more than the required number (holding capacity) whilst putting a strain on resources like physical, psychological, mental and social well-being of offenders with a mental disorder. The literature review highlighted how prisoners who are kept in African correctional institutions face a myriad of challenges ranging from many years of incarceration in often overcrowded and filthy rooms, poor sanitation and other services (Dissel, 2008; Sarkin, 2008; Sarkin, 2009). These authors claim that overcrowding dates back to the colonial era though there are varying degrees to this persistent problem from one country to another. High inmate

numbers in the institution impacted significantly on sleeping quality as there were not only too many in one cell, but some slept on the floor during their entire sentence. Prison overcrowding is a global problem (Kampala Declaration on Prison Conditions in Africa, 1996). In keeping with international protocols, the International Committee of the Red Cross (1996) seeks to ensure that prisoners live in decent, acceptable conditions and are treated humanely.

The participants in this study indicated that they were provided food although some of them resented the type that they received. Food quality and adequate nutrition is important for mental health. A recent systematic review and meta-analysis of dietary patterns and depression in community-dwelling adults carried out in several European countries, USA, Australia, Japan, Taiwan and United Kingdom found a positive relationship between food and mental health symptoms (Lai et al., 2014). Participants reporting a high intake of fruit, vegetables, fish and whole grains reported fewer symptoms of depression than those with lower intake of this food group (Kulkarni, Swinburn, & Utter, 2015; Rienks, Dobson, & Mishra, 2013). In another systematic review on nutritional aspects, it was found that, food supplements with amino acids are essential in boosting neurotransmitters which prevents depression and other mental health problems (Khanna, Chattu, & Aeri, 2019). It is therefore of paramount importance for psychiatric institutions to incorporate the area of nutritional neuroscience for the prevention and management of mental disorders through a healthy diet (Khanna et al., 2019; Lakhan & Vieira, 2008).

5.2 The quality of the mental health services provided at Chikurubi Hospital

Participants underscored benefiting from various mental health services and programmes whilst inside Chikurubi Hospital. Most participants highlighted receiving a comprehensive package of mental health services from a diverse multidisciplinary team which was comprised of psychiatric doctors, psychiatric nurses, psychologists, social workers and occupational therapists who were acquainting the inmates with what a mental disorder is, the reason for taking medication and how to continue adhering to it when discharged from hospital. Most of these services were externally funded at the time by Médecins Sans Frontières (MSF) or "Doctors without borders".

Other research in prisons that included a service of a multidisciplinary mental health teams providing comprehensive services have also reported promising findings. It has been argued

that offering comprehensive mental health service in prison has the potential to treat people with mental health and substance use problems who otherwise would be difficult to reach for health services (Forrester, Till, Simpson, & Shaw, 2018; Watkins, Burnam, Kung, & Paddock, 2001). Several European countries namely Norway, England, Portugal and France detain offenders with mental disorders in special psychiatric institutions where comprehensive mental health services are routinely offered until they fully recuperate (Forrester et al., 2018). This model of care has shown to be effective in providing specialized care pathways to offenders with mental disorders, ensuring they have access to high quality mental health services. These mental health services included evidence-based interventions on clearly identified needs and service user preferences. Special psychiatric institutions for offenders with mental disorders can function not just as confinement centers but also as treatment centers where mental health service providers monitor adherence regularly (Konrad & Lau, 2010). South Africa has some of the best hospitals namely Tara hospital and Sterkfontein Hospital which offers specialized inpatient and outpatient services to persons with serious mental illness. The hospitals provides multidisciplinary services ranging from psychology, occupational therapy, psychiatric and nursing care.

The length of time in prison and the comprehensive services available provide an opportunity to treat a difficult to reach population that would often be missed by the public health services. Some inmates had been serving their sentences for long periods of time. Length of time the participants were in prison allowed them to develop a good relationship with the mental healthcare providers from whom they described receiving good service delivery. Developing good relationships has been described as strengthening emotional resilience and reducing structural barriers that inhibit the promotion of mental health whilst in prison (Gilburt, Rose, & Slade, 2008). Relationships developed in treatment are thought to be the basis of social networks needed to sustain individuals' mental health whilst inside the institution (Heaney & Israel, 2008). Given the good rapport and trusted relationships, participants responded well to the psychosocial support from mental health personnel at Chikurubi. Psychosocial support programmes offered to participants whilst at Chikurubi Hospital worked towards the goal of reducing suffering and improving participants' mental and psychosocial wellbeing.

A number of key features of the services offered at the psychiatric prison were highlighted as critical to the recovery of the participants. First, peer support seemed to play a role in the mental healthcare of the participants. According to (Gillard, 2019), peer support involves recognition of shared experiences of benefits, difficulties and suffering, and makes up an interactive link

on that basis for the purpose of supporting and learning from each other. Peer support and sharing was fundamental in this study in accommodating new offenders in the system including the understanding of mental conditions. Peer support enables recovery within mental health as it increases positive self-esteem which is vital for recuperation (Repper & Carter, 2011). Not surprisingly a number of participants credited peer support they received whilst in Chikurubi as the turning point in their lives.

Second, a large number of participants credited the Chikurubi mental health team as having played a pivotal role by increasing their mental health literacy. Mental health literacy comprises the capacity to be familiar with specific disorders, knowing how to seek mental health information and knowledge of risk factors (Jorm, 2000). Prior to receiving treatment at Chikurubi psychiatric hospital, many participants were not aware that they had a mental disorder nor that treatment was available. Being diagnosed and receiving comprehensive treatment started them on the road to recovery and provided insight into their behaviours and understanding their mental health issues. Mental health literacy also focussed on the importance of adherence to medication. Research suggests that mental health literacy is associated with effective use of medical information predominantly to better understand and adhere to medical treatments (Kutcher, Wei, & Coniglio, 2016). It has also been noted by various scholars that mental health literacy helps in retention in care and reducing recidivism (Kugbey, Meyer-Weitz, & Asante, 2019). Above all mental health literacy is an important empowerment tool, as it supports people to understand their own mental health as well as increasing resilience. Improved mental health literacy may help in the reduction of load on health and social care service.

Unfortunately, the mental health service provided at Chikurubi psychiatric hospital were not sustained given that MSF project withdrawal in 2017. This has severe implications for prisoners with mental health problems at this hospital. Currently, we do not know what is being provided.

5.3 The experience of inmates upon discharge from prison psychiatric facility

Offenders released from imprisonment face a variety of challenges. The diversity of offenders' experiences and needs makes the transition from psychiatric prison care to community a complex task. Participants released from Chikurubi Psychiatric hospital had mixed experiences

of integration depending on the severity of the crime committed and whether or not they were integrated back into the same community where the crime was committed. Emerging literature suggests that, community reintegration of ex- offenders with a mental disorder is associated with marked resistance to accept offenders (Kim, 2015).

One of the major barriers affecting social reintegration of ex-offenders with a mental disorder in the current study was discrimination and stigma. For example, participants who were incarcerated for heinous crimes like murder, rape and violence against minors reported difficulties with transition into community. The community was fearful of those who had committed heinous crimes because they had not come to terms with offences committed prior to incarceration. In some instances, they (participants) relocated to another community due to perceived discrimination and stigma. This finding is similar to other studies investigating where offenders reported perceiving stigma preceding their release into the community (Moore, Stuewig, & Tangney, 2016). Hence it is essential to understand psychological responses to stigma by ex-offenders with mental disorder as well as understand their reintegration into the community, post discharge.

For participants who were experiencing discrimination, advance talks with family members of the victims and community members took place. The discussions were facilitated by family members of the participants or if required, by trained social workers. The family has to deal with separation and the consequences of their relatives' absence from the home and stigma attached to imprisonment. Literature supports the view that institutional, community-based reintegration services and government should have seamless intervention programmes like victim offender mediation and justice restorative system as a way of addressing barriers like stigma and discrimination (Hai, Dandurand, & Tucker, 2013). Seamless intervention programmes should incorporate advance talks, community dialogue and conferencing (Mirza, Gossett, Chan, Burford, & Hammel, 2008). The participants studied also highlighted that in some instances, discharge occurred through halfway homes to allow the family and community time to come to terms with what would have transpired and preparing successful re-entry into the community.

Aside from the discrimination experienced a result of the crime committed, further discrimination was reported due to having a mental disorder. A few participants reported challenges re-engaging in employment due to a criminal record. Participants highlighted that,

having a criminal record creates extensive barriers and has far reaching consequences in securing employment since employers are reluctant to hire people with criminal records. Some studies revealed that, employment is essential for many reasons beyond the basic need of income as it provides stabilizing routine, occupies time and keeps individuals responsive to employers' needs or demands always (Birnbaum, 2012; Noon, Blyton, & Morrell, 2013). Being incarcerated is associated with stigmatization and it comes with increased reluctance among employers to hire ex-offenders and this is worsened if they have a mental disorder (Flake, 2015). A criminal record may be seen to signal a dishonest worker, which is worse for offenders with a mental disorder as they are likely to be viewed as having an increased propensity to break rules or harm customers (Baur, Hall, Daniels, Buckley, & Anderson, 2018). In Zimbabwe, the government requires individuals to have no criminal record in order to be employed hence making it difficult for ex-offenders with mental disorders to secure work.

Some studies indicate that, low educational attainment is a major barrier to employment for many ex-offenders, and not their criminal record (Kethineni & Falcone, 2007). Education gives individuals basic skills to enter the job market. Some scholars have also suggested that work programs should be overseen whilst inmates or offenders are still in prisons so as to prepare them with requisite skills to increase their employability upon discharge (La Vigne, Davies, Palmer, & Halberstadt, 2008).

The second major barrier to the integration of ex-offenders with mental disorders was the availability of few incapacitated mental health services in the communities which only focused on clinical recovery. Research has shown that in most LMICs, upon discharge, the primary focus is on clinical recovery whilst ignoring integral intervention programmes like rehabilitation, reintegration and personal recovery which moves beyond treating symptoms of illness (Cleaver & Nixon, 2014; Petersen, Lund, & Stein, 2011). Personal recovery is important to people with SMI as they should be major participants in the journey to recovery since it is a process of healing or recuperation (Leamy et al., 2011; Leonhardt et al., 2017). Some scholars argue that active and continuous mental health treatment is the best defence against relapse and personal recovery (Slade, 2009). This contrasts with the reality that people living with severe mental disorders in LMICs do not receive treatment once discharged from institutions due to lack of resources and coordination because of centralized system (Glasziou et al., 2017; Petersen et al., 2011). Despite the drive to deinstitutionalization, in many countries mental health care is still centralized in large hospitals thereby making services inaccessible to many

ex-offenders who will be in need of them (Petersen et al., 2011; Saraceno et al., 2007). For example. the participants studied described times when they had to travel far distances to access medication. In some instances, medication was not available at clinics and they would have to travel to access at larger referral centers or purchase it from pharmacies at a high cost. Successful reintegration upon discharge becomes a challenge as the community mental health services are focusing primarily on clinical recovery in the form of medication, impacting on the mental health of the people with SMI.

5.4 Implications and recommendations for future practice, policy and research

Based on the findings from this research study, the following recommendations are suggested to improve the ex-offenders reintegration programmes in the community. These are:

1. There is need for further research in area of social services and rehabilitation post discharge of ex-offenders with mental disorders in Zimbabwe so as to attain a clear picture of actual magnitude of the burden of mental disorders faced by this vulnerable population.
2. Employment agencies should be encouraged treat ex-offenders with mental disorders the same way they handle persons living with disability when it comes to job placements by offering equal opportunities regardless of infirmity or disease.
3. The government should provide resources for community-based projects geared towards strengthening or empowering ex-offenders with mental disorder post discharge so as to improve conditions and standards of living in communities.
4. There is need for family reunification and community education services as a way of improving acceptance of ex-offenders with mental disorders.
5. Reintegration programmes should address the risks and needs of ex-offenders with a mental disorder as well as developing preventive measures to reduce vulnerability to commission of crimes and recidivism.
6. There is need for collaboration and partnerships between all relevant stakeholders such as community, family, church organizations, employment agencies, prison officials in order to improve reintegration of ex-offenders with mental disorders.
7. There is need to decentralize mental health services from primary health care centres.

8. There is need to have follow-up programmes and offer some form of continuity of services to assist with the adjustment period post discharge.
9. There is need for peer support groups post discharge as a way of supporting each other.

5.5 Strengths and limitations

Currently, there is dearth of literature on the experiences of ex-offenders with mental disorders returning from criminal justice system. Few studies have reported the lived experiences of this special population. The present study sought to explore the convergence of the factors that are effective for their recourse and that may affect their adherence to prescribed medication in preventing relapse and reoffending. This study is one of the few that has explored the experiences of ex-offenders living with mental disorders following discharge from psychiatric prison care and it contributes to the literature on lived experiences of ex-offenders post discharge from psychiatric care

The study had a sample of thirteen participants and by nature it may have posed serious limitations to the study. Thus due to this limitation, the study's generalizability is restricted only to ex-offenders with a mental disorder who took part in this study. It is also noted that none of the family members participated in the study. It would have been a noble idea to hear from family members of ex-offenders with mental disorders since they are likely to be well versed with array of needs of their relatives. The research took place in Harare Metropolitan Province and as such this limits again the ability of the researcher to generalize his findings to the rest of the population with a mental disorder in the whole country or in some other provinces.

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Appendix A: Participant information sheet and consent form

Dear Participant

You are kindly invited to be part of this study that will attempt to investigate the experiences faced by ex-offenders with mental illness and their caregivers within 3 -12 months following discharge from psychiatric prison care in Zimbabwe.

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Sponsor African Mental Health Research Initiative (AMARI)

Research Title: *The experiences faced by ex-offenders with severe mental illness and their caregivers within three to twelve months following discharge from psychiatric prison care in Zimbabwe: A qualitative Study*

Introduction: I am Wellington Mhishi employed by Zimbabwe Prisons and Correctional Service as a directing staff (lecturer) at Zimbabwe Prisons and Correctional Service Staff College and currently pursuing my postgraduate studies with University of Cape Town in South Africa. As part of the programme requirements, I am expected to carry out a research study. The focus of my study is on the experiences faced by ex-offenders with mental illness and their caregivers within three to twelve months following discharge from psychiatric prison care. I am kindly asking you to take part in an in-depth interview. The following information is provided in order to help you make an informed decision on whether or not you will like or be able to take part. If you have any questions please do not hesitate to ask.

Purpose of the Study

The purpose of the study is to explore the experiences faced by ex-offenders with severe mental illness and their caregivers within 3-12 months following discharge from psychiatric prison care in Zimbabwe. I would like to hear your thoughts about the barriers and facilitators to community re-integration of ex-offenders with severe mental illness following discharge from psychiatric prison care, to explore available services and identify further service requirements of ex-offenders with mental illness and explore the experiences, challenges and perceived needs of caregivers of ex-offenders with mental illness following discharge from psychiatric prison care.

What to expect in the study
The study will involve face to face interview where you will be asked some questions regarding your views on possible key drivers and barriers to community reintegration following your discharge from psychiatric prison care and how they can be addressed. The questions are designed to allow you to share your experiences. I would also like to ask you about available services and identify further service needs for ex-offenders with mental illness following discharge from psychiatric prison care. I am kindly requesting for your permission to audio tape these interviews so that I don't miss out on any information you provide and your name will not be mentioned. During the interviews, there might be five minute breaks if there is need and please feel free to stop me for a break if you need to. Each interview will last up to an hour. I value your input because the information you provide will help to improve addressing the barriers and services for ex-offenders with mental illness following discharge from psychiatric prison care.

Voluntary Participation
The decision of you taking part in the study lies with you and is entirely voluntary. It will be entirely upon your choice to get involved in in this study or not. If you decide to participate and feel that you are no longer comfortable with questions in the interview, you may choose to stop participation any time. There will be no consequences taken against you. If there are questions posed to you which you are uncomfortable to answer feel free not to answer them.

Potential risk factors and discomforts
I do not foresee any risk factor in participating in this interview; however, some of the questions may make you uncomfortable. You will not be pushed to answer any questions. Participation in this study is fully voluntary.

Potential benefits of taking part in the study
There are no direct benefits for participating in this interview. However, the interview may help you to reflect on barriers and facilitators to community reintegration following your discharge from psychiatric prison care and available services for ex-offenders with mental illness following discharge from psychiatric prison care. The information and feedback will help us share experiences to improve in lobbying for mental health service provision in future. It is also hoped that, individuals with clear biopsychosocial needs may be assisted by the inquiry through referrals to doctors, psychiatrist or social worker if unwell.

Privacy and Confidentiality
The participant's name will not be recorded and I will start by saying the study ID. The audio data will be stored electronically on a password protected hard drive that only the researchers have access to. Consent forms will be stored in locked cupboard. Data will be kept for five years, after which it will be destroyed. The dataset will not contain participants' names or identifying information and will be stored in password protected hard drive.

Gesture of thanks for Participation

Taking part in this study will be on voluntary basis. No payment is going to be paid for your participation in this study but I recognize your time and at the end of the interview you will receive a snack box. The snack box will contain a three piercer chicken and a juicy drink for purposes of refreshment.

N.B For any question or inquiry about the study you can also contact my supervisors mentioned above.

Declaration by Participant

I……………………………. (**Participant full name**) agree to give consent and participate in the study that has been explained to me in detail by the researcher.
N.B If you agree to participate in the study tick at the end of each question.
I declare that:

- I have read and also understood the consent form or that it has been read in clear language that I understand and I am comfortable with.
- I will also be given the opportunity to ask questions and all my questions will be adequately answered.
- I understand that taking part in this study is voluntary and I have not been coerced to take part.
- If I choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I have been assured total privacy and confidentiality throughout the study.

Participant Signature	**Date**	**Signed at (Place)**
…………………………..	……………………	

…………………………….

Appendix B: Interview Guide for ex-offenders with mental illness

Study Title: The experiences faced by ex-offenders with mental illness within 3-12 months following discharge from psychiatric prison care in Zimbabwe. A qualitative study

QUESTIONS IN BOLD ARE CORE WHILST THE OTHER QUESTIONS ARE OPTIONAL.
I would like to ask you a few questions about your thoughts on possible barriers and facilitators to community reintegration following your discharge from psychiatric prison care and how they can be addressed

1. Briefly tell me about the health care which you were provided while in psychiatric prison?
Prompts
(a) Did you get adequate health care while in psychiatric prison?
(b) What do you think should be improved on the health care you were provided while in psychiatric prison care?

2. May you kindly, describe to me what you understand by mental illness?
Prompts
(a) In your opinion, which mental condition led to your admission in psychiatric prison care?
(b) What is the diagnosis that psychiatrists came up with?
(c) How has your condition changed following your discharge from psychiatric prison care?

3. Were you on any kind of medication during your stay in psychiatric prison care?
Prompts
If yes
(a) What kinds of medication were you taking and for what condition(s)?
(b) How frequent were you taking your medication whilst in psychiatric prison care?
(c) Are there any differences in taking medication then and now?
(d) Have you ever skipped taking your medication?

4. Overall what has been your experience of being treated of your mental health condition in a psychiatric prison care?
Prompts
(a) Can you mention any treatment programmes offered at the hospital?
(b) How effective were treatment programmes offered at the psychiatric prison hospital?

5. When were you discharged from psychiatric prison care?
Prompts
(a) Did you experience any challenges integrating into community life outside prison?
(b) How did you manage to overcome challenges that you experienced following discharge from psychiatric prison care?

6. How has the community supported you following your discharge from psychiatric care?
Prompts
(a) What support is available for you from the community or caregiver?
(b) Did you experience any challenges in reintegration?

7. Have you had any means of livelihood following your discharge from psychiatric prison care?

Prompts

(a) Do you have any income generating projects?
(b) Are you generating or making enough income to survive?
(c) In the case that you do not have income generating projects, who then pays for your medication and related costs like attending hospital reviews?
(d) Do you have challenges accessing food, shelter and other basic needs?
Probe specifically for food insecurity (whether ever short of food in the home, how many meals they have a day, whether they go hungry or miss meals because there is not enough) Probe for the reason of change of economic status – related to improved mental health? Related to cost of burden of medication and travel to clinic for reviews?

8. Following your discharge, were you given any supplies of medication to take home?

Prompts

(a) If yes, were the supplies adequate enough to cover the period before your next initial review?
(b) How far is the nearest community health centre from which you get your medication when it runs out?

9. How often do you attend reviews at any nearby community health centre?

Prompts

(a) Are there any challenges you face in accessing services from the nearby community health centre?
(b) Besides medication, are there any other social support services you are offered, i.e. alternative medication, counselling, psychotherapy, prayer or yoga?

10. Are there any follow ups made by any other care providers for ex-offenders with mental illness to see whether they are complying with their medication?

Prompts

If yes

(a) Which follow up programmes are there?
(b) How do the follow up programmes by some care providers assist in your adherence to medication?

If no

(c) Do you think it's necessary to have follow up programmes?

11. How has the community health center helped you following your discharge from a psychiatric prison care?

Prompts

(a) Which assistance is being given to you by the community health centre?
(b) How has the assistance helped you?

12. Is there anything you would like to tell me about your experiences with prison psychiatric care?

Prompts

(a) In your view, is the diagnosis and treatment of prisoners with a mental illness effective?

If no

(b) How can the diagnosis and treatment of prisoners with a mental illness be improved?

Appendix C: Study Documents ChiShona Translation

(HREC 727/2018; JREC 185/19; MRCZ /B/1733)

Chinyorwa chino chinopa mvumo yokupinda mutsvagurudzo yokupa nhoroondo yevanhu vaimbove vasungwa mujeri revane dambudziko rechirwere chepfungwa

Musoro/Chinangwa chetsvagurudzo: Zvinosangana nevasungwa vakaburitswa mutirongo/muusungwa pamwe nevachengeti vavo munguva ingaita mwedzi mitatu kana gumi nemiviri vaburutswa.

Muiti Wetsvagurudzo	Wellington Mhishi Zimbabwe Prisons and Correctional Service Staff College Tsambambozha:wmhishi@gmail.com Nharembozha +263772846064 / +263716279974
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Mubhadhariri	African Mental Health Research Initiative (AMARI)

Musoro/Chinangwa chetsvagurudzo: Zvinosangana nevasungwa vakaburitswa mutirongo/muusungwa pamwe nevachengeti vavo munguva ingaita mwedzi mitatu kana gumi nemiviri vaburitswa.

Nhanganyaya: Ndini Wellington Mhishi mushandi wepa rimwe bazi remajeri omuno muZimbabwe. Ndiri kuita zvidzidzo zvangu paYunivhesiti ye Cape Town iri kuJoni. Chimwe chinangwa chezvidzidzo zvangu ndechekuti ndinofanira kuita tsvagurudzo. Chinangwa chetsvagurudzo yangu ndechokuongorora zvinosangana nevasungwa vakaburitswa mutirongo/muusungwa pamwe nevachengeti vavo munguva ingaita mwedzi mitatu kana gumi nemiviri vaburitswa. Ndinoshuvira kuzoita tsvagurudzo yangu ndichikuvhunzai mibvunzo tiri panhu pamwe. Chinangwazve chechinyorwa chino ndechekuti musarudze kana muchizoda kutora mukana wokupinda mutsvagurudzo iyi. Kana muine mibvunzo yamusinganzwisisi muchinyorwa chino makasununguka kuzondibvunza.

Chinangwa chetsvagurudzo ino: Chinangwa chetsvagurudzo ino ndechokunzwisisa zvinosangana nevasungwa vakaburitswa mutirongo/muusungwa pamwe nevachengeti vavo munguva ingaita mwedzi mitatu kana gumi nemiviri vaburitswa. Tinenge tichida kuona maonero enyu imi pamusoro pezvimhingamupinyi kana zvingabetsera kuti vasungwa vane chirwere chepfungwa vanenge vaburitswa mumajere varegere kuparazve mhosva

dzavakambosungirwa; mamwewo matanho amunotora kubetsera mapoka awa uye kuzoongorora mashandire anoita mabatsirire amunoita vasungwa vakadai vanenge vari mumaoko enyu.

Zvamungatarisira mutsvagurudzo iyi: mutsvagurudzo ino tichazokurukura takatarisana mumwe agree apa mumwe aria pa tichida kuhwisisa maonero enyu nezvinosangana nevasungwa vakaburitswa mutirongo/muusungwa pamwe nevachengeti vavo munguva ingaita mwedzi mitatu kana gumi nemiviri vaburitswa. Muchatipawo maonere enyu pamusoro pezvimhingamupinyi kana zvingabetsera kuti vasungwa vane chirwere chepfungwa vanenge vaburitswa mumajere varegere kuparazve mhosva dzavakambosungirwa; mamwewo matanho amunotora kubetsera mapoka awa uye kuzoongorora mashandire anoita mabatsirire amunoita vasungwa vakadai vanenge vari mumaoko enyu. Kaungano kedu kanogona kutora awa rimwe chete kureba uye tinozogonawo kushandisa tepi rekodha kuitira kuti zvimwe zvinenge zvapotseka pakunyorwa zvigozowanikwa patinenge tohwerengedza zvakabuda mutsvagurudzo. Tinokoshesa zvikuru pfungwa dzamuchapa nokuti dzichatibetsera kuvandudza matambudziko anosangana nevasungwa vakadai kana vari mumaoko evachengeti vavo pavanobuda mumajeri.

Kuzvipira kupinda mutsvagurudzo iyi: Danho rokupinda mutsvagurudzo ino rinongobva pakuzvipira kwenyu imi. Kana mukasarudza kuramba kupinda mutsvagurudzo ino zviri kwamuri. Nyangwe mukazoramba kupinda muchirongwa chino hamupiwi mhosva nyangwezve mukazosiira tsvagurudzo ino panzira. Kana muchinge muine mimwe mibvunzo pamusoro petsvagurudzo ino, makasunungunuka kuibvunza.

Njodzi dzinogona kusanganikwa nadzo mutsvagurudzo ino: hationi pachizova nenjodzi yamungaasangana nayo pakupinda mutsvagurudzo ino. Dzimwe nguva mimwe mibvunzo ingangogozha kana kuvhenda zviri kutsi kwemoyo wenyu. Munenge makasununguka henyu kuzoibvunza kana kurega kuipindura.

Zvakanakira kupinda mutsvagurudzo ino: Tsvagurudzo ino inobetsera kuti imi muchatipawo maonere enyu pamusoro pezvimhingamupinyi kana zvingabetsera kuti vasungwa vane chirwere chepfungwa vanenge vaburitswa mumajere varegere kuparazve mhosva dzavakambosungirwa; mamwewo matanho amunotora kubetsera mapoka awa uye kuzoongorora mashandire anoita mabatsirire amunoita vasungwa vakadai vanenge vari mumamisha. Tikawana ruzivo rwakadai rungabetserawo kuti titsvake zvimwe zvingabetserawo vasungwa vanenge vari muboka rakadai munzvimbo dzakasiyana siyana.

Tsindidzo uye Vigiridzo: Pakuita tsvagurudzo ino mazita enyu haazonyorwi pasi uye hapana kana mifananidzo yenyu ichazotorwa. Zvichabuda mutsvagurudzo zvichange zvakachengetedzwa panokiyiwa kwenguva yakareba. Zvichatepiwa ne tepi rekodha zvichavhavharwa nema pasiwedhi.
Mubhadharo wokupinda mutsvagurudzo: Munhu unopinda mutsvagurudzo ino uchapiwa mubhadharo wepakiti yechikafu yokuti adye ipapo.

Kana muchinge muine mimwewo mibvunzo maererano netsvagurudzo ino munokwanisa kubvunzawo vadzidzisi kana vamaki vetsvagurudzo ino vane mazita nematsambambozha uye nharembozha dzakanyorwa pamusoro idzo.

Mhiko youkpinda mutsvakurudzo:

Ini ………………………………………. (Zita Rizere) ndinobvuma kupinda mutsvagurudzo ino uye ndanzwisisa tsanangudzo yapiwa nomuiti wetsvagurudzo.
Ndinobvuma kuti:

- Ndaverenga ndikanzwisisa zvose zvakanyorwa pamusoro nomutauro kwawo wandinohwisisa ini
- Ndapiwa mukana wokubvunza mibvunzo uye mubvunzo yangu yose yapindurwa.
- Ndanzwisisa kuti kupinda mutsvagurudzo ino kuzvidira kwangu uye handina kumanikidzwa.
- Ndinogona kusiya tsvagurudzo ino chero nguva uye hapana zvandinoitwa.
- Ndavimbiswa kuti pachava nevigiridzo kana tsindidzo yezvose zvichataurwa mutsvagurudzo ino.

Siginecha yangu	**Dheti**	**Nzvimbo yacho**
…………………………..	……………………	…………………………….

Mibvunzo kuvasungwa vakaburitswa muchipatara chiri mukati metirongo munguva ingaita mwedzi mitatu kana gumi nemiviri vaburitswa.

Musoro/Chinangwa chetsvagurudzo: Zvinosangana nevasungwa vakaburitswa mutirongo/muusungwa pamwe nevachengeti vavo munguva ingaita mwedzi mitatu kana gumi nemiviri vaburitswa.

Nhanganyaya: Ndini Wellington Mhishi mushandi wepa rimwe bazi remajeri omuno muZimbabwe. Ndiri kuita zvidzidzo zvangu paYunivhesiti ye Cape Town iri kuJoni. Chimwe chinangwa chezvidzidzo zvangu ndechekuti ndinofanira kuita tsvagurudzo. Chingwa chetsvagurudzo yangu ndechokuongorora zvinosangana nevasungwa vakaburitswa mutirongo/muusungwa pamwe nevachengeti vavo munguva ingaita mwedzi mitatu kana gumi nemiviri vaburitswa. Ndinoshuvira kuzoita tsvagurudzo yangu ndichikuvhunzai mibvunzo tiri panhu pamwe.

Mibvunzo kuvasungwa vakaburitswa mutirongo/muusungwa munguva ingaita mwedzi mitatu kana gumi nemiviri vaburitswa muZimbabwe.

MIBVUNZO IYO YAKAKODZWA NDIYO YAKANYOKOSHA, IYO ISINA NDEYOKUBATSIRIDZAWO

Ndinoda kukubvunzai mibvunzo mishomanana pamaonere enyu pavasungwa vakaburitswa mutirongo/muusungwa munguva ingaita mwedzi mitatu kana gumi nemiviri vaburitswa. Muchataurawo zvimhingamupinyi nezvingaitwa kuzvipedza uye zvimwewo zviri kubatsira kuti boka iri rigare zvakanaka.

1. **Muchidimbu ndiudzeiwo zvishoma pamusoro perubatsiro rwezveutano hwepfungwa rwamakawana panguva yamaive muchipatara chiri mukati metirongo?**
   a) Mungati makawana rubatsiro rwakakwana here rwezveutano hwepfungwa muri muchipatara chiri mukati metirongo?
   b) Ndezvipi zvamunofunga kuti zvinosungirwa kuvandudzwa pamusoro perubatsiro rwezveutano hwepfungwa hwamakawana panguva yamairapwa mchipatara chiri mukati metirongo?

2. **Makasununguka kunditsanangurira here zvamunoziva pamusoro pechirwere chepfungwa?**
   a) Mumaonero enyu ndezvipi zvamunofunga kuti zvakakonzera kuti mugariswe muchipatara chevanorwara nepfungwa chiri mukati metirongo?
   b) Ndechipi chirwere chakazoonekwa nachiremba wenjere mushure mekunge akuongororai?

3. **Pane mishonga yamaitora here kana kuwana panguva yamaive muchipatara chevanorwara nepfungwa chiri mukati metirongo?**
   Kana maitora
   a) Maitora mishonga ipi uye muchitorera chirwere kan kuti zvirwere zvipi?
   b) Maitora mishonga iyi kangani pazuva?
   c) Pane musiyano here pamatorero amaita mushonga muri muchipatara nazvino?
   d) Pane pamakambomira here kutora mishonga?

4. Pamusoro pazvose ndezvipi zvamakasangana nazvo mukurapwa kwamaitwa chirwere chepfungwa muchipatara?

a) Mungandidomerawo here zvirongwa zvekurapa zvaishandiswa kwamuri panguva yamaiva muchipatara?
b) Zvirongwa izvi zvakakubatsirai zvakadini?

5. Makabuditswa rini muchipatara?

a) Munematambidziko here amakasangana nawo pakudzoka mudunhu ramunogara mushure mekubuditswa muchipatara chiri mukati metirongo?
b) Makakwanisa kukunda sei matambudziko amakasangana nawo mushure mekubuditswa muchipatara?

6. Nharaunda yamunogara yakakutambirai sei mushure mekunge mabuda muchipatara chiri mukati metirongo?

a) Nderupi rubatsiro rwamunowaniswa nevamunogarisana navo mudunhu renyu kana kuti kubva kumhuri yenyu?
b) Mune matambudziko amakasangana nawo here mushure mekubuditswa muchipatara?

7. Mune chouviri here chinokuraramisai chamunacho mushure mekubuditswa muchipatara chiri mukati metirongo?

a) Mune mabhindauko here amunoita anounza mari?
b) Mungati mari yamuri kuwana kubudikidza nemabhindauko iri kukwana here kuti murarame?
c) Ngatitii hamuna mabhindauko anounza mari ndiyani anaokubatsirai kutenga mishonga nezvimwe zvingadiwa semuenzaniso kuenda kuchipatara chiri pedyo nemi kuti mnoongororwa?
d) Mune matambudziko here amunosangana nawo mukuwana zvekudya, pekugara nezvimwe zvakakosha mukurarama?

8. Mushure mekubuditswa muchipatara mune mishonga yamakapihwa here kuti kuzoshandisa mava kumba?

a) Kana zvirizvo mungati mishonga yamakapihwa yakakukwanirai here kuti mushandise muchimirira nguva yekuzonoonekwazve kuchipatara chemunharaunda yenyu?
b) Muri kure zvakadini kubva kuchipatara chiri pedyo munharaunda yenyu uko kwamunokwanisa kunotora mishonga yenyu?

9. Pane nguva dzamunomboshanyirwawo here nevamwe veutano vachiona kana muchiri kutora mishonga yenyu zvine mwero?

a) Kana zvirizvo nde zvipi zvirongwa zvokutevera varwere vepfungwa kumba zviripo?
b) Zvirongwa zvokutevera varwere kumba zvinokubatsirai sei mukuteedzera matorerwo emishonga yenyu?

Kana zvisirizvo

c) Mungazvione sechinhu chakanaka here kuti pave nehurongwa hwekutevera varwere vepfungwa kudzimba pachionekwa kuti varikutora mishonga yavo here zvine mwero

10. Inguva ngani dzamunotarisirwa kuenda kunoongororwa pachipatara chiri pedyo kana kuti chiri munharaunda yenyu?

a) Mune matambudziko amunosangana nawo here mukuwana rubatsiro rwezvekurapwa chirwere chepfungwa kubva kuchipatara chiri pedyo nemi?

b) Kunze kwekupiwa mishonga yekubaiwa kan yekunwa, pane here rumwe rwubatsiro rwamunowana rwakaitsa senzira yekurapwa muchivanhu, kugara pasi muchikurukura nekuonesana zvinobatsira, munamato kana zvimwewo?

11. Chipatara chiri pedyo nemi chiri kukubatsirai nenzira dzipi kubva zvamabuditswa muchipatara chiri mukati metirongo?

a) Nderupi rubatsiro rwamuri kupihwa nechipatara chiri munharaunda yenyu?

b) Rubatsiro urwu rwakakubatsirai kusvika papi kana kuti nenzira dzipi?

12. Pane zvimwe zvamungada kundiudza zvamakasangana nazvo mukurapwa kwenyu munguva yamakagara mukati mechipatara chiri mutirongo?

a) Mumaonero enyu mungati kubatwa kwezvirwere nekurapwa kwazvo muvarwere vepfungwa kuri kuitwa nemazvo here?

b) Kana zvisirizvo kubatwa kwezvirwere zvepfungwa nekurapwa kwazvo kungavandudzwa sei?

Appendix D: Ethics approval from the UCT

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Department of Psychiatry
Rondebosch

PROJECT TITLE: THE EXPERIENCES OF EX-OFFENDERS WITH MENTAL ILLNESS AND THEIR CAREGIVERS WITHIN THREE TO TWELVE MONTHS FOLLOWING DISCHARGE FROM PSYCHIATRIC PRISON CARE IN ZIMBABWE: A QUALITATIVE STUDY

Thank you for submitting your response to the Faculty of Health Sciences Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has formally approved the above mentioned study.

Approval is granted for one year.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

Appendix E: Ethics approval from UZ

Joint Research Ethics Committee For The University of Zimbabwe, College of Health Sciences and Parirenyatwa Group of Hospitals

JREC Office No. 4, 5th Floor College of Health Sciences Building
Telephone: +263 4 708140/ 791631 Exts 2241/2242
Email:jrec.office@gmail.com/jrec@medsch.uz.ac.zw, website:www.jrec.uz.ac.zw

APPROVAL LETTER

Date: 21 August 2019 **JREC Ref: 185/19**

Names of Researcher Wellington Mhishi
Address: Department of Psychiatric

RE: THE EXPERIENCE OF EX-OFFENDERS WITH MENTAL ILLNESS AND THEIR CAREGIVERS WITHIN THREE TO TWELVE MONTHS FOLLOWING DISCHARGE FROM PSYCHIATRIC PRISON CARE IN ZIMBABWE: A QUALITATIVE STUDY.

Thank you for your application for ethical review of the above mentioned research to the Joint Research Ethics Committee. Please be advised that the Joint Research Ethics Committee has reviewed and approved your application to conduct the above named study. You are still required to obtain MRCZ and RCZ approval before you commence the study if required by the nature of your study.

- **APPROVAL NUMBER: JREC/185/19**
- **APPROVAL DATE: 21 August 2019**
- **EXPIRY DATE: 20 August 2020**

This approval is based on the review and approval of the following documents that were submitted to the Joint Ethics Committee:

a) Completed Application Form
b) Full Study Protocol
c) Informed Consent in English and/or appropriate local language

After this date the study may only continue upon renewal. For purposes of renewal please submit a completed renewal form (obtainable from the JREC office) and the following documents before the expiry date:

a. Progress report
b. A Summary of adverse events
c. A DSMB report

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OHRP IRB Number: IORG 00008914
PARIRENYATWA GROUP OF HOSPITALS FWA: 00019350

Appendix F: Ethics Approval from MRCZ

Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: http://www.mrcz.org.zw

Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

REF: MRCZ/B/1733 **11 June 2019**

Wellington Mhishi
17 Gardenia Crescent
Msasa Park
Chadcombe, Hatfield
Harare

RE: The experiences of ex-offenders with mental illness and their caregivers within three to twelve months following discharge from psychiatric prison care in Zimbabwe: A qualitative study.

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review:-

1. Completed MRCZ 101 form
2. Full protocol

•**APPROVAL NUMBER** : **MRCZ/B/1733**
This number should be used on all correspondence, consent forms and documents as appropriate.

- **TYPE OF MEETING** : **EXPEDITED**
- **APPROVAL DATE** : **11 June 2019**
- **EXPIRATION DATE** : **10 June 2020**

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted three months before the expiration date for continuing review.

•**SERIOUS ADVERSE EVENT REPORTING**: All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.

•**MODIFICATIONS**: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).

•**TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.

•**QUESTIONS**: Please contact the MRCZ on Telephone No. (0242) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.
- In addition to this approval, all clinical trials involving drugs, devices and biologics (including other studies focusing on registered drugs) require approval of Medicines Control Authority of Zimbabwe (MCAZ) before commencement.

Yours Faithfully

....

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH