PSYCHOSOCIAL REHABILITATION PROGRAMMES IN MENTAL HEALTH: THE PERCEIVED IMPACT OF A PSYCHOSOCIAL REHABILITATION PROGRAMME ON THE RECOVERY OF PERSONS WITH A HISTORY OF MENTAL ILLNESS.

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MASTERS IN CLINICAL SOCIALWORK

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Abstract

This study explored psychosocial rehabilitation programmes in mental health and investigated the perceived impact of participation in a psychosocial rehabilitation (PSR) programme on the recovery of persons with a history of mental illness. The study focused on how their participation in psychosocial rehabilitation programmes impacted the well-being of the mental health users individually and socially as well as their perceptions of the benefits and or disadvantages of participation in the programmes as well as their recommendations for improvements. A qualitative explorative research design was applied. Sixteen participants were selected using purposive sampling and data collected by means of face-to-face semi-structured interviewing. The data obtained was analysed using qualitative methods.

Most significantly the findings of this study further supports the value of psychosocial rehabilitation programmes for mental health users. Most notably improved individual personal development and independence. Social wellbeing improvements were found with an emphasis on growth in confidence to approaching further socialisation, improvements in the quality of individual relationships and the expansion of support networks. No significant critique of the programmes was identified and the most significant improvements recommended related to the expanding of interactive activities such as more peer socialisation and recreational activities to further the therapeutic value experienced in them.

The most important recommendations from the findings include expanding PSR, incorporating PSR programmes into the public service, encouraging PSR programmes through supportive legislation, integrating families more in PSR programmes, expanding research on the outcomes of PSR within a South African context and exploring research that includes the perspectives of the family members living and caring for individuals with mental illness.

TABLE OF CONTENTS

Chapter 1

Problem Formulation

Chapter 2

Literature review

Chapter Three

Research Methodology

Chapter Four

Findings

Chapter Five

Conclusions and Recommendations

List of Annexures

List of Figures

List of Tables

Chapter 1

Problem Formulation

1.1 Introduction

Although mental health is a global phenomenon, the lifetime prevalence of mental illness in South Africa is high (Stein, Seedat, Herman, Moomal, Heeringa, Kessler, & Williams, 2008). This is indicative of the need for access to mental health services for all those affected South Africans. There have been a number of shifts in the treatment of mental health over the decades away from institutionalisation and biomedical models, to a more rehabilitative approach with recovery as a central philosophy. In line with international trends on health policies, the deinstitutionalisation and treating of mental health as an integral part of primary health care is being promoted in health policy in South Africa (Kotzè, 2010:80). This is supported by Lazarus (2005:65) who states that "In South Africa, as part of a package of reforms of mental health care post-1994, a key governmental policy initiative (expressed in various forums and in unpublished documents) has been an attempt to reduce the historical reliance on long-term institutional care for people with severe and chronic mental disorders". Through advancements in the field of mental health, the treatment of patients is refocusing on restoring quality of life to patients who suffer from mental illness. The method currently being utilised and expanded on is deinstitutionalisation, and a tool used to achieve this method is using psychosocial rehabilitation programmes (Cape Mental Health, 2017/18:8).

The South African Mental Health Care Act 17 of 2002:14 highlights that entities responsible for mental health service provision should promote the use of community based-care, treatment and rehabilitation. As a role-player in the South African mental health service provision, psychosocial rehabilitation programmes are being utilised by organisations such as Cape Mental Health to treat persons with mental health problems with the overreaching aim of improving the quality of life of this vulnerable population.

The following section will present the background of the research study through elaborating on the statement of the problem, contextualising the problem and providing a rationale highlighting the significance of the study. It will clarify the research topic, the main research questions to be explored as well as the main assumptions of the study. The research objectives and the main concepts underpinning the research will be clarified. The section will also highlight the main ethical considerations that guide the research process; this is followed by concluding remarks for the chapter.

1.2 Statement of the Problem

In the mid – 1900's there was little effective psychiatric treatment resulting in a limited number of patients being discharged from institutions. This population grew rapidly and the demand for institutional care increased, which placed a huge strain on the available funding (Parker, 2014:76). Institutions became notorious for being places of overcrowding, abuse and neglect as conditions deteriorated (Parker, 2014:76). Deinstitutionalisation therefore allowed for the closure of huge asylums which helped to allay costs but there was an increased potential for the abuse of human rights due to the vulnerability of this marginalised group (Parker, 2014:76). In 2016 the South African department of health came under scrutiny following the termination of a contract with Life Esidimeni, which was a hospital responsible for rendering highly specialised chronic psychiatric care to patients. These patients were transferred to various non-governmental organizations (NGO's), which did not necessarily have the proper facilities, skills and expertise to care for the concerned patients, despite numerous warnings not to. As a result, 94+ patients tragically passed away whilst in the care of these facilities after they were moved (Makgoba, 2017:1). The report on the tragic event revealed that the department of Health's decision to terminate their contract with Life Esidimeni, and transfer the patients to various NGO's was unwise and flawed, and went against the 2013-2020 policy framework and strategic plan. This plan clearly stipulates that "Deinstitutionalization of patients must be done systematically and with adequate provision made for community services" (Mental Health Care Act, 2002 Act No. 17 of 2002, as cited in Makgoba, 2017:1). According to the report, the department's decision was chaotic, rushed, hurried and contradicted the National Mental Health Policy. It further expresses that "the cost rationale could not be justified above the rights of the mentally ill patients to dignity and the state's constitutional obligation to accessible health care" (Makgoba, 2017:1).

Expansion on psycho-pharmacological armamentaria led to a broadening scope of practice outside of asylums as well as the diversification of care for persons with mental illness which was also a result of deinstitutionalisation (Parker, 2014:76). Psychiatry has steadily gained recognition as a medical discipline and psychiatric treatment is becoming more socially acceptable with the delink from the negative associations with institutions (Parker, 2014:76). Priebe, Hoffman, Isermann, & Kaiser as cited in Kliewer, McNally & Trippany (2009:41) identified additional benefits outside of institutions to include patients regaining some forms of independence, a better quality of life as well as a reduction in the psychotropic medication needed to treat them.

The Psychosocial Rehabilitation approach to treatment is part of a bigger transformative development where many countries and organisations are currently developing plans to transform their mental health care systems in accordance with a more recovery orientated approach which is evidenced in South African mental health care legislation. The South African Mental Health Care Act 17 of 2002:14 clearly stipulates that all organs of State responsible for the delivery of mental healthcare services must determine and co-ordinate the implementation of its policies and measures in manners that include the promotion of the rights and interests of mental healthcare users. It is also compulsory that they aim to promote and improve the mental health status of the population. Recovery-oriented approaches such as psychosocial rehabilitation are believed to have a positive impact on rates of overnight hospitalisation and the individual's ability to function in communities.

Psychosocial Rehabilitation programmes as an approach or method of treatment has gained momentum globally with the transformation towards recovery-orientated approaches. This movement in mental health is acknowledged as a growing movement in respect of donors and funders, and consequently, researchers and NGOs, clinical practitioners, advocates and service users who share common objectives. These common objectives being, to improve mental health and development and to provide services that support people's right to mental health. Historically human rights approaches to mental health treatment can be traced back to having some roots in Italy, spearheaded by individuals including Benadetto, Saraceno and Michele Tansella in the 1970s and 1980s (Brooke-Sumner, 215:9). Developments in South Africa are on par with the developments of the rest of the world where some of the recovery-orientated approaches are reflected in the roll out of the psychosocial rehabilitation programmes in organisations like Cape Mental Health. The value of psychosocial rehabilitation programmes within a South African context is reflected in their inclusion by organisations such as Cape Mental Health, and further expressing their vision to expand on programmes like the Rainbow Foundation into rural communities. Research on the clubhouse psychosocial rehabilitation model has indicated that clients are able to achieve a variety of quantifiable outcomes which include them gaining employment, a larger social network and reducing the experience of stigma related to their illness (Rousea, Mutschlera, McShanea, & Habal-Brosekb, 2017:140).

Within a local South African context, there is little research on the effectiveness of psychosocial rehabilitation interventions within our communities and therefore limited information available on the impact of psychosocial rehabilitation interventions on persons with mental illness within a South African context.

The purpose of this study is to explore the perceived impact that psychosocial rehabilitation programmes have on the recovery of persons with a history of mental illness within the context of Cape Town, South Africa.

1.3 Problem context

The proposed research study will be conducted in Cape Town in the Western Cape Province, South Africa where a few non - institution based mental healthcare services are available for people with mental illness with a focus on those utilizing the Psychosocial Rehabilitation intervention approach. Data will be gathered from a sample of participants accessing psychosocial rehabilitative treatment services for mental health related issues through a non-profit organisation, Cape Mental Health (CMH). CMH renders psychosocial rehabilitation (PSR) programmes for adults with severe mental illness in order to facilitate the improved functioning that is necessary for integration of persons with mental illness into community life. The organisation's main vision and mission for all the participants in its PSR programmes is the "highest possible level of mental health and quality of life". The programme under investigation is a unique psychosocial rehabilitation programme (PSR) with a comprehensive continuum-of-care model that offers a best practice response to deinstitutionalisation (Cape Mental Health 2016/17:8). Cape Mental Health is 105 years old and through their growth and development, introduced their psychosocial rehabilitation programmes in its later years of operation. Cape Mental Health PSR programmes are divided into four sub-programmes, which include, namely, community-based support groups (Rainbow Foundation), the Fountain House clubhouse model, a self-advocacy body (Cape Consumers Advocacy Body) and supported housing (Kimber House). The Rainbow Foundation has a total of 26 groups that meet in the greater Cape Town area reaching a total number of more than 219 participants (members) and their families.

The proposed study aims to focus on the perceived contributions of the Fountain House and Rainbow Foundation programmes as examples of Psychosocial Rehabilitation intervention programmes implemented in South Africa.

1.4 Rationale/ Significance of the study

According to the South African Health Care Plan 2010 developed by the Department of Health, there is a shift from hospitalisation to the provision of services at a community level (Grobbelaar, 2010:10). This is supported by the South African Mental Health Care Act. 17 of 2004, which places emphasis on people with mental illness having the right to rehabilitative services. Although there appears to be sufficient evidence to support the use of rehabilitative services within the mental health field, there is limited research and literature available to support evidence for the impact of psychosocial rehabilitation interventions within a South African context. By providing qualitative insight into the impact of psychosocial rehabilitative intervention from those accessing the service within a South African context will allow for the development and provision of services that is beneficial to its recipients. It will also provide increased evidence for best practices within a local context which could allow for the continual improvement of services rendered. Psychosocial Rehabilitation Programmes like Rainbow Foundation are cost effective, and can be replicated with great success in rural communities (Cape Mental Health, 2017/2018). This research could also provide evidence to support efforts at securing funding for the continuation and expansion on these services into rural communities like the Eden Karoo. This should form part of the vision for South African mental health and is in line with the goals for the expansion of Cape Mental Health PSR services in an effort to increase the accessibility of mental health services for all those in need.

1.5 Research topic

Psychosocial Rehabilitation Programmes in Mental Health: The perceived impact of a psychosocial rehabilitation programme on the recovery of persons with a history of mental illness.

1.6 Main research questions

1. How has participation in psychosocial rehabilitation programmes impacted the well-being of the mental health users individually? (Emotionally, psychologically, medically – relapse prevention, treatment compliance etc.)
2. How has participation in a psychosocial rehabilitation programme impacted the well-being of the mental health care users socially? (family, peers, community)
3. What aspects of the psychosocial rehabilitation programme did mental health users perceive to be most beneficial?

4. What aspects of the psychosocial rehabilitation programme did mental health users perceive to be least beneficial?
5. How do mental health users of the Cape Mental Health Psychosocial Rehabilitation Programme perceive that the programme could be improved?

1.7 Main assumptions

1. Mental healthcare users experience of the psychosocial rehabilitation programme has contributed to change at an individual level.
2. Mental healthcare users experience of the psychosocial rehabilitation programme has contributed to change at a social level.
3. Mental healthcare users may have experienced aspects of the psychosocial rehabilitation programme as more beneficial than others.
4. Mental healthcare users may have experienced aspects of the psychosocial rehabilitation programme as less beneficial than others.
5. Mental healthcare users of the psychosocial rehabilitation programme possess opinions on how the programme can be improved.

1.8 Research objectives

1) To investigate the perceptions of mental healthcare users about the impact their participation in the psychosocial rehabilitation programme had on their individual well-being.
2) To explore the perceptions of mental healthcare users about the impact their participation in the psychosocial rehabilitation programme had on their social well-being.
3) To determine the aspects of the psychosocial rehabilitation programme mental healthcare users perceived to be most beneficial to their wellbeing.
4) To determine the aspects of the psychosocial rehabilitation programme mental healthcare users perceived to be least beneficial to their wellbeing.
5) To ascertain what improvements mental healthcare users of the psychosocial rehabilitation programme recommend.

1.9 Clarification of Concepts

1.9.1 Psychosocial Rehabilitation

Psychosocial rehabilitation is an approach to treatment that stems from the humanistic style of psychology in that it assumes that each person is capable of improving his or her level of functioning (Rousea et. Al. 2017:139). For the purpose of the study psychosocial rehabilitation will be defined and understood as such. The definition includes a motivation towards better use of their potential, social, emotional, mental, and working capacity (Rousea et. Al. 2017:139), in order to improve their level of functioning.

1.9.2 Mental illness

Mental illness refers to the positive diagnosis made by a mental health or medical practitioner authorised to make such a diagnosis. The diagnosis can be of any mental health related illness in terms of the accepted diagnostic criteria (Mental Health Care Act 17 of 2002:10). Mental illness in respect of this study will be implied and elaborated on according to this definition.

1.9.3 Recovery

This is a general term used for the conveyance of the idea that despite having a mental illness, individuals are able to live meaningful and productive lives (O'Brien, Samuelson and van Nostrand, 2013:429). Recovery for the purpose of this study will be defined according to the mentioned definition and includes the person's ability to improve their level of functioning.

1.9.4 Deinstitutionalisation

Perko, Kreigh, Rawlins, Williams & Beck as cited in du Plessis, Greeff & Koen (2004:4) state, "deinstitutionalisation is the process that takes place when institutions, and long-term institutionalisation is replaced by community-based mental health services and community support systems in order to promote the psychiatric outpatient's integration and normalisation in the community**".** For the purposes of this study, deinstitutionalisation will be referred to according to this definition.

1.10 Main Ethical considerations

1.10.1 Harm to participants

There are various categories of harm to participants, these include physical harm, psychological abuse, and legal jeopardy. Harm can also be economical which affects an individual's income (Neuman, 2011:145).

1.10.2 Physical harm:

What is considered one of the core ethical principles is that the research conducted causes no physical harm to the participants. This implies anticipating risk before the research begins; including basic safety concerns such as safe buildings, equipment and furniture. High-risk subjects should be screened out if the study involves stress, such as persons with heart disease and mental illness. The danger of injury and physical attacks on researcher(s), participants or assistants should be anticipated (Neuman, 2011:146). In order to ensure that no participant is physically harmed, the researcher will ensure, prior to engaging, that the venue selected is safe and the furniture is appropriate. Because the research will include persons with mental illness, the researcher will ensure that all those participants engaging, are stable at the time and do not have a history of violent or aggressive behaviour.

If being interviewed evokes any painful or difficult memories for the clients, the researcher will contain the client if necessary, and then refer the client to resources at Cape Mental Health. This supportive counselling will be available to participants should they feel they need it after participating in the research study.

1.10.3 Psychological Abuse, Stress or Loss of Self-Esteem:

Social researchers in certain instances may place participants in stressful, embarrassing, anxiety-provoking, or unpleasant situations. A sensitive researcher is someone who is aware of the potential harm to an individual's self-esteem when engaging in the research process. As a core ethical principle, researchers should never create unnecessary stress in participants. Unnecessary harm implies beyond the minimal amount required to create the desired effect, or stress without a direct and/or legitimate research purpose (Neuman, 2011:146).

Individuals who suffer from psychotic disorders and even those with mood disorders have the potential when ill, to become violent or exhibit behavioural outbursts. Despite the screening of participants for predictable risk, displays of physical aggression could manifest should clients become unstable or evoked through emotional pain. In such an instance, the researcher will try their very best to contain the participant and then call on the necessary help which could include medical staff at the day hospital applicable, or the emergency unit at the hospital the participant attends. All the intended participants are clients of the Cape Mental Health programmes. In the event, that during an interview the participants makes statements about the organization and its staff that could harm its reputation and image, with the consent of the participant, the researcher will refer the matter to the organisation through formal grievance lodging processes by documenting the statement in an incident report. This will be forwarded by the researcher to management to then be formally addressed by the organisation depending on the nature of the dissatisfaction.

1.10.4 Informed Consent

Informed consent refers to a written agreement to participate in a study given by people after they have learned some basic details about the research processes (Neuman, 2011:149). The researcher will communicate all of the basic details of the research study including the goal/purpose of the study, procedures which will be followed during the study, the possible advantages, disadvantages, and dangers to which participants may be exposed to, the credibility of the researcher and the nature of the research (De Vos, Strydom, Fouche` and Delport, 2005). Information about the research will be communicated openly with the participants and they will be asked for their permission to include them in this research project.

1.10.5 Deception of participants

Deception of participants is closely linked to the concept of voluntary consent, which forms a major ethical tenet. Voluntary consent implies that no one should ever be forced to participate in the research (Neuman, 2011:149). Not to lie to research participants is a related ethical rule. As a very serious ethical standard in research is participants agreeing to participate in the study. Deception is never the preferred option, if the researcher can accomplish the same thing without the use of deception. It is only acceptable to use deception if it has a specific methodological purpose, and even then, it can only be used to the minimal degree necessary (Neuman, 2011:149). All the necessary information about the study will be shared with the participants prior to the onset of the study. This will be done so that there is clearly no deliberate misrepresentation of facts and violation of respect by disguising the goal of the study to the participants.

1.10.6 Violation of Privacy/ anonymity/ Confidentiality

Social researchers should take precautions to protect participant's privacy because they transgress the privacy of subjects in order to study social behaviour (Neuman, 2011:152). The importance of the following concepts, although interrelated, should be recognised and understood in their individual capacity too.

1.10.7 Privacy

An ethical researcher is an individual(s) who violates privacy only to the minimum degree necessary. Researchers should in addition also protect the information on research participants from public disclosure (Neuman, 2011:152). In an effort to protect the privacy of the participants, the researcher will ensure that the information gathered for the purposes of the research is protected and not accessible to the public.

1.10.8 Anonymity

In order to protect the privacy researchers do not disclose the identity of participants after information is gathered. This is achieved through the use of confidentiality and anonymity. Anonymity is defined as the people remaining anonymous or nameless (Neuman, 2011:152). Anonymity will be upheld through the protection of the client's identity, client's personal information such as their names or any pictures which will not be disclosed to any party. The participant's names will also not be used when reporting the research findings. In addition, the researcher will use pseudonyms such as participant one, in order to protect the identity of the participants.

1.10.9 Confidentiality

Even if it is not possible to protect the person's anonymity, it is important to protect the confidentiality of participants. Confidentiality is defined by the parameters that names may be attached to information, but that it be held in confidence and/or kept secret from the public (Neuman, 2011:153). The researcher can provide anonymity without confidentiality or vice versa, although the two commonly go together (Neuman, 2011:153). Confidentiality will be upheld through preserving the information shared by participants in the interviews, it will not be shared with others and retrieved in a setting that does not allow people to overhear the information shared. Furthermore, all manuscripts will be treated with the strictest confidence in the way they are stored. Confidentiality will be openly communicated and emphasised to the participants before the onset of the interviews.

1.10.10 Actions and competence of the researcher

It is an ethical obligation of the researcher to ensure that they are competent and adequately skilled to undertake the proposed research (De Vos et al., 2005:63). The researcher's training in social work and research methodology allows him to be sensitive when conducting interviews. The researcher will utilise all the appropriate skills he possesses when conducting the interviews, and will be sensitive to cultural diversity and boundaries. Sensitivity to cultural boundaries will be executed through reserving value judgements. Careful consideration will be given not to impose the values and beliefs of the researcher onto the participants.

1.10.11 Release of publications

According to De Vos (2005:65) research studies should be introduced to the reading public in written form and these reports should be compiled as accurately and objectively as possible. The formulation and conveying of information should be clear and unambiguous to avoid or minimize misappropriation by subjects, the public and colleagues. The study and its results will be available on the university library portal for access to the public for reading and will be provided to Cape Mental Health. Participants will also be provided with an opportunity to receive the results should they make a request to do so.

1.10.12 Debriefing participants

Debriefing refers to the session after the study in which participants get the opportunity to work through their experience of participating in the study. Debriefing constitutes one of the possible ways in which the researcher can assist the participants in the study and minimise harm (De Vos et al., 2005:66). The researcher will make available referral pathways to Cape Mental Health social workers for all those participants who indicate the need for intervention.

1.11 Reflexivity

In a qualitative research paradigm, the researcher is the instrument in data analysis. For this reason, it is important that the researcher take cognizance of their own feelings around the subject area of the study in order to adequately separate their personal feelings from the research process (De Vos et al., 2005:). The researcher has had a personal experience with depression and has insight into mental health as a social worker within the mental health field. The researcher has also had close friends and family who suffer from mental health related challenges.

The researcher works in the field of mental health within the same organisation in which the research sample will be identified. The researcher might have some insight into some of the cases presented in the research study. With a background in working therapeutically with mental health care users, it is important for the researcher not to empathise and engage on the therapeutic level with the participants. If any concerns and distressing symptoms pertaining to the participant and their mental health manifests during the interview, the researcher should refer the clients to the relevant support system, or take the necessary crisis intervention. The researcher will make use of the skill of bracketing his own perceptions and feelings in order to maintain an objective standard in reference to the study and data collection.

1.12 Conclusion

This chapter presented the statement of the problem, contextualising the problem and providing a rationale highlighting the significance of the study. It clarified the research topic, the main research questions to be explored as well as the main assumptions of the study. The research objectives and the main concepts underpinning the research were clarified and the main ethical considerations highlighted. The following chapter, the literature review, will discuss relevant literature pertaining to the study.

Chapter 2

Literature review

2.1 Introduction

The literature review aims to contextualise the study. The information discussed in this chapter serves as a foundation of existing knowledge and theory relevant to the focus of the study. The review of literature includes the recovery paradigm, psychosocial rehabilitation as an intervention, the relevant policy and legislation applicable to the study, and the theoretical frameworks that underpins the study. The literature reflects the individual and social impact of attending psychosocial rehabilitation programmes, the benefits and criticisms of psychosocial rehabilitation programmes as well as the advancements in psychosocial rehabilitation. This will be followed by concluding remarks for the chapter.

2.2 Living with mental illness

2.2.1 Onset of mental illness

One of the reasons people need access to holistic interventions for mental illness such as psychosocial rehabilitation programmes, is due to the unique and complex way in which mental illness is experienced by individuals. This unique experience from its onset is different for each individual. There are a variety of contributing factors to the onset of mental illness. Certain illnesses are associated with triggers such as the use or abuse of illicit substances. There have been clinical observations on the association between illnesses such as depression, and the abuse of alcohol and other drugs (Deykin, Levy & Wells, 1987;178). Deykin et al. (1987:178) states that alcohol and many other illicit drugs are depressogens and by repeatedly using them, individual(s) produces the subjective feelings of depression as well as the neurovegetative signs of appetite or sleep disturbances. There is also clear evidence highlighted in research between trauma and its link to the onset of mental illness. According to DeHart, Lynch, Belknap, Dass-Brailsford and Green (2013:2), in several studies conducted on general community members, it has been found that individuals are at greater risk of developing psychological problems if they have experienced some kind of trauma among many other associated causes for the onset of mental illness.

2.2.2 Warning signs

While the nature and presentation of mental illness and its associated symptoms can occur spontaneously and is unique to every individual, there have been some studies that have shown evidence of some precursors or warning signs to an episode or regression in health and functioning as a result of mental illness. According to Novacek & Raskin (1998:376) when decompensation warning signs also known as prodromal symptoms is addressed as a part of treatment, it is often associated with favourable treatment outcomes. Hospitalisation is seen as a last resort, but when people with mental illness begin to experience psychological decompensation, there is usually a specific behavioural pattern that presents, indicating that they may need to be hospitalised. This can include the loss of appetite, hearing voices, becoming socially withdrawn, exhibiting excessive anger and becoming overly hostile (Novacek & Raskin, 1998:376).

2.2.3 Challenges living with mental illness

Individuals who suffer with severe mental illness such as depression, anxiety or schizoaffective disorder among others, show a common trend of manifesting a combination of dysfunctional and/or disturbing behaviours, thoughts, emotions and relationships (Wong-Anuchit, Chantamit-o-pas, Schneider, Mills, 2019:122). There are a wide range of features, symptoms and manifestations that people with severe mental illness may display. These may include depression, anxiety, psychosis and substance abuse. In addition they may also experience the side effects of the medication. (Wong-Anuchit et al., 2019:122). The way in which a mental illness presents allows professionals to provide individuals with guidance on a diagnosis. This is done partially through the use of a diagnostic and statistical manual which provides the professional with the necessary criteria needed for a person to meet a specific mental illness diagnosis. Depending on the illness, there are associated symptoms which make up these criteria. Bolhuis Koopman-Verhoeff, Blanken, Cibrev, Jaddoe, Verhuls, Hillegers, Kushner & Tiemeier (2018:16) states that there are elevated levels of risk of subsequent psychotic like experiences in most adult psychiatric disorders including impulse control, anxiety and mood disorders.

In addition to the experience of the often debilitating features and symptoms, people with mental illness are often also subjected to stigma. Research has shown that there has been a historical tendency for the public to have a negative opinion towards individuals with mental illness, and this has been very slow to change over the years (Wahl, 2017:9). This experience of stigma makes individuals reluctant to seek treatment, thus delaying their access to treatment. There is a tendency to avoid situations which may expose them to rejection and devaluation, which in turn results in lower treatment adherence. This is because people are attempting to distance themselves from social exclusion labels (Wahl, 2017:9). Research and advocates have also indicated that one of the common experiences of people with psychiatric diagnoses is that of being discriminated against. It is less likely that an applicant with a psychiatric diagnosis will be offered a job, a rental agreement or admission into a professional school over someone without a psychiatric history (Wahl, 2017:9). The experience of stigma is often reinforced by family. Research indicates that as little as a quarter and as much as half of family members believe their relationship with a person who has a mental illness is a source of shame or should be kept a secret (Corrigan, Miller & Watson, 2006:239).

Research further indicates that families who are caring for members who battle with mental illness often find the task of having to care for these individuals to be demanding, which takes a toll on their lives and their personal relationships (Jeon & Madjar, 1998:698). Jeon & Madjar (1998:698) further state that the provision of care to a family member with chronic mental illness is indicative of an existence of a unique life where the individual's world is centred around the person who develops the mental illness and these individuals are seen as needing to have ongoing protection and care. The carers world is defined subjectively by a strong sense of responsibility. This constructs and dictates the caregiver's life in particular ways, which can affect both temporality and relationality (Jeon & Madjar (1998:698). It is therefore understandable why people with mental illness have a difficult time enjoying good family relationships, healthy lifestyles, satisfying jobs and being productive members of society. These are considered some of the goals of rehabilitation, but are also considered to be some of the expectations in life that most people aspire to. These expectations to enjoy healthy lifestyles, enjoy good family relations and have a satisfying job are profoundly affected for individuals with mental illness (Crosse, 2003:178).

It is indicated in literature that there are few natural structures within an individual's local community to encourage socialisation for persons with mental illness. This could be due to a myriad of factors, including the combined impact of having a mental illness and being subjected to stigma which makes establishing and maintaining relationships difficult for these individuals (Sheridan, Drennan, Coughlan, O'Keeffe, Frazer, Kemple, Alexander, Howlin, Fahy, Kow & O'Callaghan, 2015:242). The establishment of social networks as well as extending and maintaining engagement with these networks require the ability of individuals to exploit existing opportunities which is greatly lacking in individuals with mental illness. According to Seridan et al. (2015:242) this is achieved in adult life through occupying educational, occupational and social roles, like parenting and intimate relationships. Illness related factors including the negative symptoms of illnesses such as schizophrenia, medication side effects and reduced social and interpersonal skills. Another contributor to reduced social networks for persons with mental illness is the likelihood that they lack opportunities to meet people in occupational roles due to unemployment, living in sheltered and restricted environments, and the lack of intimate partners which restricts the opportunities to develop friendships and build social networks (Seridan et al., 2015:242). In a study conducted among a group of Swedes living with mental illness, participants in the study identified the following five sources of meaning they associate with the activities they had done within a 24-hour period (Hancock, Honey & Bund., 2015:509)

1. Enjoyment and having fun in life.
2. Connecting with others
3. Productivity and a sense of achievement
4. Routine and projects to work on in a time stream
5. Self-care to maintain one's health.

A key finding from this study notes that people with mental illness are likely to prioritise socially derived sources of meaning and that this can be gained from a diverse number of occupations (Hancock, Honey & Bund., 2015:509)

2.2.4 Accessing treatment for mental illness

The access to mental health services is often done through referral by a family member. Young people in particular are most likely going to open up to someone they trust. They are therefore consequently more likely to turn to their family or friends for personal or emotional problems, rather than other sources, including mental health professionals (Richwood, Deane &Wilson (2007:35). There are many role players who enable people to gain access to mental health services. Another important role player in the referral for accessing mental health treatment are professionals. An example of an important professional referral is the referral of young people by their teachers. According to Pearcy, Clopton and Pope (1993:165) the referral for behavioural or emotional problems is often initiated by teachers. Professionals such as general practitioners are also seen as crucial in the referral process, and it is therefore important that general practitioners (GP's) know and refer people to support organisations, as people trust recommendations from their GP over that of strangers (Crosse, 2003:179). Further efforts to encourage people to access mental health services has been making the availability of such services known to the public whether it be the persons needing the services or family and friends caring for someone with a mental illness. In a study conducted by Henderson, Robertson, Evans-Lacko & Thornicroft, (2020:320) it was identified that there is an association between public awareness campaigns and a number of favourable outcomes. These favourable outcomes include disclosing a mental health problem to employers, feeling comfortable disclosing to a family member or a friend, and seeking help.

2.3 The recovery paradigm

2.3.1 Origins and overview of the recovery paradigm

In line with the reform on mental health through deinstitutionalisation, the concept of recovery from severe mental illness among organisations providing behavioural health services has gained increased prominence (Malinovsky, Lehrer, Silverstein, Shankman, O'Brien, Samuelson, van Nostrand: 2013:428). The concept of 'recovery' emerging in mental health is traceable to consumer advocacy initiatives dated back to as early as the first half of the 20th century, but had little impact on the mainstream approaches to treatment. Since the mid-1980's the concept has gained increasing prominence and consideration among psychiatric rehabilitative service providing organisations for persons with severe mental illness, as well as among policy makers. This shift has been in light of evidence which suggest that individuals can recover from illnesses like schizophrenia (Malinovsky et. al., 2013:429). Out of the predominant deficit approach in mental health systems during the mid-20th century, emerged the notion of recovery, which is generally used to convey the idea of individuals living productive and meaningful lives despite a psychiatric illness. The concept has been defined and redefined by various stakeholders such as researchers, professionals and consumers, which has resulted in a plethora of diverging definitions (Malinovsky et. al., 2013:429).

According to Liberman et al., 2002; Noordsy et al., 2002 as cited in Malinovsky et. al., (2013:429) there are many popular conceptualizations of recovery, however, they have been characterised as being vague and inconsistent, making it difficult to evaluate the findings in research and to compare their outcomes. For this reason, it has been argued that deconstruction of the concept into meaningful and measurable components could have important implications on the direction of consumer care and education of service providers (Liberman et al., 2002; Noordsy et al., 2002 as cited in Malinovsky et. Al., 2013:429).

According to Onken, Craig, Ridgway, Ralph, and Cook (2007) as cited in Malinovsky et. al., (2013:429) in their review of literature on recovery, they have argued that recovery consists of both the re-establishment of social integration and an individual's mental health. Within their own framework, each individual acquires the key elements of self-determination, hope, awareness/potential, and meaning/purpose in the context of recovery-promoting social relationships. These relationships include family, friends and mental health professionals. Among providers of mental health services, process-orientated definitions of recovery have been very popular while outcome-oriented definitions have been the dominant approach in research. Various research groups have attempted to refine operational definitions of recovery in order to inform disciplined empirical inquiry into the phenomenon. Liberman, Kopelowicz, Ventura, and Gutkind (2002) as cited in Malinovsky et. al., (2013:429), for example, it is suggested that in order to recover from mental illness an individual should:

1. Display symptom remission which is measured by an objective symptom rating scale
2. Participate in roles appropriate for the individuals age and culture i.e. full or part time employment, schooling or other gainful employment'
3. Individuals should live independently from their family or caregiver's supervision and have complete responsibility for their own daily living and activities; and
4. Be actively involved in friendships and relationships and/or social relations or recreational activities that are appropriate to the individuals age and is done without the supervision of a professional**.**

In this framework the duration of remission of symptoms and functional improvement must be present for a period of 2 years.

There have also been efforts made in identifying the promoting of organizational characteristics and practices that facilitate the recovery of its service users. This, at an organisational level, is characterized by increased peer support, the access to services, having choices and a more helpful orientation and systems culture (Malinovsky et. Al., 2013:429).

2.3.2 Recovery Orientated Models

According to Frost, Tirupati, Johnston, Turrell, Lewin, Sly, Agatha, Conrad. (2017:1) many people with severe mental illness have been discharged from long-stay care facilities thanks to the likes of psychopharmacological treatments. This however did not always address all of people's needs, and in many reported cases, the only intervention provided was the prescription of psychiatric medications. Despite being considered fundamental to illness management, psychopharmacology is described as, at best, limited in its role to restore the skills considered essential for living a satisfying and fulfilling life (Frost et. Al. 2017:2). With the increasing burden of severe mental illness, countries like Australia have called for a reform in mental health to include a broader framework which called for an integrated recovery- oriented model (ROM) for mental health services. This model seeks to support and promote the idea of remediation, restoration and reconnection. The Australian national framework for recovery-orientated mental health services is described in literature as being "... centred on and adapts to people's aspirations and needs, rather than people having to adapt to the requirements and priorities of services" (Frost et al. 2017:2). It further states that people or entities responsible for delivering mental health services have a "...responsibility to provide evidence-informed treatment, therapy, rehabilitation and psychosocial support that assist in achieving the best outcomes for people's mental health, physical health and wellbeing" (Frost et al. 2017:2). Torres-González, Ibanez-Casas, Saldivia, Ballester, Grandón, Moreno- Küstner, Xavier, Gómez-Beneyto, as cited in Frost et al. 2017:3) highlights some of the key features of a recovery orientated model, and identify six areas of specific needs. These areas include "frequent complications and co-morbidities (e.g. substance misuse); psychological, social and economic needs; early interventions to reduce illness progression; treatment augmentation with rehabilitation in evidence-based interventions (EBIs); maintenance of service contacts; and greater research efforts into existential needs" (Torres-González et al., as cited in Frost et al. (2017:3). The term recovery in mental health is multi-layered, and among authors there are varied nuances. However, they share a common understanding that, one of the overreaching goals of a recovery orientated model, is that it carries an unequivocal message of a better outcome for the user, therefore conveying a sense of hope (Frost et al. 2017:3). In addition, Frost et al. (2017:3) states that it may also carry expectations around how the interventions should be carried out, the time frames as well as support. In order to contextualise this overreaching goal, the definition of hope is described as "the person's perceived ability or internalised belief that he or she can produce goals, pathways and agency" (Frost 2017:3). This definition, according to Frost et al. (2017:3) then suggests that hope, as a goal directed motivational process requires constant feedback and agency. According to Frost et al. (2017:6) clinical rehabilitation in mental health is based on principles and priorities which include "recovery-oriented; promoting independence; person-centred; flexible, responsive and inclusive; accommodating different learning styles; focusing on strengths; utilising evidence based interventions; providing integrated multidisciplinary care (including service continuity); and facilitating community and environmental supports." Based on the principles and priorities of clinical rehabilitation, the goals for intervention include having the clients aspirations on hope included, to work with the individuals personal goals, to make sure goals are self-identified, and lastly to assist the client in properly formulating their goals (Frost et al. 2017:7).

From the literature it appears that one of the common themes among authors when trying to define recovery, is that it has been historically difficult to find a consensus among the various stakeholders in mental health on a common definition of recovery from mental illness. There is, however, agreement that progress has been made from a more deficit approach to a more empowering one, promoting the fact that persons with mental illness still have the possibility of living productive lives. In order to live productive lives, there is varying degrees of recovery possible, and this can be achieved through various interventions i.e. the use of psychosocial rehabilitations. The difficulty in defining recovery, and the varying degrees of recovery has also resulted in the need to develop identifiers of recovery, which sometimes share similarities in literature, but often also differ. The concept of recovery forms some of the fundamental principles on which the idea of psychosocial rehabilitation is built. It suggests that persons with mental illness, despite their illness can live meaningful and productive lives, with an intervention that appropriately focuses on the individual's capabilities, and fosters hope. The following section will unpack the modern use of psychosocial rehabilitation in mental health, and how persons, through such goal directed interventions can achieve and live meaningful and productive lives, and recover from mental illness.

2.4 Psychosocial Rehabilitation

What makes psychosocial rehabilitation programmes unique is the contrasting focus on symptom stabilisation and acute care which is how psychosocial rehabilitation sets itself apart from other types of rehabilitation. Coming from a humanistic style of psychology the approach assumes that each person has the capability of improving their level of functioning (Rousea et. al. 2017:139). Service providers of psychosocial rehabilitation use motivation to encourage clients to make use of their inherent potential in respect of their social, emotional, mental and working capacity as a tool in intervention. Psychosocial rehabilitation programmes do not place limitations on the person accessing the service; this implies that any person who has ever been impacted by mental health difficulties is accepted into the programme (Rousea et. al. 2017:139). In comparison to other mental health treatment facilities that require a diagnosis with symptoms currently present, the psychosocial rehabilitation approach allows for individuals who are constantly in a state of recovery to receive the help and support they need (Rousea et. al. 2017:139).

The following section provides an overview of resources/tools which government departments have put in place to encourage, promote and facilitate the implementation of PSR programmes within mental health. This is achieved through the development and implementation of supportive policies and legislature which also serves to guide and frame the development and implementation of PSR programmes in the country.

2.5 Policy and legislation

2.5.1 The South African Mental Health Care Act

As briefly introduced in chapter one, there are various forms of policy and legislation that support and protect the rights of persons with mental illness. These include guide interventions, that promote and regulate the development and implementation of mental health services in the country. The development and adoption of the South African Mental Health Care Act 17 of 2002 was one of the first and notable advancements in South African legislation as it emphasises the specific human rights of persons with mental illness as well as the access to services for persons with mental illness. Further advancement was taken by the National Health Council in July 2013 when they adopted the Mental Health Policy Framework (MHPF) for South Africa and the Strategic Plan 2013-2020 (Stein, D.J., 2014:1)

In line with the South African legislation to promote the deinstitutionalisation of mental health services, which has opened the door to interventions like psychosocial rehabilitation programmes, the South African Mental Health Care Act promotes the use of community based-care, treatment and rehabilitation. It further articulates the scope of services which mental health service providers such as Cape Mental Health and psychiatric hospitals may provide in terms of treatment and rehabilitation. The objectives of the act aim to regulate mental health in such a manner that people receive the best possible mental health care, treatment and rehabilitation. It then further emphasises that such treatments be executed fairly, efficiently and that it be done in the best interest of the mental health user within the confines of the resources available (South African Mental Health Care Act 17 of 2002:7). It also states that access should be co-ordinated according to various categories of mental health care users. This implies that mental health services should be accessible to persons with all mental health related conditions and not specific categories only, such as persons with psychiatric disability only, not including persons who might have intellectual disability, dual or poly diagnoses. Human dignity is highlighted as a key guideline within the South African Mental Health Care Act (2002:9) where it is stated that, "every mental health care user must be provided with care, treatment and rehabilitation services that improve the mental capacity of the user to develop to their full potential and to facilitate his or her integration into community life".

2.5.2 National Mental Health Policy Framework and Strategic Plan

The promotion of community mental health services according to the National Mental Health Policy Framework and Strategic Plan (2013-2020:23) aims to upscale community mental health services, to match the national recommended norms, and provides three core components to service provision:

1. Community residential care (including assisted living and group homes);
2. Day care services; and
3. Outpatient services (including general health outpatient services in public health care and specialist mental health support).

This reiterates that in accordance with the South African Mental Health Care Act (2002) consumer organisations and NGOs will be eligible to provide and be funded by the government for community programmes and/or facilities. These plans laid out by the mental health care act can be observed through initiatives by government departments such as Social Development, and the Department of Health's efforts to fund community-based initiatives by organisations such as Cape Mental Health in respect of their psychosocial rehabilitation programmes, among others.

These two legislative documents have contributed directly to the field of mental health as the focus for its development. However, there are also additional policies and legislation that apply to protecting people with mental illness. These include the South African Constitution, Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000, The South

African Bill of Rights, and the United Nations Convention on the Rights of Persons with Disabilities, among others. These policies act as additional tools to protect the dignity of people affected by mental illness. It also aims to uphold and promote their human rights and the access to basic needs as well as services to function optimally with their disability. The literature on policy and legislation clearly indicates an inter-relatedness which supports the best interests of persons affected by mental illness. It serves not only as protective factors for persons with mental illness, but is also a guideline for people and institutions that render services to persons impacted by mental illness directly or indirectly.

Through supportive legislation like The South African Mental Health Care Act, National Mental Health Policy Framework and Strategic Plan, stakeholders have a blueprint from which to execute and further develop mental health services. One significant shift in policy and legislation was the deinstitutionalisation of mental health care. This intention not only promotes the rights of people with mental illness to being part of society, but also makes room for alternative interventions such as psychosocial rehabilitation. It solidifies and legitimises psychosocial rehabilitation's role in mental health and the importance of promoting such interventions, or we wouldn't have accessible mental health for many South Africans. The following section will highlight the theoretical frameworks that support psychosocial interventions, and guide the design of such programmes and interventions.

2.6 Theoretical framework

In the literature on psychosocial rehabilitation programmes, two appropriate theoretical frameworks were identified. In order to understand the psychosocial rehabilitation programmes as well as people's experiences of being a part of such programmes, the researcher explored some theories to better understand this model of treatment. As the title of the research study eludes to, psychosocial rehabilitation programmes suggests an intervention strategy that is informed and framed by psychosocial theory. With this background, psychosocial theory is identified as one of the theories that will frame and guide this research study. The self-determination theory will be a secondary theory informing the study. This theory was selected as it supports a basic understanding around how mental illness should be viewed, and informs professionals on how to manage individuals. This is achieved by highlighting the importance of the person receiving treatment. The second theory also further supports, and in some instances reinforces psychosocial theory and its people centred approach. Self-determination and psychosocial theories provide a lens through which to view treatment(s) and intervention(s) like the PSR programmes being explored in the study.

2.6.1 Psychosocial theory:

Most social work theory prior to the 1960's was based on psychodynamic ideas, and this is now regarded as psychosocial theory (Payne, 2014:109). Psychosocial theory was developed from various streams of thought including **psychosocial**, formally known as diagnostic theory, which focuses on diagnosing, assessing and classifying treatment as a basis for exploring the 'person-in-situation'. Functional theory where emphasis is on the function of social work agencies in giving social work practice its form and direction. And lastly, problem solving casework that focuses on the exploration of problems individuals present and how to improve their capacity to cope with these problems. These psychodynamic ideas are collectively now referred to as psychosocial theory (Payne, 2014:109).

The psychosocial theory in social work emerged from efforts to support the wellbeing of individuals and families, and to respond to people's need to restore their social functioning, better their interpersonal relationships as well as their life situations (Turner, 2011:388). The psychosocial perspective consistently recognises the influence and interplay of biological factors, internal psychological and emotional processes, and external social and physical conditions. Psychosocial interventions are intended to reduce problems arising from some kind of disequilibrium between individuals, families, and their environments (Turner, 2011:389).

One of the fundamental steps in the psychosocial model is studying individuals and families within their environments, and the 'person-in-situation' gestalt so there can be meaningful assessments and diagnoses of these formulated. The context of the client is comprised of many interacting systems, of which several may need to be studied in order to proceed. Based on mutual understanding between clients and workers, problems and their origins, of the client's motivations and goals, and the balancing of forces, are how interventions are planned (Turner, 2011:391).

The emphasis in psychosocial treatment are interventions tailored to address those aspects that are most accessible and most capable of change, rather than the so-called 'pathological' or 'dysfunctional' aspects of the gestalt. Workers in psychosocial rehabilitation work collaborate with clients in order to recover, reinforce and mobilise strengths and coping abilities, locating resources and finding optimal ‘fits’ between people and their social and physical environments (Turner, 2011:390).

The psychosocial theoretical approach is solidly grounded in the idea that people’s behaviours are developed within the context of many open systems that are interacting in mutually causative ways. According to Turner (2011:389), humans adapt based upon a dynamic interplay between the person and a situation in which new and shifting equilibriums are continually established to make a better fit between the person’s individual needs and environmental resources. An essential and enduring value in psychosocial theory is the abiding respect for the innate worth of all individuals. From this value, a profound concern for the commitment to the well-being of individuals is strongly rooted within the theory. (Turner, 2011:390-391).

The psychosocial theory speaks directly to the concept of psychosocial rehabilitation in that it supports the concept of the person-in-environment and promotes interventions that seek to promote the inclusion of the person’s external environment and the various systems they interact with in the design and implementation of interventions. The following theory explains further considerations that support, guide and inform psychosocial rehabilitation programmes. It further reiterates the importance of considering the interactions between the person and their environment, particularly their social environment.

2.6.2 The self-determination theory

The second theoretical framework used to understand the implementation of the psychosocial interventions being explored is the **s**elf-determination theory. The theory is common among the pioneering work done in the Clubhouse model, which is described in literature as the leader in the evolution of recovery orientated models of care (Raeburn, Schmied, Hungerford, Cleary, 2015:145). It is suggested that the extensive use of recovery models such as the clubhouse highlights the need for research to start identifying theoretical frameworks that are able to inform studies that explore how recovery-orientated practices are used by these services. Strong links are identified between recovery-oriented practices and the core propositions of the self-determination theory (Raeburn et al. 2015:1545).

The self-determination theory is a general theory of human motivation that focuses on how relationships between social environment and psychological motivation affects people’s wellbeing. The central proposition of this theory is that all people are born with three fundamental psychological needs, which include competence, relatedness and autonomy (Raeburn et al. 2015:146). The proposition of competence refers to the inherent desire of people to feel they are capable of influencing the outcomes of their lives and contribute to their community. Relatedness refers to the need for people to have supporting and satisfying relationships. The final proposition, autonomy, is defined as the element of the theory that is concerned with people's freedom of choice (Raeburn et al. 2015:146).

Proponents of the theory is that people have the potential to either be 'a-motivated', which is a state where no motivation is present, 'extrinsically motivated', this involves the inclusion of people in activities to obtain external rewards. Lastly, 'intrinsic motivation' refers to activity which is undertaken to satisfy an individual's core interests and values (Raeburn et al. 2015:146). The stages of a person's motivation are believed to be strongly influenced by the person's interaction with their social environment and the equality found in their relationships. The highest level of motivation is considered intrinsic and the lowest a-motivation, and between the two, are various stages of extrinsic motivation. A core tenant is that the person who is more intrinsically motivated will involve themselves in activities and behaviours more, thereby valuing their autonomy and ability to choose (Raeburn et al. 2015:146). According to the theory the more an individual's behaviour progresses from being driven by obvious external rewards towards developing autonomous, intrinsic motivation, the more likely the individual is to engage in self-motivated behaviours, which would subsequently increase their life satisfaction (Raeburn et al. 2015:146).

A common thread in the self-determination theory, and that of the psychosocial models such as the Clubhouse model implemented at Cape Mental Health, is an emphasis on the social environment, and the attribution of meaning to the social group the person belongs to, regarding their notions of recovery and mental illness (Raeburn et al. 2015:148). These theoretical frameworks provide a foundation from which interventions can be expanded and developed from. They guide and inform practitioners and professionals on how to go about formulating interventions and what aspects are important to consider when developing programmes such as those being explored in this study. The following section will discuss some of the varied possible outcomes for psychosocial model treatments as reflected in the literature.

2.7 Benefits of psychosocial rehabilitation programmes

According to research cited in Rousea et. al. (2017:139), mental health care users accessing psychosocial model treatments have reported a variety of quantifiable outcomes. These outcomes include the gaining of employment and reducing the individual's experience of stigma. According to research on the Clubhouse model, one of the psychosocial rehabilitation models adopted by Cape Mental Health's Fountain House project(s), it is suggested that the Clubhouse model services are generally more economical compared to other mental health service delivery models such as the traditional clinical milieu. Literature further suggests that the model contributes to the decreased rates of hospital recidivism and the increase in employment rates for people with mental illness (Gumber et. al, 2018). In addition to the decrease in hospital recidivism, accessing psychosocial rehabilitation is also reported by individuals who suffer from mental illness and those who have reduced their use of inpatient care are also likely to experience symptom reduction, improved self-management, or other similar positive quality of life changes (Gumber et. al, 2018).

The various potential outcomes for psychosocial rehabilitation models for treatment will be discussed according to two focus areas. These will be discussed in the sub-sections to follow and will reflect the benefits on an individual level, followed by the experienced changes on a social level.

2.7.1 Individual benefits of attending a psychosocial rehabilitation programme

A study conducted on veterans with severe mental illness found that those individuals who were accessing psychosocial rehabilitation programmes were accessing inpatient services less frequently, and their utilisation of outpatient services increased in frequency. It was also found that those veterans who were accessing psychosocial rehabilitation programmes had reduced their length of stay in hospital, which resulted in reduced cost for health care and increased savings. Psychosocial rehabilitation interventions appear to reduce costs to health care systems (Barton, 1999; Bond, 1984; Isenwater et al., 2002 as cited in Van Meerten, N.J., Harris, J.I., Nienow, T.M., Hegeman B.M., Sherburne, A., Ann Marie Winskowski, AM., Schumacher, M., Sponheim, SR. 2013), but the cost reduction alone does not define either the intent or essential value of psychosocial rehabilitation. Literature also indicates that should psychosocial rehabilitation interventions be executed earlier in the course of severe mental illness treatment, individuals would experience sustainable improvement in the long-term prognosis of their disorder (Van Meerten, et. al. 2013).

Other outcomes include clients experiencing reduced symptoms of their conditions as well as reduced distress (Penn, Waldheter, Perkins, Mueser, & Lieberman, 2005 as cited in Van Meerten, et. al. 2013). It is mentioned in literature that it is common for persons undergoing mental health treatment to associate the reduction of their symptoms to their medications. It is however reported by some participants of psychosocial rehabilitation programmes (PSR) that the programme in itself has resulted in the improvement of symptoms associated with their mental illness, such as the occurrence of headaches (Brooke-Sumner, Lund, Selohilwe, & Petersen, 2017:259). In a study that investigated the outcomes of psychosocial interventions carried out by trained traditional health practitioners (THP's) among Kenyan patients, the patients in the study showed significant improvement in their depressive symptoms. The improved symptoms among persons in psychosocial interventions is similar to that seen in primary care settings. Literature further informs that people attending psychosocial rehabilitation programmes have improved their quality of life through their participation (Chue, 2006; Dilk & Bond, 1996; Penn et al., 2005 as cited in Van Meerten, et. al. 2013). In a study conducted by Brooke-Sumner, Lund, Selohilwe, & Petersen (2017:258), it is indicated by facilitators of PSR programmes that participants gain knowledge of their illness, and particular changes were seen in practical aspects of member's lives, such as improved self-care efforts. Further indications in a study reported on by the Brooke-Sumner et al. (2017:259), participants reported increased self-esteem and confidence, which was achieved through increased motivation to be more active, contribute to their households, forming friendships, as well as improved feelings of members towards themselves. There was the experience by some participants of seeing themselves as more "human" which was not the case prior to their participation in a PSR programme. Participants in the same study indicated that they had gained a new sense of pride in themselves from seeing their participation in a PSR programme as their "work" (Brooke-Sumner et al.,2017:259).

Literature also indicates that clients attending psychosocial rehabilitation programmes improve medication compliance, physical health care, and health management (McDevitt, Snyder, Miller, & Wilbur, 2006; Pratt et al., 2008 as cited in Van Meerten, et. al. 2013). There have also been studies which have highlighted the reduced rate of incarceration for persons with mental illness (Vogel, Noether, & Steadman, 2007 as cited in Van Meerten, et. al. 2013). This has been found to varying degrees to be associated with psychosocial rehabilitation programmes (Vogel, Noether, & Steadman, 2007 as cited in Van Meerten, et. al. 2013).

In addition to psychosocial interventions having potential outcomes for people on an individual level, literature also describes benefits on a social level. The outcomes and contributions of psychosocial model interventions as reflected in an individual's social environment and interactions, are reflected in the sub-section bellow.

2.7.2 Social impact of attending a psychosocial rehabilitation programme

Social integration is part of the intentions of the psychosocial rehabilitation models for treatment and forms a core part of the intended outcomes for individuals attending psychosocial rehabilitation programmes. While social integration in the past referred to the expectation of physical integration, a more modern definition has been developed (Gumber & Stein, 2018). According to Gumber and Stein (2018:29) social integration can be defined as "engagement in social relationships with other community members outside of the mental health system". A study by Gumber and Stein, (2018) found that members of the Clubhouse model, a psychosocial rehabilitation programme model, reported that they have a small social network of up to five network ties that include fellow members of the clubhouse as well as non-members of the programme. Friends who were not Clubhouse members were reported to be the most frequent social ties, while other Clubhouse members constituted the smallest composition of participants and their perceived social network (Gumber and Stein, 2018). This is supported by a study by Brooke-Sumner, Lund, Selohilwe, & Petersen (2017:258) who explain that one of the products of PSR is the experience of a reduction in social isolation. According to Brooke-Sumner et al. (2017:258) this was achieved by the persons affected with mental illness, firstly, from the experience of being in a social setting and being a part of the treatment group. The participants saw their treatment group as a valuable opportunity for interacting socially; it provides those who are a part of the intervention with a sense of belonging. It is noted that being part of the treatment group also encouraged understanding by family members that isolating themselves in the home was not necessary. Being part of the treatment group also served as a motivating factor for persons with psychosocial disabilities to accept invitations by family members (Brooke-Sumner et al., 2017:258).

Brooke-Sumner, Lund, Selohilwe, & Petersen (2017:259) further indicate in their study that while initially participants at baseline experienced stigma and discrimination by community, friends and family, this later improved. There was the experience of family members, community members and clinic staff treating them better, after gaining more understanding of the illness. Family members are reported to take better care of them, and being supportive following their engagement in psychosocial rehabilitative treatment. In support of improved family and community dynamics, a separate study indicates that there is reduced burden on families and communities who support individuals who suffer from mental health related challenges (Pratt, Van Citters, Mueser, & Bartels, 2008; Prendergast, 1995 as cited in Van Meerten, et. al. 2013 as cited in Van Meerten, et. al. 2013).

According to Rousea et al. (2017:143) one of the quantifiable benefits of being part of a psychosocial rehabilitation programme is gaining a larger social network, reinforcing the Gumber & Stein (2018) reported findings. Van Meerten et al. (2013) highlights the social benefit of attending a psychosocial rehabilitation programme and mentions that persons attending could achieve improved functioning in valued social roles, including obtaining employment. The attainment of a social network is not the only social benefit, according to Rouse et al. (2017:143) The acquisition of a social network for persons with mental illness is also a good predictor for preventing future hospitalisations (Rouse et al. 2017:143).

While it is clearly evidenced in literature that there are some quantifiable outcomes for psychosocial model interventions, there are many criticisms against the model. One of the earlier criticisms highlighted earlier on in the discussion is the difficulty in standardising how to measure recovery outcomes, and what should be the indicators of recovery. The following section will briefly highlight some of the criticisms that are highlighted in literature and that were considered for the purposes of this study.

2.8 Criticisms of psychosocial rehabilitation programmes

There are still several limitations and weaknesses in psychosocial rehabilitation that are highlighted in literature. The first of these include the very limited number of participants being users and ex-users (experts by experience of the illness) in the “real world” rehabilitation settings. Involvement of the patients or their relatives in the development of individual and service treatment projects and even less in the process of service evaluation, organisation, or management are limited in experience in reality (Vita, Corrivetti, Giulio, Mannu, José, Semisa, Domenico, Viganò and Caterina, 2016). Another substantial limit identified in literature is the subsidiary role of the rehabilitation interventions in many mental health departments. History has proven that the first line interventions are, very often, those that involve primarily pharmacological interventions and the admission to hospital settings. Many Italian professionals consider psychosocial rehabilitation a “second line” or ancillary treatment, and these interventions are more than likely offered many years after the onset of the psychotic syndrome (Vita et al. 2016). The literature highlights that in comparison to medical interventions psychosocial treatments are infrequently utilised in the first episode of psychoses and never in ‘at-risk’ mental states. In addition, psychosocial rehabilitation is usually limited to patients with non-affective psychoses, with marginal application to subjects with affective disorders or personality disorders. In many other contexts, rehabilitative interventions are implemented by professionals who work independently from the psychosocial community treatment team settings, with scarce coordination and control on procedures and the outcomes of their interventions (Vita et al. 2016). In spite of the huge developments in the PSR field to date, there is still much effort needed to better define the discipline, some of the methodology, the techniques used, and management of psychosocial rehabilitation in Italy. Although the phenomenon highlighted appears context specific to Italy, it is indicative of the need for data reflecting the South African context.

Rousea et. Al. (2017:139) mentions that beyond research on gaining of employment and reducing the individual’s experience of stigma there is little known about the recovery experience of people attending psychosocial rehabilitation programmes. For example, minimal research is available on the changes that occur for persons attending psychosocial programmes, and the perceived outcome of utilising these programmes. The lack of information on psychosocial rehabilitation and it’s use and impact within the South African context is evidently lacking based on the lack of available research literature on the benefits as perceived by South Africans accessing such services. Constructive criticism is a useful source of potential growth, and also allows for a holistic understanding of the circumstances around a phenomenon. It brings to attention the areas that require improvement, or further exploration. It can also serve as a caution on how we interpret theories, models, and their respective outcomes. From this it could then be implied that criticisms is one of the ways in which concepts and ideas are able to evolve. The following section aims to discuss the evolution of mental health treatment from a fundamentally psychopharmacological approach to psychosocial interventions like PSR programmes.

2.9 Treatment evolution

2.9.1 Psychopharmacology

The effectiveness of psychopharmacology is believed to have a role to play in initiating the development of the era of community mental health. This came with the discovery of chlorpromazine in the 1950s which launched a revolution in the treatment of severe mental illness. In the past, pharmacological treatments consisted of nonspecific agents that merely sedated patients and reduced their agitation (Drake et al. 2003:430). This medication unfortunately did not specifically ameliorate the individual's symptoms or treat the illnesses they were diagnosed with. With chlorpromazine however, patients who were previously considered untreatable were being released from restraints and discharged from hospitals where they were institutionalised. Some became free of symptoms entirely and returned to functional lives in their community. In the years since the introduction of chlorpromazine, medications used in the treatment of many psychiatric disorders have increased, including schizophrenia, bipolar illness, depression, and anxiety disorders, have become more efficacious, specifically ameliorating symptoms and improving quality of life (Mellman et al., 2001 as cited in Drake et al. 2013:430). Fortunately, many of the new medications introduced during this time have also had relatively favourable safety standards and side-effect profiles (Drake et al. 2013:430).

Mental health treatment and rehabilitation, though still largely palliative in nature rather than curative, has evolved in very distinct and important ways over the years (Drake et al. 2003:429). There has been a progression from the institutionalised care of and imprisonment of persons with mental illness, to the development of a variety of models for working in mental health. Even within the development of models for working with mental health there has been significant progression from institutional containment of persons with mental illness, towards a recovery orientated approach in treating mental illness. Evolution has seen remarkable progression in effective treatments, both pharmacological and psychosocial, and this is documented in research (Lehman et al., 1995; NIH/NIMH, 1999; President's Commission, 2003; Report of the Surgeon General, 1999 as cited in Drake et al. 2003:429). Though the interventions are not curative, or aimed at curing individuals, these interventions offer the potential for greater symptom control, improved functioning, and higher quality of life (Drake et al. 2003:429). Evolution in the psychosocial treatment model can be seen in the effective development and implementation of treatment models to address mental health related challenges such as the clubhouse model being run by Cape Mental Health, or their psychosocial rehabilitation groups, known as Rainbow Foundation.

2.9.2 Evolution in Psychosocial Treatment

Changes in the psychosocial treatment of severe mental illness have been as equally dramatic as psychopharmacology in the evolution of mental health treatment. Literature from the 1950's was dominated by psychogenic theories of aetiology, for example, that the cause of schizophrenia was seen to be from early problems in the interaction between child and mother, and psychoanalytic models of treatment (Bellak, 1958, as cited in Drake et. al. 2003:435). Psychoanalysis was considered the treatment of choice by many and was thought to be a curative intervention. Careful research demonstrated, however, that psychoanalytic approaches were largely ineffective in the treatment of conditions such as schizophrenia (Gunderson et al., 1984 as cited in Drake et al.:434)), and they have since largely disappeared as the preferred method of treatment for such disorders. Current psychosocial treatments are based on the development of a trusting relationship between individual and helper in order to help the affected individual cope with an extremely serious illness (Herz and Marder, 2002; Hogarty, 2002 as cited in Drake et al.:235). The practitioner attempts to form a collaborative partnership with the goal of maximising the individual's self-control over symptoms and minimizing interference from the illness. The current forms of psychosocial intervention are collaborative, educational, cognitive behavioural in nature, and often involve peer groups. All aim toward helping the client develop skills for the management of the illness (Drake et al. 2003:435)

2.9.3 Evolution in Rehabilitation

Psychiatric rehabilitation became the dominant method in community mental health by the 1990's. Rehabilitative interventions emphasized helping individuals to succeed in functional roles of their choice and thereby to develop satisfying lives (Anthony et al., 2002 as cited in Drake et al. 2003:435). Specific interventions have been developed to help people identify and achieve their own individual goals, including living independently in community housing, being successful in competitive employment, participating in routine educational settings, developing better relationships with their families, and pursuing leisure activities. Drake et al. (2003:435-437) identifies in literature specific trends in the development of psychosocial rehabilitation over the years:

1. Rehabilitation over the years continues to emphasize patient-centred services, such as empowering the individual who is receiving treatment to make choices regarding goals and interventions, to direct the services they receive, and to be as independent as possible.
2. The focus of rehabilitation continues to be on the development of skills and building the support needed for participation in routine community life.

3. There is a range of rehabilitation approaches from experiential learning to specific training sessions. However research and clinical experience have led to a greater emphasis on specificity.
4. There is increasing emphasis on the development of support that is needed to help individuals attain success within their communities or home environments, such as housing, work, school, and social settings, rather than in mental health treatment environments which requires specific skills for particular tasks and individual settings.
5. There is increasing acceptance that step-wise approaches to community integration are relatively ineffective (Bond et al., 2001).
6. Rehabilitation services are most effective when they are integrated with clinical services (Bond et al., 2001).
7. There is recognition at the public policy level that not only supports but also accommodates and reduces stigma which is sometimes needed to help people to function in community settings.

2.10 Conclusion

The focus of the literature on treatment evolution focuses primarily on the introduction of interventions to address mental illness and its associated symptoms of dysfunction. There appears however to be a lack of specificity on the impact of the specific programmes within a South African context as suggested early on in the discussion. The following chapter will explain the research methodology in detail.

Chapter Three

Research Methodology

3.1 Introduction

The following chapter will discuss the research processes according to the chosen methodology. The chapter will elaborate on the chosen research design, the sampling technique, characteristics and procedure. Discussion in this chapter will also include the data collection approach used, the methods to collect data, as well as the tools that will be involved in the data collection process and data analysis, followed by a conclusion.

3.2 Research Design

According to Babbie as cited in De Vos et al. (2005:261-262) the research paradigm "is a fundamental model or frame of reference we use to organise our observations and reasoning". The research paradigm utilised is the qualitative research paradigm which is dictated by the soft data, such as words, sentences, photos and symbols, that ultimately further dictates qualitative research strategies and data collection techniques. Qualitative research relies on the principles from interpretive or critical social sciences. The research design speaks to a language of 'cases and contexts' and of cultural meaning. The emphasis is on conducting detailed examinations of specific cases that arise in the natural flow of social life (Neuman, 2011). The following study will be partially informed by the worded responses of the participants, it will rely on the interpretive and critical social sciences principles to guide the processes including the interpretation of the information shared by participants. It will also aim to study a very specific case within the natural flow of life, that being the individual who encounters mental health related challenges and how their recovery is notably influenced by psychosocial rehabilitation programmes. For these reasons, the qualitative research paradigm is the most appropriate selection for this particular study.

There are various types of qualitative research designs, and the design will differ among qualitative researchers depending on the study's purpose, the nature of the research question and the skills and resources available to the researcher. The design selected to be most appropriate for this particular study is the phenomenological design, as this design aims to understand and interpret the meaning that subjects give to their everyday lives (De Vos et al. 2011:316). This compliments the study's interest in understanding and interpreting the meaning given to people's experiences of a mental health treatment programme. A phenomenological study according to Creswell as cited in De Vos et al. (2011:316) is a study that describes the meaning or the experience of a phenomenon, concepts or topics for different individuals. The researcher will, through the utilisation of this approach, eventually reduce experiences to a central meaning or the essence of the experience, "and the product of the research is a description of the experience being studied" (De Vos et al. 2011:316). In order to accomplish this the researcher would need to submerse himself into the subject's world by entering into the subjects "life world or "life setting", and place themselves in the shoes of their subjects (De Vos et al. 2011:317). This is achieved through mainly naturalistic methods of study, analysing the researcher's conversations and the interactions that the researcher has with subjects. Interpretive design inquiry usually makes use of participant observation or long interviews (with up to ten people) as method of data collection (De Vos et al. 2011:317). Due to the nature of the characteristics mentioned, phenomenological research design is selected and found to be the most appropriate for this study, as the study sets out to understand and interpret the concept of psychosocial rehabilitation within a South African context. It will then attempt to reduce the concept to a central meaning, that being the impact of such programmes on the recovery of people affected by mental health related challenges. The study further hopes to achieve this through exploring people's experiences through the researcher entering the subject's life or world by engaging in long interviews with at least 16 participants. With these as motivating factors, phenomenological research design compliments the intended study as well.

3.3 Population & Sampling

The sample population will be all mental health care users of Cape Mental Health psychosocial rehabilitation programmes and will come from across the greater Cape Town area. They will all be attendees from any Rainbow Foundation PSR programme, or the Fountain House programmes.

3.3.1 Sampling technique

Purposive non-probability sampling is the selected sampling technique. Non-probability sampling refers to a method of sampling predominantly used in qualitative research. The goal in qualitative sampling is to deepen understanding about a larger process, and to allow the researcher to make statements about categories in the population which non-probability sampling allows (Neuman, 2011:241).

The purposive sampling technique is used in exploratory or field research, and uses the judgment of an expert in the selection of cases, or makes use of the selection of cases with a specific purpose in mind (Neuman, 2011:268). In this case the researcher who is a social worker is the expert who will be selecting the participants based on a specific purpose, which is to explore the experiences of participants who attend a specific psychosocial rehabilitation programme offered by Cape Mental Health. While the researcher is employed at Cape Mental Health as a social worker, he does not work within the psychosocial rehabilitation programmes. Purposive sampling is appropriate when wanting to select unique cases that are especially informative (Neuman, 2011:268). This, in an effort to gather relevant information pertaining to the perceived impact of psychosocial rehabilitative treatments offered by Cape Mental Health on the participants who have mental health related challenges.

3.3.2 Sampling characteristics

The selected sample includes males and females from the age of 18 and older, all of South African nationality and consist of different racial categories. The sample will all have a psychiatric diagnosis which includes the entire spectrum of diagnoses according to the DSM V and could have a single, dual diagnosis or poly diagnosis'. In addition to this criterion, all the participants are presently users of the programme and would have to have been part of the programme for a minimum period of at least one month. This is to allow the participant to have insights into the programme for adequate participation.

3.3.3 Sampling Procedure

Access to the sample will be gained through Cape Mental Health's client database, specifically those clients who are accessing the organisation's psychosocial rehabilitation support programmes. In order to gain access to the intended participants, a meeting with the organisation's deputy director and psychosocial rehabilitation programme managers was held. The researcher explained the study in order to obtain preliminary permission. A copy of the research proposal and university ethical approval document was then submitted to the organisation's external research ethics committee for their further approval before gaining access to the research participants.

3.4 Data Collection Approach

3.4.1 Data Collection Method

The data collection method most appropriate for this particular study was the use of semi-structured one-on-one interviews. Interviews are considered as one of the predominantly used data collection methods in qualitative research (De Vos et al. 2011:347). According to Seidman as cited in De Vos et al. (2011:351), "you interview because you are interested in other people's stories". Researchers use semi-structured interviews in order to gain a detailed picture about participant's beliefs, and/or about accounts or perceptions of a particular topic of study. This particular method gives the researcher and the participants much more flexibility. The researcher will be able to follow and explore particular interest avenues that emerge during the interview, and the participants will able to give a fuller description (De Vos et al. 2011:351). The use of semi-structured interviews according to De Vos et al. (2011:351) is especially suitable where the researcher is interested in the complexity or process around controversial or personal topic areas. Due to the already sensitive nature around the topic of mental illness, and the associated stigma, there is also the sensitivity of wanting to explore people's personal journeys around their illness. This forms part of the motivation for the selection of this particular method, as the researcher is interested in people's personal stories about their recovery journey as part of a psychosocial rehabilitation programme. According to De Vos et al. (2011:351) with semi-structured interviews, the researcher will have an interview schedule as guide, rather than be dictated by it. This will be useful in allowing the researcher to stay within the particular context of recovery in relation to people's experiences of psychosocial rehabilitation, but allowing the participants some control and freedom to explore it according to their natural experience thereof.

The researcher conducted one-on-one, in-depth, face-to-face semi structured interviews with 16 participants; an hour was dedicated to each participant interview. The number of participants interviewed for the study is indicated in the University of Cape Town departmental standards for a minor dissertation in clinical social work. Each interview was face to face at the Cape Mental Health head office and the respective psychosocial rehabilitation venues, in a separate private and confidential space away from the rest of the group or other members in the programme. Due to the data collection being complete prior to the COVID-19 restrictions, the pandemic restrictions had no impact on the data collection method.

3.4.2 Data collection instrument

The data collection instrument used was an interview schedule, which refers to a questionnaire written with the intention of guiding the interview. Morse as cited in De Vos (2011:352) states that interview schedules, "provides the researcher with a set of pre-determined questions that might be used as an appropriate instrument to engage the participant and design the narrative terrain". By producing a schedule beforehand, the researcher is forced into explicitly thinking about what they hope to cover and achieve during the interview and the difficulties that might be encountered along the way (De Vos et al. 2011:352). This would be particularly useful in this study due to the sensitive nature of the research area on mental illness and the unique challenges the participants may bring to the process. Once an overall issue is identified by the researcher that will be tackled in the interview, the researcher's job is to think about a broad range of themes and question areas to be covered during the interview. These areas are arranged in the most appropriate sequence. In order to address the issue, the researcher is interested in, they need to think about appropriate questions which relates to each respective area (De Vos et al. 2011:2352).

For the purpose of this study, the researcher developed an interview schedule with a set of predetermined questions that guided the interview process. The interview schedule questions was guided by the five main research questions that are highlighted in chapter one, as well as the objectives of the research study. The interview schedule accompanied the researcher to each interview, the researcher was guided by the questions in the interview schedule and followed any additional themes that were prompted through exploring the information shared by the participant.

3.4.3 Data collection tools

Data collection tools included the interview schedule as already discussed, a voice recorder to record all interviews verbatim. This is to ensure data integrity and verification gathered in each interview, and allows for ease of transcription for data analysis. A battery operating voice-recording device was utilised to record each interview. The use of a battery-operated device could be challenging due to the potential failure or death of batteries, as well as audio distortions from device microphones. In order to ensure the best possible outcomes, the device was charged a day before and tested for audio quality. This procedure was then repeated on the day of each interview. The research also took a set of spare batteries to each interview, or a battery charger made available at every interview. In order to record the interview, the researcher needed the consent of the participant; this was achieved through written and verbal consent agreements between the participant and the researcher, signed prior to their participation. The researcher also made use of field notes during the interview and recording some of the most noteworthy information in writing on a notepad, that transpired during the interview which was relevant to the study,

3.4.4 Pilot study

The pilot study is a method that the researcher can employ to obtain thorough background knowledge on the specific topic. It is a way in which the researcher can orientate themselves to the project they are interested in investigating. A pilot study involves the pretesting of a measuring instrument which consists of carrying out all aspects of the total data collection process but done on a smaller scale, with only a couple of participants (De Vos et. al. 2011:237). According to Barker as cited in De Vos et. al. 2011:237 a pilot study is defined as "a procedure for testing and validating an instrument by administering it to a small group of participants from the intended test population". By conducting a pilot study, the researcher is able to improve the success rate and effectiveness of the investigation. This however, should involve a space given for comments and criticisms by the participants on the questionnaire. The researcher then needs to carefully consider the feedback given. The pilot study must also be executed in the same manner as is planned for the main research investigation (De Vos et. al. 2011:241).

The pilot study allows for the testing and adapting of the measuring instrument to have fewer problems during the main study, as it assists in determining the number of codes per question and thus allow to code accordingly, and helps to establish clearly how suitable the procedure of data collection really is (De Vos et. al. 2011:243). Through conducting a pilot study, the researcher is also able to determine the suitability of the sample frame by testing its effectiveness. The variability of the population is also testable through the conduction of a pilot study as well as the expected non-response rate and the effectiveness of the organisation in the office and in the field (De Vos et. al. 2011:243). According to De Vos et. al. (2011:237) doing a pilot study also allows the researcher an opportunity to assess their involvement, estimate the cost and length of the investigation, and determine the obstacles of the data collection process. The information gathered during the process should be used by the researcher to evaluate the total pilot study. This will also allow for the identification of the weaknesses and strengths of the study and divide the attention of the research appropriately (De Vos et. al. 2011:247).

The researcher submitted the proposed study for ethical clearance to a committee at the University of Cape Town, as well as a research committee at Cape Mental Health whose approval was required. Based on the feedback from these stakeholders, the researcher was able to test the selected data collection method and instrument by completing one-on-one interviews with the sample population identified, as if the main study was being conducted. This consisted of 2 interviews. Once the pilot study was completed, the researcher then executed the data analysis methods selected and the results were used to do a thorough evaluation to ensure that the necessary adaptations were made to ensure that the main study was conducted as effectively as possible. After the completion of the pilot study there were no changes made to the data collection instrument or tools for the main study.

3.5 Data analysis and Interpretation

The data analysis method utilised is guided by the identified research design, phenomenological research. There are multiple ways of analysing data and the most relevant to this study is a method with its roots embedded in grounded theory. The process of data collection is one of inductive reasoning, thinking and theorising, which is far removed from mechanical, structured and technical procedures to make inferences of social life from empirical data (De Vos et. al. 2011:399).

In the process of qualitative data analysis, it is pointed out by Patton (2002:434) as cited in De Vos et. al. 2011:403) that qualitative researchers have an obligation to monitor and report on analytical procedures used in their work. There are variations in the steps and processes of data analysis. Steps are also not always able to be followed rigidly, and some may overlap. De Vos et. al. (2011:399) describes the following steps, that was carried out in this study:

3.5.1 Preparing and organising the data:

3.5.1.1 Planning for recording of the data

This involves the researcher planning for the recording of the data in a manner that is systematic and appropriate to the setting, research participants, or both, and that will facilitate analysis before the collection process begins (De Vos et. al. 2011:404).

The researcher ensured that he had a copy of the interview schedule and that he had arranged the date and time as well as the venue for the interview prior to meeting. The researcher also familiarised himself with the interview schedule and the questions contained therein.

3.5.1.2 The data collection and preliminary analysis

In the qualitative processes, data analysis necessitates a twofold approach. The first involves analysis while gathering data in the field, and the second involves analysis of data away from the field after all the data is collected. The latter method known as the 'office approach' focuses more on the pragmatics such as sorting the data, retrieving, indexing and the handling of the qualitative data (De Vos et. al. 2011:405).

Through the process of data collection, the researcher paid close attention to the nuances of the interview as it was being conducted and made the necessary relevant field notes on the process as it was is unfolding.

3.5.1.3 Managing the data

This is the first step of the process away from the field, referred to as the intensive data analysis phase. This involves sorting and storing of the information gathered including the audio recordings of interviews. This process also involves the action of transcribing the information on the recordings (De Vos et. al. 2011:408).

Following the data collection, the researcher loaded and stored all audio recordings with specific names on various devices for safe keeping and transcribed the interviews verbatim before reflecting on them. Transcription entailed retyping the audio into a word document using a computer.

3.5.1.4 Reading and writing memos

In an effort to get a feel for the data, this part of the process has the expectation that the researcher will read the transcripts repeatedly to get immersed in the details and understanding the interview as a whole before breaking it up into parts. Writing little memo notes in margins of the field notes or transcripts or under photographs helps. They are key concepts, short phrases or ideas that the researcher writes for themselves about the coding process, which is called analytical coding. It serves as the link between the data and the researchers more abstract thinking (De Vos et. al. 2011:409).

The researcher reflected on the transcriptions of the various interviews and immersed himself in the content of each one to fully grasp the interview as a whole to allow for the identification of subtler nuances.

3.5.2 Reducing the data:

3.5.2.1 Generating categories and coding the data

Category formation is considered the heart of qualitative data analysis, and is considered one of the more challenging elements of the process. It involves the process of identifying subtleties that would form themes, such as the presence of reoccurring language, or idea patterns of belief that link people and settings together (De Vos et. al. 2011:410). Codes can come in several forms such as abbreviated key words, colourful dots, numbers; the choice is up to the researcher.

3.5.2.2 Testing the emergent understandings and searching for alternative explanations

In summary, this section introduces to the researcher how they can begin the evaluation process, which is done by looking at things that are not in the data set and how it can be important for the data analysis process. (De Vos et. al. 2011: 415). According to De Vos et. al. (2011:415) evaluating the data for usefulness and centrality is also part of this phase.

3.5.2.3 Interpreting and developing typologies

This section involves the researcher making sense of the data and the lessons they might have learned. According to De Vos et. al. (2011:416) the development of typologies or systems for categorising things or concepts is a very useful aid when trying to make sense of qualitative material (De Vos et. al. 2011:416).

3.5.3 Visualizing, representing and displaying the data:

3.5.3.1 Presenting the data

This part of the process involves the researcher representing the data, and represent what was discovered in various forms namely as text, tables, graphs and figures.

Once the data has been analysed, and depending on the nature of the results, the researcher will document the findings in various forms, including text. The most appropriate method chosen will be dictated by the results.

3.6 Trustworthiness

The issue of trustworthiness in qualitative research is not so easily accomplished and generally questioned by positivists. According to Shenton (2004:63) this is perhaps due to the fact that "concepts of validity and reliability cannot be addressed in the same way in naturalistic work". There have been several writers however, that have demonstrated how measures can be incorporated by qualitative researchers to deal with these issues. Qualitative studies are not deemed to be credible unless it is dependable, and this is ensured through key concepts which include credibility, transferability, dependability and confirmability.

3.6.1 Credibility

What is commonly known as internal validity in quantitative research, which is defined as a process aimed at ensuring that the study measures or tests what it actually has intended to. The equivalent of this concept in the qualitative process is credibility. According to authors Lincoln and Guba as cited in Shenton (2004:64), the following provisions can be made to ensure that the phenomenon is accurately recorded:

1. The researcher should adapt research methods which are well established within the qualitative paradigm as well as within general information sciences in particular. In the case of the study the researcher used research methodologies such as phenomenological research design and data collection methods such as one-on-one interviews.
2. The researcher should develop an early familiarity with the culture of the organisation's participant. In this study the researcher is already an employee of the organisation from which the research sample is drawn, providing him with inside knowledge and awareness of the organisation's functions regarding its services and the clients who will serve as research participants.
3. The researcher should use tactics to ensure honesty from the participants in the study. In the study the researcher made use of methods such giving participants an opportunity to refuse to participate in the project, therefore the data collection sessions will involve only persons who are willing to and want to offer data freely.
4. The researcher should make use of frequent debriefing sessions. For this study the researcher had supervision sessions with his supervisor at the university. This allowed for widening of the investigators experiences and perceptions.
5. The background, experience and qualifications of the investigator. As a factor in ensuring credibility of the proposed study, the researcher has a formal academic background holding bachelor's degrees in the field of psychology and social work. The researcher is also a practicing social worker in the mental health field and works at grass roots within the area of investigation.

3.6.2 Transferability:

The transferability in trustworthiness refers to the extent to which the findings of the study could be applied to in a different context. The following two strategies are described by Guba and Linchol 1984 as cited in De Vos et al (2012:277), Thick description and Purposive sampling. Only 2?Transferability in qualitative research relies on the similarities between sending and receiving contexts. The researcher then collects sufficient and detailed descriptions and reports them, in order to allow a transferability judgment to be made by the reader.

In addition to doing a pilot study to gather a thick description of the events to test the method and instrument of data collection, the researcher was also able to add to the intended gathering of what is referred to in transferability as 'thick description. This was achieved through the gathering of information through one-on-one interviews with at least 16 (ideally 20) participants in order to report on the investigating phenomenon.

In qualitative research, the researcher, in contrast to quantitative methods, seeks to maximize the range of specific information that is obtainable about and from the context. This is done by purposely selecting locations and informants that differ from one another, also known as purposive sampling (Guba and Linchol 1984 as cited in De Vos, 2012:277). For this study purposive sampling was included into the selection criteria for the research participants which reflected characteristics relating to mental health. It also included participants being located in the Western Cape where they attend the psychosocial rehabilitation programmes provided by Cape Mental Health. It also identified the differences such as racial classifications, age and the geographical location of the residential community the participant lives in.

3.6.3 Dependability

Dependability is concerned with an inquiry being able to provide evidence to an audience that should the study have been repeated with the same or similar participants, in the same, or similar context, that the feelings would be similar (De Vos et. al., 2012:278). According to De Vos et. al. (212:278) there is no validity without reliability and therefore in qualitative research similarly, there can be no credibility without dependability. So in order to test dependability a demonstration of the credibility is sufficient to establish the existence of the latter. Additionally, De Vos et. al (2014:278) identifies the method of inquiry audit to determine dependability. This entails an auditor examining documentation of critical incidents such as documents and interview notes, and a running account of the process of inquiry such as the daily journal of the researcher. The auditor, in making a decision about the acceptability of the study, attests to the dependability of the inquiry. A single, properly managed audit can be used for the determination of dependability and confirmability simultaneously (De Vos et. al., 2014:278). Dependability will be determined spontaneously through the efforts made to confirm the credibility of the inquiry.

3.6.4 Confirmability

The confirmability refers to the degree to which the findings of the inquiry are the product of the focus of the inquiry and not the biases of the researcher (De Vos et. al., 2014:278). According to Lincoln Guba as cited in De Vos et. al. (2014:278-796) this can be achieved through a confirmability audit trail. An audit trail is a trail of adequacy completed by auditors in an effort to determine if the conclusions, interpretations, and recommendations can be traced to their sources. It also confirms whether the interpretations, recommendation and conclusions are supported by the concerned inquiry. Such a trail involves the review of at least six sets of data, which can include raw data (written tapes and field notes), data reduction and analysis products (example: write up of field notes), data reconstruction and synthesis products (themes developed), process notes (example: methodological notes), material relating to intentions and dispositions (example: proposal) and lastly, the instrument development formation (example: pilot forms and preliminary schedules). Through the use of these methods a confirmability audit trail can be executed to establish the confirmability of the inquiry (De Vos et. al. 2014:278). For the purposes of confirmability, the research was audited by academic support at the University of Cape Town, this ncluded the researcher's supervisor as well as specially established bodies that approve and critique the inquiry at various points, such as the ethical approval processes before data collection is carried out.

3.7 Limitations

The limitations of this study pertain to:

3.7.1 Research Design

When focusing on the meaning of the participant's responses, resulted in the researcher having to rely heavily on the subjectivity of the data collected (Fouche & Schurink, in De Vos et al, 2011). Additionally, this form of inquiry does not allow for findings to be generalised to populations which are outside of those under the study (Creswell, 2014). Despite all limitations in research designs; the qualitative paradigm remained the most appropriate approach for the purpose of this study as the researcher was not wanting to obtain numerical data, but rather valued the active involvement of the participants. This approach was an effective tool which facilitated understanding the perceptions and experiences of psychosocial rehabilitation programmes.

3.7.2 Sampling

The small sample used in the study is not a representation of the larger South African population and is relatively limited in the selection of participants. According to Strydom and Delport in De Vos et al (2011), non-probability purposive sampling is not generalised to larger populations and relies heavily on the judgement of the individual researcher. In saying this, each patient engaging in a psychosocial rehabilitation programme was not provided with an opportunity to be selected for the sample. The findings of this study can increase awareness of the needs of individuals participating in psychosocial rehabilitation programmes. Although the researcher was unable to meet the requirements of a larger sample, new participants were brought into the study until the data was able to be replicated. Morse et al (2002) refer to this replication as the process of saturation for the purpose of increasing the scope and appropriateness of the data. Furthermore, the opinions voiced by the sample in this study are in-depth and assist in evaluating the effectiveness of the existing PSR programmes, and calls for further investigation.

3.7.3 Data Collection

The response to semi-structured interviews has the potential to become problematic when the subjects are untruthful about their experiences and therefore the process relies heavily on the researcher's ability to probe (Greeff as cited in De Vos et al, 2011). It is the researcher's assumption that the subjects may have felt pressured to provide positive feedback as it may affect their relationship with their treatment provider and team members. This could account for incomplete responses that do not effectively evaluate the programmes. In order to minimise this, the researcher clarified with each subject that their participation will not affect the service they receive at Cape Mental Health and individual responses will be kept confidential. In addition, an informed consent form explained this in writing and was given to each participant at the beginning of the interview (Annexure A).

Face-to-face interviewing is a time consuming approach and requires the energy of both the researcher and the participants in the study (Greeff in De Vos et al, 2011). Additionally, participants undergoing supporting treatments such as medication with side effects may have felt tired and unwell, and this would have affected the overall quality of the interviewing process. The researcher was careful **to** not take on the counsellor role during the interview, as this contributes towards researcher bias. The inclusion of a pilot study aided in preparing the researcher for the data collection process.

A Dictaphone has the advantage of easing the possibility of data overload and allows the researcher to be present and focus solely on the interviewing process. However, a limitation lies in the fact that the quality of the data may be jeopardised by the possibility that some participants could be affected by the presence of a recording device during the interview, despite giving their consent. The researcher adhered to Greef in De Vos's (2011) who suggest that overcoming this limitation, the researcher can place the instrument unobtrusively so as to avoid distracting the participants.

3.7.4 Data Analysis

Schurink, Fouche and De Vos in De Vos et al (2011) highlight that data analysis is heavily reliant on the researcher's ability to code and categorise the data they obtain. In light of this, the researcher may overlook certain themes that arise in the analysis of the data. Furthermore, the analysis should not be restricted to findings that have an immediate bearing **on** the investigation, but should also allow for an exploration of economic conditions, social trends and cultural values (De Vos et al, 2011). The limitation lies in the fact that this study investigates the subject's attitudes and not their demographics; for this reason, the findings of this study could not be compared to findings from other studies where factors such as socio-economic status and the availability of resources were included to assess the PSR experience. However, the aim of the study was to examine the perceptions of attendees of PSR practices in South Africa and the findings therefore do not need to be generalised to the wider international community.

3.7.5 The Researcher

The researcher is the central figure in the research study and both "influences and constructs the collection, selection and interpretation of data" (Finlay, 2002:212). Due to the researcher's employment as a social worker at Cape Mental Health, the participants of the study may have felt pressured to provide positive feedback. In an attempt to minimise this, the sample excluded all clients that were seen by the researcher in a professional capacity. The researcher should also be conscious of over reporting on the strengths of a service in an attempt to minimise the weaknesses (Stake & Mabry, 1998). The researcher was therefore obligated to report on findings as accurately as possible, fully disclosing both the supportive findings and shortcomings of the study. The researcher had to carefully consider the concept of reflexivity in undertaking this investigation. The use of supervision assisted in avoiding researcher bias during the data collection and interpretation process.

3.8 Conclusion

Guided by the qualitative research paradigm the research design was identified based on the most appropriate characteristics suited for the study and what the study was aiming to achieve. Further guidelines on processes and procedures were selected which included the most appropriate data collection method, instruments and tools. The following chapter will reflect on the information gathered during the interviews, and interpret the information according to what the research question had set out. It will summarize the study's findings and provide the concluding remarks.

Chapter Four

Findings

4.1 Introduction

In the following chapter the analysis of the data and the findings of the study are discussed with reference to relevant literature outlined in chapter two. The profile of the participants is indicated and findings are presented within a framework of analysis. The findings are further categorised under the themes linked to the research objectives. A conclusion completes the chapter.

4.2 Profile of participants

Table 4.1: Profile of participants

Par.	Age	Sex	Race	Diagnosis	Year Diag.	Psych Meds.	Clinic	Reason for attending clinic	Cape Mental Health PSR programme attended	Duration in the prog.	Other mental health services
1	30	F	Coloured	Schizophrenia	2018	Yes	Yes	Medication	Fountain House	1 year	No
2	29	M	Coloured	Schizophrenia	2011	Yes	Yes	Medication	Fountain House	1 year	No
3	28	M	Coloured	Schizoaffective disorder	2015	Yes	Yes	Medication	Fountain House	6 months	No
4	39	M	Coloured	Schizophrenia	1999	Yes	Yes	Medication	Fountain House	15 years	No
5	19	M	Coloured	Schizophrenia	2017	Yes	Yes	Medication	Fountain House	5 months	No
6	44	F	Indian	Bipolar type II	1994	Yes	Yes	Medication	Fountain House	12 years	No
7	54	F	Coloured	Paranoid schizophrenia	1996	Yes	No	N/A	Fountain House	9 years	Yes
8	35	F	Black	Schizophrenia	2007	Yes	Yes	Medication	Fountain House	9 years	No

Par.	Age	Sex	Race	Diagnosis	Year Diag.	Psych Meds.	Clinic	Reason for attending clinic	Cape Mental Health PSR programme attended	Duration in the prog.	Other mental health services
9	41	M	Black	Schizophrenia	2001	Yes	Yes	Medication	Fountain House	11 years	No
10	31	M	Coloured	Schizoaffective	2003	Yes	Yes	Medication	Fountain House	5 years	No
11	48	F	Coloured	Depression	1996	No	Yes	Chronic medication	Rainbow foundation	7 years	No
12	45	M	Coloured	Schizoaffective disorder	1997	Yes	Yes	Medication	Fountain House	17 years	No
13	56	F	Coloured	Bipolar type II	1978	Yes	Yes	Medication	Fountain House	10 years	No
14	42	M	Coloured	Schizophrenia	1996	Yes	Yes	Medication	Fountain House	4 years	No
15	42	M	Coloured	Schizophrenia	1998	Yes	Yes	Medication	Fountain House	4 months	No
16	39	M	Mixed	Schizophrenia	2000	Yes	Yes	Medication	Fountain House	1 year	No.

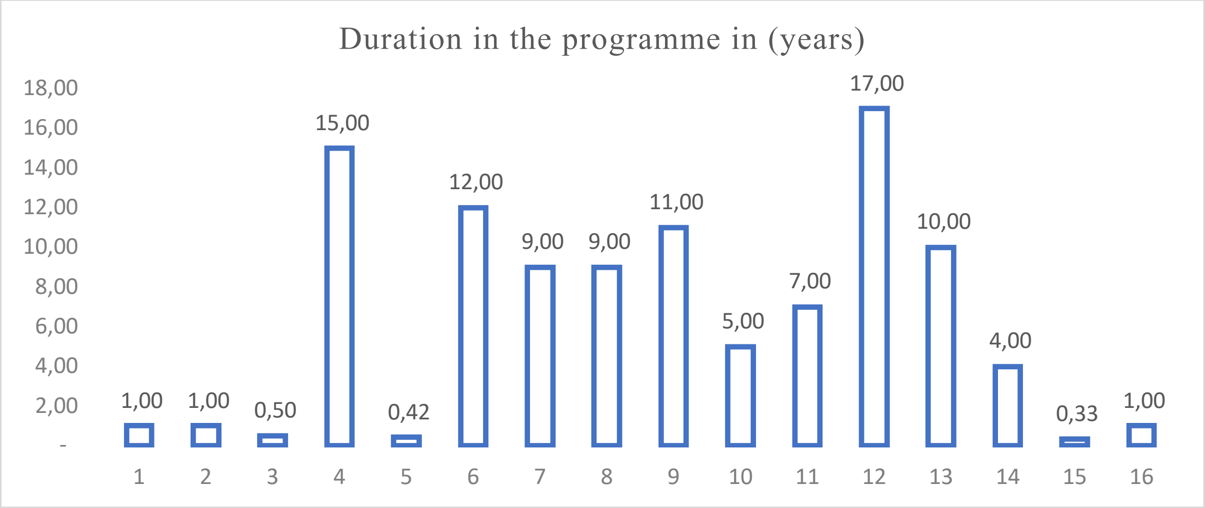

Figure 4.1: Duration in the programme in (years)

The duration the participants spent in the psychosocial rehabilitation programme ranged from 3 months to 17 years, with 3 participants having spent less than one year in the programme and 9 having been part of the PSR programme for 5 years or more. Just under half the study is informed by participants who attended the programme for less than 5 years while the remaining 9 had been in attendance for more than 5 years.

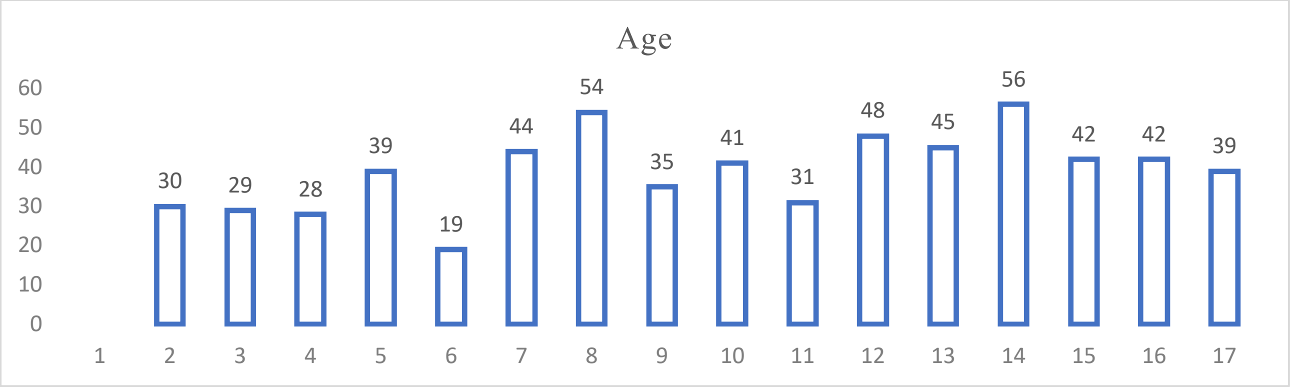

Figure 4.2: Age

Participants were between the ages of 19 and 56 years old with 4 aged 30 years or younger, 4 aged 40 years old or younger, 6 aged 50 years or younger and 2 participants between the ages of 50 and 60 years old. The data of this study is therefore informed predominantly by the perspective of people in their middle years.

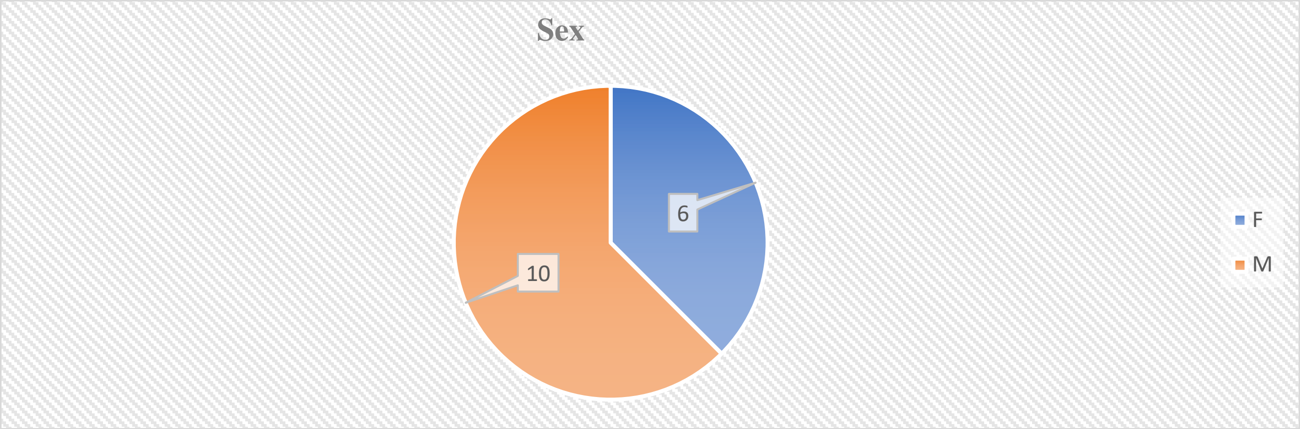

Figure 4.3: Sex

The participants in the study were represented by 10 males and 6 females. The findings of this study are more strongly informed by the perspective of male participants.

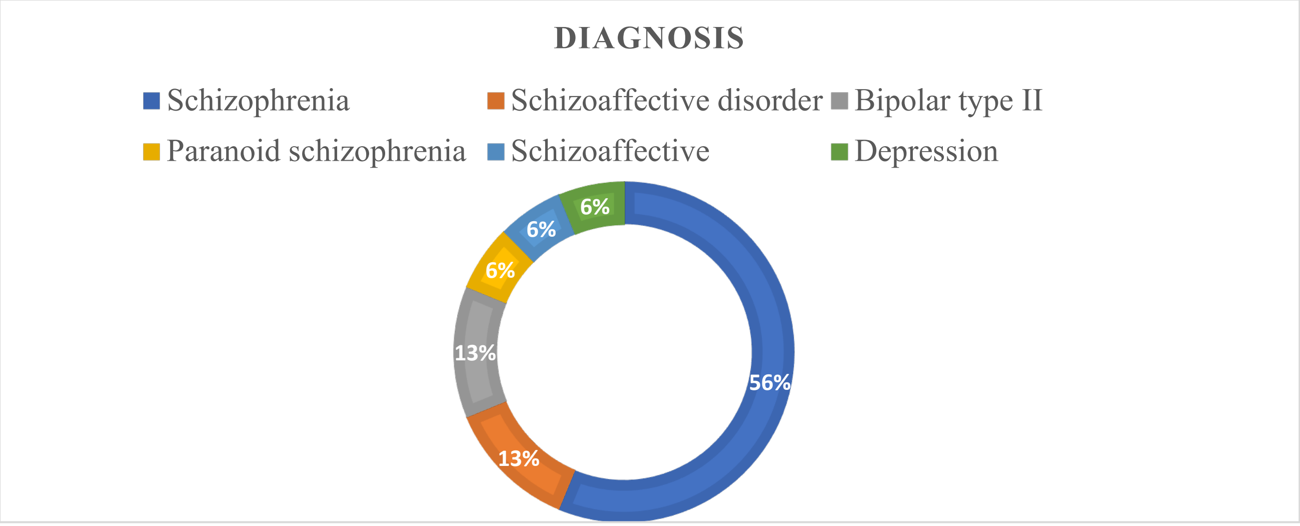

Figure 4.4: Diagnosis

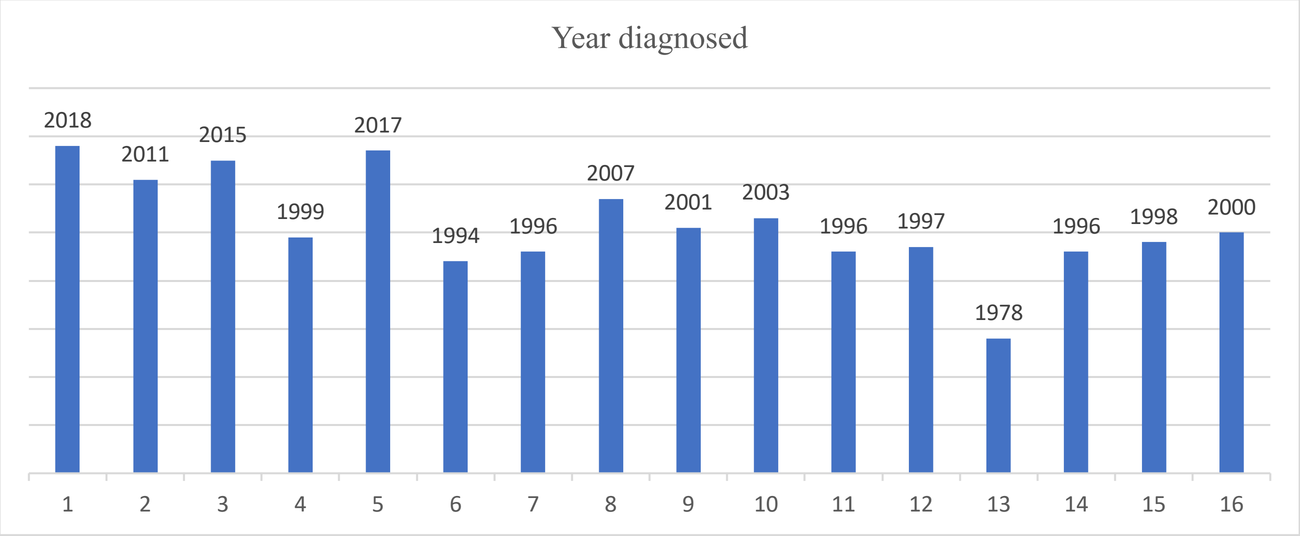

Figure 4.5: Year diagnosed

The number of participants that were diagnosed with depression, schizoaffective disorder and paranoid schizophrenia were the same and fell within the lower percentile of representation. Schizophrenia and schizoaffective disorder fell within the higher percentile of diagnoses and the study was more strongly informed by individuals with a diagnosis of schizophrenia.

Participants were diagnosed between the years 1978 and **2018** with 1 participant diagnosed in the 70's, 8 participants diagnosed between 1990 and 2000, 3 diagnosed between 2001 and 2010 and 4 diagnosed between the years 2011 and 2020. The study is informed by individuals who were diagnosed over a period of 5 decades with the majority of participants diagnosed after the deinstitutionalisation of mental health care in South Africa in 1997.

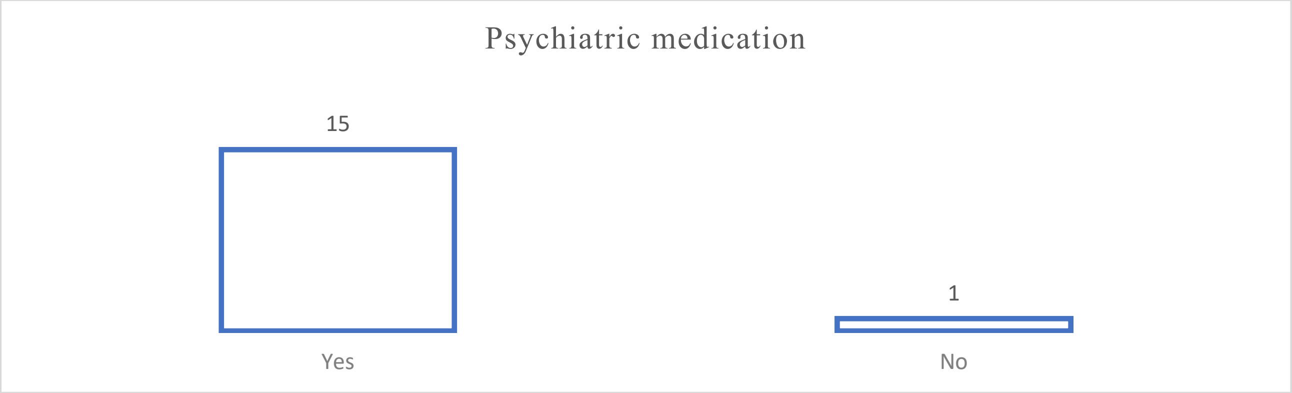

Figure 4.6: Psychiatric medication

The majority of the participants with the exception of one received psychopharmacological treatments to support the treatments of their mental illness. The study is therefore informed primarily by individuals who receive medication for the treatment of their mental illness.

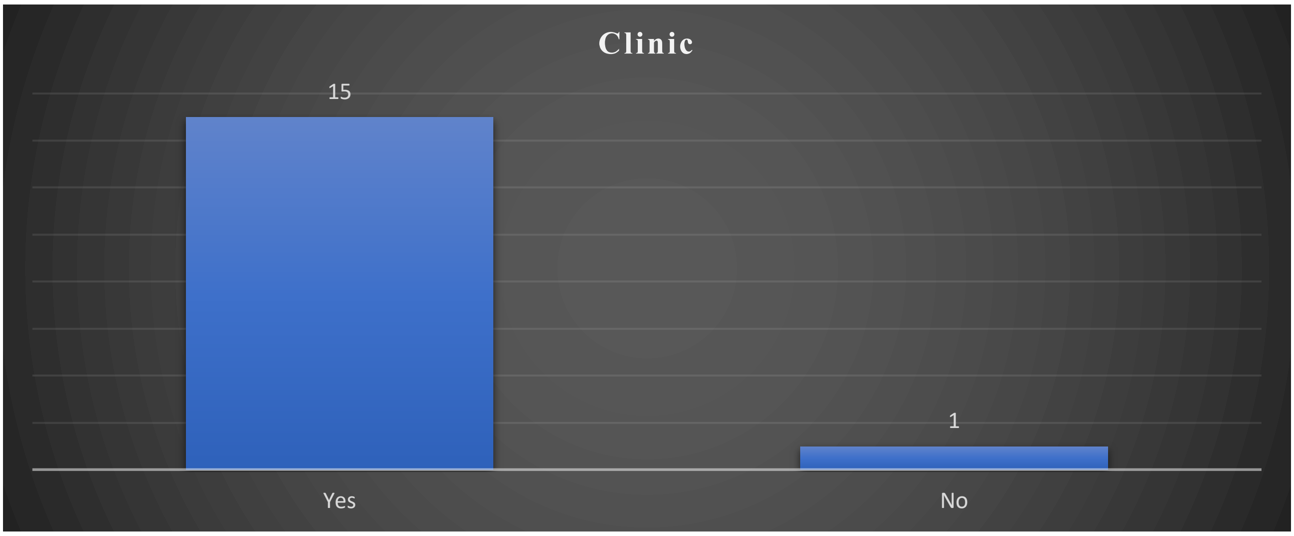

Figure 4.7: Clinic

Of the 16 participants only 1 did not attend a local community health centre (clinic). The study is informed predominantly by individuals who do not receive additional health services from their local clinic.

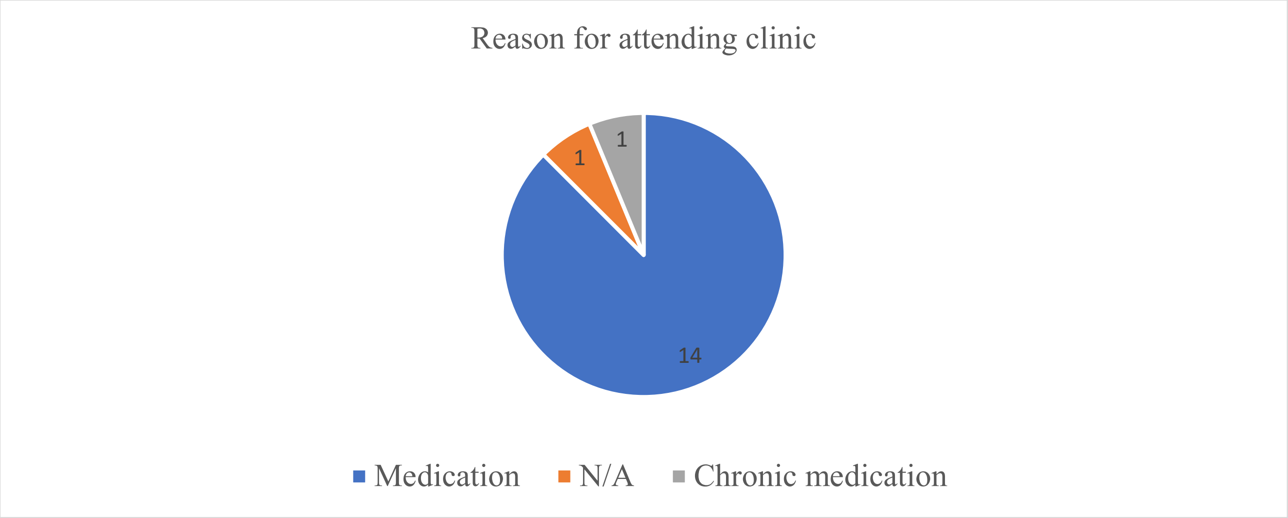

Figure 4.8: Reason for attending clinic

The participants who received additional health services from their local clinic, 14 of them attended the clinic to receive their psychiatric medication, one collected other chronic medication and one did not attend the clinic at all. The study is informed by a majority of participants who receive additional health services.

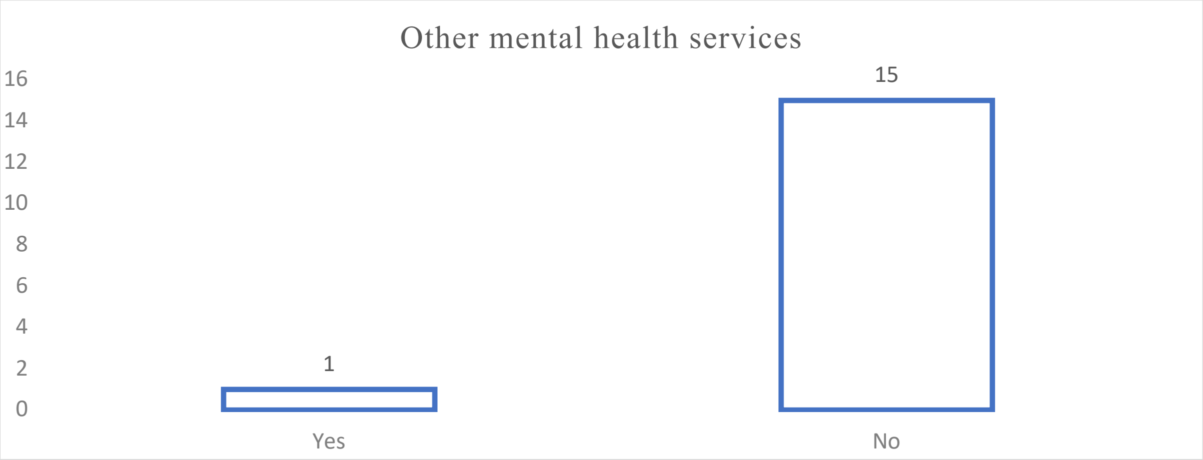

Figure 4.9: Other mental health services

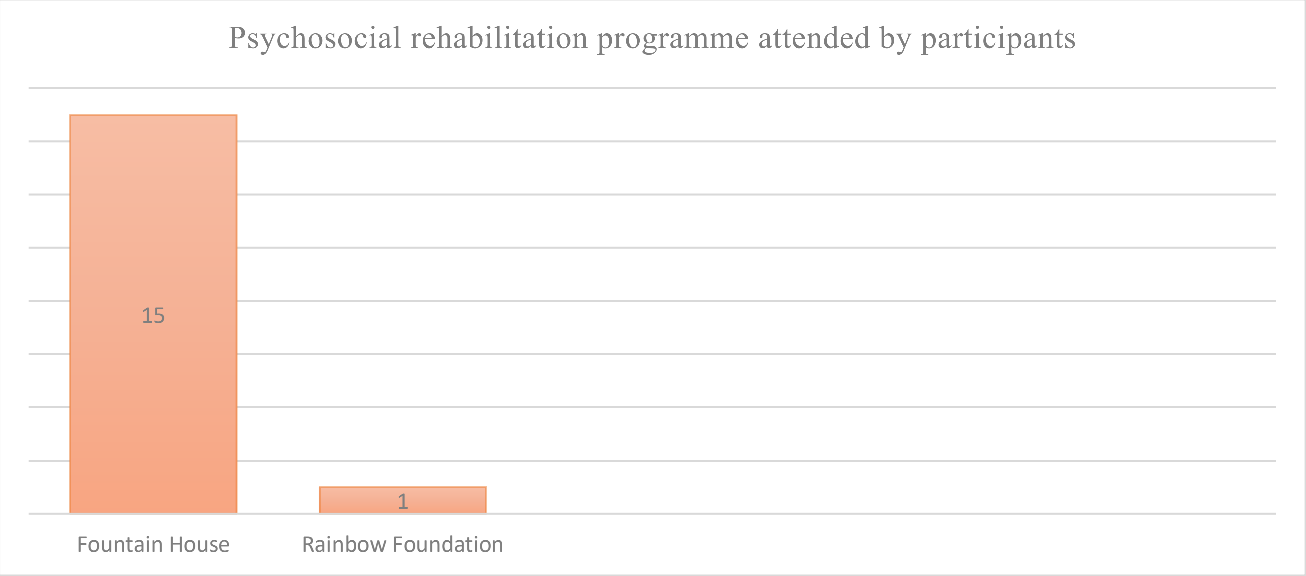

Figure 4.10: Psychosocial rehabilitation programmer attended by participants

There were two different PSR programmes that were attended by participants, 1 participant attended Rainbow Foundation, while the remaining 15 participants attended Fountain House. The findings of this study is more strongly informed by the perspective of individuals from Fountain House

4.3 Framework of analysis

Table 4.2: Framework of analysis

	Theme	Category	Sub-Category
4.4.1	Individual well-being	1. Independence	
		2. Medication compliance	
		3. Reduced hospitalisation	
		4. Improved understanding of symptoms	
		5. Improved belief in ability to productively contribute to society	
		6. Improved self-esteem	
		7. Emotional changes resulting from PSR	1. Control
			2. Awareness
		8. Psychological changes	1. Self-esteem
4.4.2	Social well-being	1. Increased support network.	
		2. Family is primary source of support	
		3. Identifying toxic relationships	
		4. Personal involvement in community activities	
		5. Difficulty socialising	
4.4.3	Beneficial elements of PSR	1. Therapeutic activities	
		2. Games	1. Bonding
		3. Socializing	
		4. Life skills	
4.4.4	Non beneficial elements of PSR	1. Nothing	
4.4.5	Recommendations to improve PSR programmes	1. Personal development	

4.4 Findings

The findings are presented below under the heading of each objective.

4.4.1 Theme One: Perceptions of PRP participation on individual well-being

In the analysis of the data relevant to theme 1 seven categories were identified. They are, Independence; Medication compliance; Reduced hospitalisation; Improved belief in ability to productively contribute to society; Increased self-esteem; Emotional changes resulting from PSR; Psychological changes. In theme one there were also 3 sub categories identified, for category 7 there were two sub-categories namely Control and Awareness, and for category 8 there was one sub-category identified as self- esteem. Each category and sub-category analysed will now be presented individually.

4.4.1.1 Category one: Independence

Nearly half the participants shared that one of the advantages of attending a psychosocial rehabilitation programme is that they had regained some of, if not the majority of their independence, and felt that they have gained confidence to function and move around autonomously.

> "I could tell you my mom took care of me, but I can't pinpoint but it was a struggle for me. It is still a struggle with me and everything that I do, I do it with - I do it with passion but Cape Mental Health taught me a lot. I'm living in Kimber house for the past seven years. My life has changed very, very much entering that house also. Kimber house is also a part of Cape Mental Health so we do attend groups there also." (Participant 4)

> "In one way - it has got nothing to do with regarding the delusions - but they actually have had a lot of faith in me, putting me in leadership positions, sending me to Joburg and putting me in internships so in that way they have really helped me but the delusions are always there. (Participant 7)

> "I found myself more independent and I started going by myself. I can actually do what I feel like doing, no one has got the right to stop me as long as it's appropriate things I do. (Participant 8)

This finding concurs with literature by Malinovsky et. al., (2013:429) which states that one of the indicators that someone has recovered from mental illness is that they're able to live independently and without the supervision of family or caregivers and that they are able to accept complete responsibility for their own daily activities. This finding further supports the value of PSR’s in the contribution it makes in promoting independence for patients.

4.4.1.2 Category two: Medication compliance

Eleven participants identified that the programme positively contributed to their understanding about the importance of taking their medication, that it enabled consistency in taking their medication and that they understood **the** adverse effects on their treatment due to medication non-compliance.

> “But they do inform you, they tell you why you should take your medication. That it's not good if you skip and they tell you that what happens to the mind it not like you sick with the flu and the flu will go away or something like that, it’s something that’s always there and the medication just kind of suppresses that.” (Participant 1)

> “I really didn’t like my medication because it has a lot of side effects. One of the side effects is that I’m restless so I didn’t know that the other medication I took was for the side effects. …. Only when I came to Fountain House did they say no you get side effects medication so one of the members had the same medication as me.” (Participant 2)

> “They will always say that your medication is important, even if you feel better still use it. Then people will tell you the other way, like ‘Tablets will make you fat and you are already huge so stop with your tablet’ and I would go back and they would say ‘No, it’s not that. Try to use it’.” (Participant 11)

This finding **is** similar to McDevitt, Snyder, Miller, & Wilbur, 2006; Pratt et al., 2008 as cited in Van Meerten, et. al. 2013 which found that a positive association can be linked to attending a psychosocial rehabilitation programme and an individual’s compliance with psychopharmacological treatments as part of living with mental illness, physical healthcare and health management. This finding further endorses the need for supportive interventions such as PSR programmes which compliment traditional medical treatment modalities and enhance their effectiveness by fostering better compliance to medical treatments.

4.4.1.3 Category three: Reduced hospitalisation

Twelve participants identified that as a consequence of attending a psychosocial rehabilitation programme they experienced less**,** if any admission to hospital for treatment for their mental health condition from the onset of their involvement in a PSR programme.

> "Well I haven't been to hospital since coming to Fountain House at all." (Participant 3)
>
> "I was never going back to hospitals since I've been in the programme" (Participant 9)
>
> "Fifteen years now of not going to hospital." (Participant 12)

This finding supports research that found that a PSR model contributes to the decrease of rates of hospital recidivism for people with mental illness (Gumber et. Al, 2018). This finding is further evidence of the value of introducing such programme modalities in a country such as South Africa, which is in line with its mandate to deinstitutionalise mental health care, and, furthermore, provides assistance in reducing the burden on an already overburdened mental health care system.

4.4.1.4 Category four: Improved understanding of symptoms

Ten participants reported that one of the identifiable changes they observed in themselves from attending the PSR programme was an increased comprehension of their illness and its associated symptoms. Some identified varied nuances as well as an understanding of their treatment such as what medication they are on and its function.

> "I've learnt that a lot of the times schizophrenia is genetic. Sometimes you have a dormant gene for schizophrenia and it can be triggered by some kind of trauma or substance abuse. A lot of varying things can trigger it and then also a lot of people experience different symptoms when it comes to schizophrenia..." (Participant 3)
>
> "The illness, when you use your medication the first few months it makes your body tired but after that you get used to the medication. Your system gets used to it and then after that you get normal, like your everyday self." (Participant 10)
>
> "Depression, I've learned that you must take it a day at a time and so many times I wanted to commit suicide but talking to them I feel much better and I understand my diagnosis and there is hope at the end of the tunnel." (Participant 11)

This finding concurs with literature which indicates that individuals participating in PSR programmes are able to gain a deeper sensitivity to treatment and how this influences their symptoms or the reduction of experiencing symptoms of their mental illness. Research indicates that participants of psychosocial rehabilitation (PSR) programmes have reported the attributed improved symptoms or associated features such as the occurrence of headaches to the attendance of PSR's (Brooke-Sumner, Lund, Selohilwe, & Petersen, 2017:259). This finding further supports the notion that mental illness presents itself differently for different people. There is significant value in being able to enhance understanding of these differences in order to better educate and foster support for people with mental illness from within the community and consequently from society at large.

4.4.1.5 Category five: Improved ability to contribute productively to society

Almost half the participants reported that being able to participate in the psychosocial rehabilitation programme allowed them to regain a sense of purpose and ability, rather than focusing on their disability.

> "Before I used to just be at home and now that I am apart of Fountain House it is different because you don't have the thought of watch tv and those things because here you get to be active and a part of Fountain House by getting along with the members and doing as the staff tells you to do." (Participants 10)

> "You see the thing is with the illness, OK there is welcome club on Fountain House premises, but if you don't find the nurse you've got the catering section, arts and crafts, your admin section, you know what I mean. So, in the program you are doing something constructive as if to say, you know what I mean. So, going to Fountain House for me is something very good." (Participant 12)

> "It has changed my routine quite a bit because in previous years when I was diagnosed, I didn't really do anything much physical out of the home environment. I used to be the person that used to cook, used to clean, I used to do the dishes. I used to do the washing of the clothes and when I got sick it was in my head a turnaround point because I stopped doing a lot of those things when I got sick and it just made me build myself into a corner. It has changed my routine, daily, because my day starts out with breakfast after which I come here, to Fountain House, either by taxi or by transport and my day ends just before or after 2pm." (Participant 16)

This finding concurs with literature which highlights the importance of incorporating the expectations to enjoy a healthy lifestyle, enjoy good family relationships and have satisfying jobs which are profoundly affected for persons with mental illness as part of the goals of rehabilitation (Crosse, 2003:178). These findings further endorse the important role PSR could play in reintegrating persons with mental illness back into society.

4.4.1.6 Category six: Emotional changes resulting from PSR

The researcher explored with the participants what they perceived to have benefited emotionally from attending a psychosocial rehabilitation programme. Thirteen participants identified changes to their emotional wellbeing as a result of attending the PSR programme:

> “The paranoia, sometimes I feel people are making fun of me and that's part of the paranoia but sometimes it's true. But I've actually learned to not fight it anymore, be angry anymore. I've learned to develop a culture of love and forgiveness. You know that's an emotional and have mercy.” (participant 7)

> “So, before I was like I said, I was a bit suicidal I was down, I was depressed. I was all over the place.” (participant 8)

> “I would say being able to be assertive. As I already said, helping others and that’s how I am and not taking the thing – I was a chairperson but I wasn’t taking it to my head like I am a chairperson yeah and boss people around. You can be assertive but not bossy. Have compassion so that the people can learn from you not only just to make them work without any lesson from what you're doing.” (participant 9)

This finding, similar to Brooke-Sumner et al. (2017:259) found that the participation in a psychosocial rehabilitation programme assisted participants to regain a sense of pride in themselves. They see their participation in the programme as ‘their work’. This finding further indicates the value of PSR programmes in making the process of dealing with emotional health and wellbeing seem less intimidating.

Sub-category one: Control

Almost half the participants identified that they had gained a sense of control over their emotions which they attributed to their participation in the PSR programme.

> "It's like I get frustrated when I talk and now, I'm just calmer. And I think clearly and everything is back to normal." (Participant 1)

> "Being with Fountain House my mood has stabilised quite a bit because I am basically integrated with society again. My mood is not like way up there or way down there. It's just more level." (Participant 3)

> "You see I'm a very straightforward person. I'll say things just as it is you know what I mean. But you know I've actually learnt that you can't just speak to everybody like that. You must learn to you know … Don't just speak, you know. Maybe you'll regret it afterwards that you've told this person this and that. So, I've learnt to, I think, calm down a bit more." (Participant 12)

This finding concurs with literature which states that, of the potential outcomes of participation in PSR programmes is the experience of a reduction of the symptoms related to their illness as well as reduced distress associated with their illness (Penn, Waldheter, Perkins, Mueser, & Lieberman, 2005 as cited in Van Meerten, et. al. 2013). This finding further supports that PSR programmes endorse emotional regulation of persons with mental illness in a more cost-effective way.

Sub- category two: Awareness

Nine participants reported that as a result of being a part of the PSR programme, they had become more aware of their emotions and how their emotions affected them.

> "I find that I'm a lot angrier when I'm lonelier and it's a sad that I never knew. It's kind of a lonely sadness kind of thing." (participant 2)

> "The emotions that I have felt while a part of the program was very loving." (participant 14)

> "I have become more sentimental." (participant 16)

This finding, similar to Onken, Craig, Ridgway, Ralph, and Cook (2007) as cited in Malinovsky et. Al., (2013:429) found that each individual within their own framework, acquires the key elements of self-determination, hope, awareness/potential, and meaning/purpose in the context of recovery-promoting social relationships when recovering from mental illness. This finding is further evidence that PSR is able to contribute to the outcome of recovery from mental illness, in support of an advancing definition which moves from a deficit approach.

4.4.1.7 Category 7: Psychological changes

The researcher explored the perceived psychological impact attending a psychosocial rehabilitation programme had on recovery from mental illness. Fourteen of the participants had identified that they had experienced some form of psychological change after being part of the programme:

> "I was always waiting for someone else to be positive towards me. I was more sucking from other people but now I've learnt I can give more. (participant 2)
>
> I am more motivated now to work. I didn't have a stigma of relapsing again. I take everything easy. (participant 14)
>
> "It helped me a lot. I used to try a lot to commit suicide because I couldn't handle even with my husband now but in that time Faldeelah used to talk to me a lot to end your life is not the thing." (participant 11)

This finding concurs with the literature by Torres-González, Ibanez-Casas, Saldivia, Ballester, Grandón, Moreno- Küstner, Xavier, Gómez-Beneyto, as cited in Frost et al. (2017:3) who highlights that some of the key features of recovery orientated models and the specific needs that they address. Six areas of specific needs are identified which includes psychological, social and economic needs. This finding further endorses the need for PSR programmes in order to meet the already diverse psychological needs of people including those with mental illness.

Sub- category 1: Self-esteem

Improvement in their self-esteem was the main psychological improvement identified by eight participants as a result of attending the psychosocial rehabilitation programme.

> "Oh, my self-confidence went skyrocketing. I'm feeling very confident now around people" (Participant 5)
>
> "Yes, I think I have lots of confidence in myself and assertiveness also because if you be positive you do have a bright future out there. If you are negative you feel that you are grey and down. That is what I believe. It is your attitude." (Participant 6)
>
> "Yes! I am more confident of myself even if somebody tells me 'Ah you're mad', I'm like it's fine. You think what you think. I think what I think. (Participant 8)

This finding supports the research on the benefits of psychosocial rehabilitation by Brooke-Sumner et al. (2017:259) which indicates that participants reported increased self-esteem and confidence. This was achieved through increased motivation to be more active and contribute to their households, as well as forming friendships and improved feelings which members of PSR programmes had towards themselves. This finding thus further emphasizes how a PSR can contribute to improved self-esteem of participants which makes a valuable contribution towards sustaining mental wellness.

4.4.2 Theme Two: Perceptions of PSP participation on social well-being

In the analysis of the data relevant to theme two, five categories were identified. They are, Increased support network; Family is primary source of support; Losing friends; Personal involvement in community activities; Difficulty socialising. Each category analysed will now be presented individually.

4.4.2.1 Category one: Increased support network.

The researcher explored what the social benefits of attending a psychosocial rehabilitation programme had on participants. Half of the 16 participants identified that they had increased their social network and support base since joining the PSR programme.

> "When I came into fountain house, I feel like I have a better support network because there are people here who know that you suffer from a mental illness and they know how to treat you. There are people here who also have the disability and they know themselves and they know that you are going through a similar thing. So, I think that grew." (Participant 1)
>
> "No, I think so, definitely. Like I said before you are amongst people, not just isolated." (Participant 12)
>
> "It went good because if you have a problem you can always come to the co-workers around here and they will try to deal with it on their own or where they can help and they are very understanding." (Participant 14)

According to research by Rousea et al. (2017:143), gaining a larger social network is one of the quantifiable benefits of being part of a psychosocial rehabilitation programme, which concurs with the finding above. The gaining of a social network is identified not only as a social benefit but also as an indicator of the prevention of future hospitalisations (Rousea et al.

(2017:143). This finding highlights the importance of PSR programmes in dealing with the issue of stigma in mental health as well as the vital role it plays in the social domain of the individual's life.

4.4.2.2 Category two: Family is primary source of support

The researcher explored the role the family played in the individual's treatment, and whether attending the programme had an influence over these familial relationships. Ten individuals identified their family as their primary source of support for coping with their illness and the circumstances around it.

> "My support network is my family now because right now I can see from the years up to now they've also learned a few things about me so they understand me better now also. So that helps me also." (Participant 14)
>
> "I have a family bond. I have a – so my elder sister, she stays in Ottery, so when it comes near to weekends, she wants me to come down to her because they've got an Xbox and they've got a nice TV and stuff like that so basically, I have a bond with my family. I have a bond with my neighbours, with a few neighbours but so far, furthermore, I don't worry with the old friends. I still see sometimes that I still get this feeling they still look around you and so basically like I said I didn't really bond with them. (Participant 15)
>
> "I have got a very good friend and confidant in my sister. She's I think a very wise person." (Participant 7)

This finding supports research of families who reported that caring for individuals with mental illness resulted in their lives often being centred around these individuals (Jeon & Madjar, 1998:6 98). This finding highlights the reliance of individuals with mental illness on their family, and the important role of PSR in the family. It further echoes the importance of PSR programmes in providing families with some relief from day-to-day supervision and the vital role of family in treatment.

4.4.2.3 Category three: Identifying toxic relationships

The researcher explored what the programme contributed to the participant's overall social network. Five of the participants identified that the programme assisted them in terminating unhealthy and toxic relationships, namely, friendships with their peers.

> "Like I said with a lot of my friends that I actually told they just decided to up and leave after I actually disclosed to them but there are some friends who stuck around even through that. I guess at the end of the day I just got a real look at who my true friends were. My relationships with a lot of my friends actually ended due to my diagnosis but I feel today I am better off without them because if they can't accept me the way that I am then don't accept me at all. Just leave me alone." (Participant 3)

> "I didn't want my friends to know. Cause you know that embarrassment, filled my head up. But when it was my second breakdown, my friends they heard of it, but the ones I grew up with they came to Valkenberg with a carrier bag full of luxuries and cigarettes and a here's a couple of bucks. Then I realised they saying "when days are dog, friends are few" cause the ones I did drugs with, they were nowhere to be seen. But my friends I had grown up with from a young age, they came. So, it meant a lot for me to see that there is friends." (Participant 12)

> "Her husband is dead now, five years but she is still there and his ashes are still there but I said, 'We are Muslim's and that is not the right way' and she got upset so I just tried to stay away and she wasn't very nice to me. She didn't want me to attend this group but she doesn't know how good it has been for me." (Participant 11)

This finding supports the research that found that the subjective experience of stigmatization makes the maintaining of social networks challenging (Sheridan et al. 2015:242). Research further highlights that stigma plays a huge role in the experience of persons with mental illness (Corrigan et al., 2006:239). These findings echo the important role of PSR in developing and nurturing healthy relationships.

4.4.2.4 Category four: Community integration

The researcher explored what the perceived role of community activity played in the individual's treatment process. Almost half of the participants not only identified a positive relationship between the role of community involvement and their treatment, but had begun personal engagement in ongoing community activities.

> "I feel that Fountain House and Cape Mental Health has helped me tremendously. And I feel that I have to give back to the community in some way whether it is for donations of money or voluntary work or you know. So, I feel like after the internship I want to give back to Fountain House maybe. (Participant 7)

> “So being involved with this community you start with C-CAB when I joined C-CAB it meant nothing. I never knew that mental ill people had rights because from what I've seen at hospitals they chain them on beds. I mean practically the doctor has a right to give you medication. You can't say no. (Participant 8)

> “I can help in the community and I can be a part of it but I first have to impose myself or show people yes I am ready to do this and then people will come and follow me. (Participant 2)

This finding concurs with literature on recovery orientated models like PSR, which highlights the idea that recovery includes individuals engaging in instrumental age and culturally appropriate roles such as volunteering (Liberman et al., 2002 as cited in Malinovsky et. Al., 2013:429). This finding is further evidence of the value of PSR in integrating people into the community as well as fostering their active engagement in community-based activities.

4.4.2.5 Category five: Difficulties socialising

Just under half of participants reported difficulties with socialising that was identified through their participation in the PSR programme. Interestingly, while there were of the participants who identified socialisation as one of the difficulties in participating in the programme, there were also a number of participants who felt that the socialising was what they had gained from being a part of the programme.

> “So, for me the most difficult one is being around people who are sick.” (Participant 2)

> “like I said it helped me a lot just to sit and listen there and talk to someone.” (Participant 11)

> “Oh, learning how to gel with them. At first it was hard to gel with them. Then I got to know them. Then it became easy to gel with them. Now we take hands, we hug each other.” (Participant 5)

> “Besides the people being humble and actually talking to them, a lot of the people also in their own world. They are just sitting there and you can't reach out to them. (Participant 7)

This finding supports the research that found that individuals with mental illness usually manifest a number of dysfunctional relationships, emotions and behaviours. This supports the apprehension for socialisation by participants in the programme due to the unique experiences and encounters directly associated with mental illness and its influence on social interactions and social norms (Wong-Anuchit et al., 2019:122). This, compounded by the experience of stigma, also makes socialisation a challenge for individuals with mental illness. They are reported to try and avoid relationships with people that will result in them being labelled, and consequently, association with persons with mental illness are considered to be label inducing relationships. (Wahl, 2017:9). This finding is further evidence that PSR programmes improve socialisation amongst individuals with mental illness.

4.4.3 Theme Three: Perceptions on the useful elements of attending a psychosocial rehabilitation programme.

In the analysis of the data relevant to theme three, four categories were identified. They are, Therapeutic Activities; Games; Socialising and Life Skills. There was also a single sub-category associated with category two, games, the sub-category identified is bonding. Each category and sub-category analysed will now be presented individually.

4.4.3.1 Category one: The Value of the PSR setting

When the researcher explored what were the elements of participation that the participants found helpful about attending the programme**,** almost half the participants identified that they found the space created in and around the programme activities to be therapeutic.

> "Like I said the speaking to people was a very therapeutic thing for me." (participant 3)

> "I'm going to come to Fountain House and do something every day to keep my mind busy and not just think negative thoughts like I'm going to go back to where I came from. So that's what I do daily." (participant 8)

> I feel like it's very therapeutic and calming. We do all kinds of things. things that we even sell. We make it beautiful and we sell them. Even those things are therapeutic when you make it." (Participant 1)

This finding concurs with literature by Rousea et. al. (2017:139) which highlights that the service providers of psychosocial rehabilitation motivates clients to make use of their inherent potential in respect of their social, emotional, mental and working capacity as an intervention. Tool. This finding further supports the value of PSR in providing comprehensive treatment to persons with mental illness.

4.4.3.2 Category two: Games

Almost half of the participants identified that playing games had a positive benefit for them during attendance of the programme:

> “Afternoon activity. It’s the end of the day and you either learn something or play games or something. (Participant 2)

> “Well, I am the person that says I like to be cooking. I like cooking and I like to entertain like singing and dancing. Hobbies. (Participant 6)

> “Maybe one day we will play dominoes or so, or the brick game when you have to concentrate and it does work and it makes you positive and it does help. (participant 8)

This finding is similar to Hancock, Honey & Bund. (2015:509) who highlight that the activities in PSR that members derived the most meaning from included having fun and enjoying themselves. This finding is further evidence that in an atmosphere of fun and enjoyment that is created by PSR programmes, positively contribute to the individual’s experience of treatment.

Sub-category one of category two: Bonding

Just under half the participants reported that they found playing games helped them to develop and improve rapport among themselves and the other members in the programme.

> “Games like scrabble. I play Jenga but you know it kind of changes your attitude… And you learn life skills. You learn boundaries, respect, building a new support network. (Participant 2)

> “Dominoes, Uno, cards, stuff like that… I don't know. It brought us closer. (Participant 5)

> “The most helpful one is peers. Peers has helped me. Last year I went to a high tea and the high teas I have been going to I've been very very out of it because for a high tea you can’t be yourself. Well, that's what I thought it was. But then when I just realized that somebody can actually just bake a cookie and make coffee doesn't cost anything, it's like why not? Why not join this. Why not engage myself and learn from other people why actually. We should teach each other and you can learn from each other.” (Participant 8)

This finding concurs with literature by Hancock et al. (2015:509) who found, that people living with mental illness attribute meaning in their day to connecting with the world and people around them. It is the same connectedness and bonds that all human beings share, regardless of whether they have a mental illness or not. These findings echo the important role PSR programmes play in nurturing bonds within the mental health community as well as the potential it has to encourage bonding outside of the treatment space through experiential learning.

4.4.3.3 Category three: Socialising

As part of the exploration of the benefits of attending the PSR programme, almost half of the participants had identified that the opportunity to socialise and engage socially with peers and professionals had a positive impact on their treatment outcomes.

> "So, the socializing part has helped you because you improve on communication and then if I understand you correctly you also said that learning, the sharing of knowledge has been powerful." (Participant 6)

> "Socialising yes. You don't have to be positive-positive but just the first step to reach out to someone. Even if you get rejected it doesn't really help but that first step – that person you talk to may not be the person you end up connecting to but other people are seeing that you are trying and putting effort. When you just sit there and do nothing nobody is going to take note of it." (Participant 2)

> "Specifically, the whole speaking to other people thing. That was the most important thing for me because that has really helped me a lot just to come to terms with things that OK this is really happening and this does happen to other people. People do go through things like this. It wasn't just all in my head that this was happening to me or whatever but it is real and it is manageable as well. Like I said the speaking to people was a very therapeutic thing for me." (Participant 3)

This finding supports research by Liberman et al (2002) as cited in Malinovsky et.al. (2013:429) which found that in order to be considered 'in recovery', individuals need to demonstrate that they are actively involved in friendships and/or social relationships or recreational activities that are age appropriate and which are independent of the supervision of professionals. Brooke-Sumner et al. (2017:259) highlight in their study that participants reported increased self-esteem and confidence, which was achieved through increased motivation to be more active and contribute to their households, as well as forming friendships, and, improved feelings members had towards themselves. This finding is indicative of the potential PSR has to address the common experience of isolation among individuals living with mental illness by offering important opportunities for socialization.

4.4.3.4 Category four: Life skills

Just under half of the participants reported that the component of life skills which formed a core part of the programme activities, played an impactful role in their treatment outcomes.

> "I got two actually. It's life skills, when they teach us stuff about bipolar and schizophrenia…" (Participant 5)
>
> "Life skills, also they speak sometimes about your illnesses so you learn about your illnesses there and the volunteers they find work so well to get the information for you to learn from them of what the topic that they've chosen for that month. They usually did that that like that with the topic of the month and the volunteers and people coming to teach us that. I really liked that." (Participant 9)
>
> "The life skills…Because each day there's a different aspect that is focused on of the various facets within mental illness. So, there will be times where in this week we will focus on schizophrenia in this time and there will be a time of the week that you focus on support for people with mental illness and then there's a time when we focus on being there for people with mental illness." (Participant 16)
>
> "The one here in this room, we are all together here and we must do the, like I said, it was the role play… It gives you a bit of a boost." (Participant 15)

The importance of life skills in PSR treatment is identified as a trend in literature over the years. There is a continued trend and focus for rehabilitation in mental health to be on the skills and support that individuals living with mental illness need for participation in routine community life (Drake et al. 2003:437). These findings suggest the vital role life-skills in PSR plays in the reintegration of persons into society.

4.4.4 Theme Four: Perceptions of the elements of the psychosocial rehabilitation programme which was not helpful in aiding recovery outcomes.

The researcher attempted to explore what the participants found did not contribute to improving their mental health, and the vast majority of participants expressed that they found that there was nothing that was not helpful or beneficial to their healing process. Based on the researcher’s field notes, this response, or lack of criticism or expression of elements that were not beneficial could be attributed to a couple of factors.

There were also a few participants who indicated aspects that were unhelpful. Some of these aspects that they reported to be lacking included journaling, more variety in arts and crafts workshops, advertising of the programme, access to more computers, more intellectually stimulating activities such as novel critiquing and more employment opportunities in the open labour market.

This factor could influence participants who appear to have an attitude of gratitude for having access to a treatment method, which is limited and even in some cases inaccessible for some individuals. Due to the limited number of free resources and services available to persons with mental illness, participants were just grateful they had something. This could potentially have contributed to the apprehension to share their negative opinions about the programme.

The second observation made by the researcher was that not all the participants had the same reasoning ability. Some participants had a mild to moderate intellectual disability which limited their ability to think critically about certain questions and provide the appropriate feedback.

Finally, the researcher also observed that participants had no exposure to, or knowledge of a comparative model or programme. The programme was their primary source of treatment aside from their medication, and there are very few alternative programmes available to persons with mental illness which are accessible to them from their communities within the Western Cape.

4.4.5 Theme five: Perceptions of the reasons for recommending PSR to other potential users of such treatment programmes

In the analysis of the data relevant to theme 5 one category was identified, which is Personal Development. This category analysed will now be presented individually.

4.4.5.1 Category one: Personal development

Almost half of the participants shared that they would recommend a PSR programme to other people who have challenges with mental illness because it contributed to their personal growth.

> “I was unemployed for more than a year before I got the internship. I also managed to move into – not my own place – but independent living. (Participant 3)

> “I will tell them about Fountain House and tell them how it is there. You learn lots of things there. You learn how to cope with your problem. You learn how to cope with your stress levels and your healthy levels and they teach you, they motivate you, they lift your sprit up. You don’t need to worry about different things around you. You’ve got lots of things to be busy with and it’s a very good thing to be there because it’s you learning to explore and then go out into the outside world. So, you can learn more so that you don’t feel harm if you are in the outside world. (Participant 14)

> “Because I benefitted here. It helps me grow because I have a better perception of myself and…–Your personality growth. It helps you shape your personality. (Participant 16)

The above finding supports the suggestion by Drake et al. (2003:435-437) that there has been a trend that over the years that rehabilitation continues to emphasize patient-centred services, such as empowering the individual receiving treatment to make choices regarding goals and interventions, to direct services, and to be as independent as possible. This finding suggests the value of PSR in assisting individuals to regain a sense of self-worth through the personal growth they experienced.

4.5 Conclusion

The findings illustrate participants’ perceptions of ways in which psychosocial rehabilitation has aided them in their recovery from mental illness, what exactly made it effective, how the PSR intervention strategy could be improved and how it can sustain its effectiveness. The feedback from participants on potential improvements and constructive criticism of the PSR programme was not as rich as the positive feedback on their experiences of participating in the programme. Some reasons cited for this was participant’s exposure to other similar programmes, together with their immense gratitude for having access to the programme due to limited alternative sources of treatment and support. It was clear that these perceptions were based on individual experiences. It is also however clear that all responses indicated the need for PSR and the value in having access to these interventions within the provision of service for persons with mental illness, particularly in a developing economy like South Africa. The final chapter of the research discusses the conclusions and recommendations of the study.

Chapter Five

Conclusions and Recommendations

5.1 Introduction

The final chapter presents the conclusions and recommendations drawn from the findings of the study. The conclusions are discussed under each research objective. Recommendations are made in relation to improving practice and further research.

5.2 Conclusions

The conclusions are presented below:

5.2.1 Objective one: To explore the perceptions of mental healthcare users about the contributions their participation in the Psychosocial Rehabilitation Programme had on their individual wellbeing

Participants identified a variety of changes to their individual wellbeing which they derived from their participation in the PSR programme. Some of these changes included the regaining of some of their independence lost through being diagnosed with a mental illness, being more compliant to their pharmacological treatment for their mental illness, accounts of shorter and reduced hospital stay related to treating their mental illness. Further changes resulting from their PSR attendance, was an improved understanding of their illness and regaining the ability to contribute productively to society.

There was also the experience of intrapersonal changes such as gaining awareness and control over their emotions and psychological change, namely the experience of an increase in their self-esteem as a result of their PSR participation.

5.2.2 Objective two: To explore the perceptions of mental healthcare users about the contributions their participation in the Psychosocial Rehabilitation Programme had on their social wellbeing

The socialisation element of the programme was significant in the experience of the participants in differing ways. For some of the participants having to socialise to begin with was challenging for a variety of reasons, so having to interact with others was initially viewed as a bit of a threat. Despite the fears and anxieties around the need to socialise in the programme, many of the participants experienced the exposure to socialisation within the programme assisted them in building their confidence to engage in social relationships.

There was however consensus among participants that they did experience an overall improvement in their social wellbeing. This was experienced through increased social networks, getting rid of toxic relationships or improving their relationships with their family.

5.2.3 Objective three: To explore which aspects of the Psychosocial Rehabilitation Programme mental healthcare users perceived to be most beneficial to their individual wellbeing

One of the significant highlights of PSR was the programme itself. Participants identified that being a part of the programme allowed them to get out of self-isolation as a result of their illness, and get out and live productive lives. They found themselves regaining confidence to socialise and interact with the outside world through employment or other educational opportunities. Their ability to participate in the PSR and its related activities provide members with an acute sense of accomplishment. The PSR programme also fostered a sense of belonging among members by being able to engage in healthy and productive relationships with peers and professionals alike.

5.2.4 Objective four: To explore the aspects of the Psychosocial Rehabilitation Programme mental healthcare users perceived to be least beneficial to their wellbeing.

There was very little criticism of the programme and when this objective was explored, a smaller portion of the participants were able to provide feedback on what they felt was not beneficial in the programme.

It was observed that this was influenced by a variety of factors which included the members lack of exposure to other alternative treatment programmes, their loyalty to the programme and to the service provider due to it being their only source of support, and the members' intellectual ability to critically think about corrective components for the programme.

5.2.5 Objective five: To ascertain what improvements mental healthcare care users of the Psychosocial Rehabilitation Programme recommend to improve their experience in the programme.

There was a unanimous sentiment shared among participants that they would recommend the programme to other individuals with mental illness due to the potential the programme has to contribute to individual personal development. Many participants were of the opinion that they observed transformational change in themselves as a result of PSR, and this is why they believed that the programme could work for others with mental health challenges.

5.3 Recommendations

Recommendations are made to Cape Mental Health and for future research in this field.

5.3.1 Recommendations to Mental Health Institutions and other mental health related services:

5.3.1.1 Expansion of PSR

It is encouraged that other mental health institutions consider adopting PSR programmes within their own service delivery models. Not only is the model practical and effective in treating mental illness in non-traditional ways, it is also a cost-effective method in addressing the needs of individuals with mental illness. Expanding PSR programmes not only allows for much needed increased access to mental health services within South African communities but also allows for decrease burden on an already overburdened public health system.

5.3.1.2 Referral of individuals to PSR programmes

It was apparent that one of the main referral pathways to accessing PSR for individuals with mental illness was through a professional referral. This places a responsibility on professionals who are encouraged to motivate and refer individuals with mental health challenges to attend psychosocial rehabilitation programmes. This not only boasts the potential to contribute to sustained mental health by encouraging treatment compliance, but is also a cost-effective and efficient tool in aiding the reintegration of individuals with mental illness back into society who may have been isolated from their communities for extended periods of time due to illness or treatment.

5.3.2 Recommendations for existing PSR programmes:

5.3.2.1 An integrated multidisciplinary model

Having a multidisciplinary team including a psychiatrist, psychologist, social worker, occupational therapist and dietician as part of the programme could provide a more integrated and comprehensive input into the further development and adaptation of the programme to a South African context. This is important in being able to address the unique mental health needs of our communities and its unique makeup. By having multidisciplinary input will allow for comprehensive input into individual cases of members in the programme, encouraging positive outcomes. It will also allow for the programme itself to be scrutinised and updated with the inputs and expertise of different disciplines which will encourage an integrated service.

5.3.2.2 Incorporating family into the programme

The family were identified as the most important source of support to individuals with mental illness, and while PSR was seen as helpful to attendees, there was little incorporation of the family within the treatment programme. While it could be assumed that the family indirectly benefit from the programme through the improvement of the individuals with mental illness, it could yield improved outcomes for the family system to be incorporated into the programme. This could be achieved through monthly family meetings, or starting a family support group and including members in the closed group

5.3.2.3 Newsletters

It is encouraged that organisations offering PSR allow for the creation of a monthly online or print newsletter that can be developed by members of the programme. This newsletter will be created to share information on the programme, updates on what is happening within the programme and information on mental health. Newsletters could be used to relay narratives on individual’s experiences of mental illness, recovery, and PSR. These newsletters could then also be used as an advertising tool for the organisation or institution running the programme, as well as an educational tool for individuals needing such services as well as the community needing to openly accept and protect this vulnerable group of individuals.

5.3.2.4 Support groups

To capitalise on the experience of the PSR space being therapeutic would be the recommendation of incorporating a support group to the daily or weekly activities scheduled in the PSR programmes. The support group should be facilitated and run by the members and could be supervised by one of the social workers or occupational therapists. Having a support group would further foster experiential learning and rapport building among attendees, and encourage the normalising of sharing and supporting one another within the programme.

5.3.3 Recommendations to Government to consider including PSR programmes in policies mandating its implementation and funding

5.3.3.1 Incorporate PSR within the public health service

The psychosocial rehabilitation programme could be made more accessible through expansion and partnership with the public sector. Organisations like Cape Mental Health with experience and interest in PSR could expand their models through partnering with government sectors such as the Department of Health and Social Development, and bringing the programme model into tertiary treatment settings as an extension of treatment within the tertiary service. Programmes could be setup in spaces that are shared with tertiary care, like a PSR programme at the hospital as an extension on their mental health service. This could help in supporting an overburdened health system and developing the expanding on the ever growing need for mental health services in South Africa. Expand them in more communities?

5.3.3.2 Funding PSR

While PSR appears effective and cost effective one of the biggest threats to the maintenance and expansion of such programmes is funding. Government more often than not cuts national budget when it comes to investment in mental health, which does not aid the growing issue of mental illness in the country. Government is encouraged to reduce budget cuts as far as funding PSR programmes, and recommend that more money be invested into developing and expanding PSR programmes in order to make it accessible to more South Africans living with mental illness.

5.3.3.3 Educating the community

It was clear that the majority of the individuals who attended the programme were either referred by a professional or were fortunate enough to know a family member who could inform them of the existence of PSR. Psychiatry and mental illness is traditionally treated within institutionalised settings, and this ignorance remains within our communities. Through educating the community, not only on what mental illness is, but also the types of treatment available will not only address the issue of stigma, but would facilitate that more individuals have access to such treatment modalities. People could be educated through information tables at cultural events, discussion panels on local radio and television, social media campaigns with popular influencers within the South African communities.

5.3.3.4 Psychosocial rehabilitation programmes reflected more explicitly in policy

In order to avoid tragedies like the Life Esidimeni incident and all the lives of individuals with mental illness lost to poor administration and efforts at reintegration, it would be recommended that government start providing guidelines and protocols within policies and legislation which makes recommendations on what the most appropriate PSR models are, and formalising expectations around how these models are carried out within the community and service sector. This will not only provide guidelines for institutions, NGO's and government sectors, it will also inform and protect the public and encourage funding from various sectors.

5.3.4 Recommendations to social work and other mental health practitioners working in mental health

5.3.4.1 Early intervention

It is encouraged that the psychosocial rehabilitation programme be offered as a first point of contact for individuals who become ill. This could be through the allowance of individual consultations to members of the community with mental health challenges by a multidisciplinary team (MDT) employed in the programme. They could then be treated by the team medically and psychosocially, and avoid possible hospitalisations. By having an MDT**,** the programme could integrate the medical and psychiatric needs of individuals by allowing them to be diagnosed, treated pharmacologically and therapeutically all within a community based setting.

5.3.4.2 Formal training in PSR

For social workers and other professionals working in the mental health space, it would be of great benefit to train these professionals formally on the models and practises of PSR in order to comprehensively equip them with knowledge on the overall practise. As opposed to compartmentalising the role players within their traditional professions only, having training in the foundations and theories of PSR could also aid professionals in understanding the principles of PSR, which will encourage quality and creative interpretations and engagements in their respective roles in PSR.

5.3.5 Recommendations for further research

Not much research has been found regarding the effectiveness of international psychosocial rehabilitation programme models within a South African context, and the effectiveness of adopting these international models. More research in how individuals with mental illness experience these PSR models and their feedback on what is and is not effective about them could continue significantly to adapting and developing our own unique models for PSR. This will not only make the models suitable and appropriate for our local context, but will encourage the overall development of mental health service delivery and the deinstitutionalisation of mental health services.

Further research would be valuable in determining if the needs of individuals with mental illness are being appropriately met within the practices that offer psychosocial rehabilitation services. Future research could expand on this study with a larger number of participants from a number of different psychosocial rehabilitation programmes across the country, to determine if this model of intervention is effective in other parts of the country i.e. other urban cities and our rural communities.

What could also be of further value for future research is to do a similar study on how the family members or carers for individuals with mental illness perceive the PSR programmes to be of value for themselves, their loved ones or employers. To explore the perspectives of family members and carers could provide valuable input in improving the intervention strategy and informing the development in PSR from the perspective of the carers who have a different view and experience as that of the individuals with mental illness.

It was also found that the research design did not cater to the unique intellectual abilities of the different members found in the programme. It would be valuable to have further research, using more tailored and nuanced data collection methods which allows for the feedback from individuals who might not have the same intellectual abilities as someone with an average intellectual capacity.

5.4 Conclusion

Psychosocial rehabilitation Programmes were evaluated in this study through the lenses of Psychosocial Theory and Self-Determination theory. This was done by exploring the experiences of 16 individuals with mental illness who were a part of Cape Mental Health’s PSR programmes namely Fountain House and Rainbow Foundation. Through their responses, the immense value of PSR was highlighted within the treatment of mental illness. It further served as an indicator for the needs of the members in the programme, and highlighted aspects of the programme that were well received by members. The conclusions reached by most participants, was that despite the challenges they experienced, they had still benefited from the programme and would recommend the PSR programme to others. Recommendations were provided to address some of the challenges as well recommendations for future research.

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Appendix A: Interview Schedule

The interview will consist of 5 main sections. In the first section I would like to explore how attending the psychosocial rehabilitation programme has affected your perception on recovery from mental illness as an individual. In the second part I would like to explore what the potential social benefits of attending the programme are. In the third section I would like to reflect on what you found to be the most useful parts of the programme. In the fourth part I would like to look at what parts of the programme were not so beneficial. Lastly, I would like to reflect on how you think the programme can be improved, to have better outcomes for its members.

Demographic Information:

Name		
Age:		
Gender		
Race		
Do you attend a community health center (clinic)?	Yes	No
What do you attend the clinic for?		
Diagnosis:		
When were you diagnosed?		
Are you on medication for the treatment of your mental health condition?	Yes	No
What medication are you on for it, if any?		
When did you first join Cape Mental Health (CMH):		

What services do you receive from CMH?	
Which Cape Mental Health Programme do you attend:	
Duration in the programme:	
Any other services that you receive related to your mental health:	

1) **How has participation in Cape Mental Health's Psychosocial Rehabilitation Programme contributed to the individual's perception of their mental health recovery individually? (Emotionally, psychologically, medically – relapse prevention, treatment compliance etc.)**
    - Please tell me about your history with mental illness?
    - How has your mental illness influenced your life?
    - What made you enter the programme?
    - Since joining the programme how has it contributed to your daily life and routines?
    - By being a part of the programme, has there been any changes to the time you've spent in hospital for the treatment of your mental illness?
    - Since being a part of the programme have you observed any changes to your perception on your symptoms?
    - How has being part of the programme contributed to the way that you use your medication?
    - What have you learnt about yourself since being a part of the programme?
    - What have you learnt about your illness since being in the programme?
    - What have been some of the emotional changes you've observed since being a part of the programme?
    - What have been the psychological (self-esteem, self-confidence, assertiveness) changes you've experienced and observed in yourself since being a part of the programme?
    - What are your relationships like with the people around you since being a part of the programme?

2) **How has participation in Cape Mental Health's Psychosocial Rehabilitation Programme contributed to the individual's perception of their mental health recovery socially? (family, peers, community)**
   - How has being a part of the programme contributed to your relationship with your family?
   - What has your relationship with your friends been like since being a part of the programme?
   - How do you think attending the programme has contributed to your views on community involvement?
   - Can you tell me about your support network?
   - How has being part of the programme contributed to your support networks?
3) **What aspects of the Psychosocial Rehabilitation Programme did mental health users perceive to be most beneficial?**
   - What about attending the programme has helped you deal with your illness, and why?
     - Living
     - Learning
     - Socializing
     - Working
     - other
   - Which activities do you find to be the most helpful and why?
4) **What aspects of the Psychosocial Rehabilitation Programme did mental health users perceive to be least beneficial?**
   - What were the most challenging aspects of attending a psychosocial rehabilitation programme, and why?
     - Travelling
     - Financial
     - Working with other individuals
     - Other
   - Which parts of the programme or which activities did you not find to be beneficial?
   - Looking back, what was the most challenging part of the psychosocial rehabilitation programme, and why?
5) **How does mental health users of the Cape Mental Health Psychosocial Rehabilitation Programme perceive that the programme could be improved?**

- What would you change about the programme that could improve your experience?
- Is there anything you would add to the programme that would improve your experience?
- As **a** member of the programme what would you remove from or not include in the programme that you find did not help you?
- Are there any parts of the programme that you believe should have more focus?
- If you had to tell someone about the programme, what would you share?
- Would you recommend this programme to someone else you know who has a mental illness, and why?

Appendix B: Participant Information and Consent Form:

Title of Dissertation: Psychosocial Rehabilitation Programmes in Mental Health: An Explorative Study of Clients' Experiences of a Psychosocial Rehabilitation Programme in Relation to their Mental Illness Recovery.

Researcher:	Musiegh Madatt
Contact Email:	musieghm@gmail.com
Contact number:	+27 68 000 1227

You are invited to take part in this research project. Please take some time to read the following information about this study. You are welcome to ask questions at any point. Please note that participation in this research is completely voluntary. If you agree to participate, you are still entitled to withdraw from the study at any point. I am a staff member of Cape Mental Health (CMH) but am undertaking this study as part of a master's degree in clinical social work, and not in my capacity as a social worker for the organisation. This study has been approved by the ethics committee of the University of Cape Town, as well as management at CMH.

What is this research about?

The aim of this study is to explore psychosocial rehabilitation and the experiences of clients who have been a part of one of the Cape Mental Health Psychosocial Rehabilitation Programmes (PSR). The researcher is interested in the way in which patients have benefited from the programme and recommendations that can lead to further programme development of the PSR programmes at Cape Mental Health.

Why have you been invited to participate?

You have participated in a psychosocial rehabilitation programme at Cape Mental Health and therefore are an expert of your own experience.

What will be required of you?

The researcher will interview you about your experience of being a part of one of the respective psychosocial rehabilitation programmes at Cape Mental Health. This interview should take about one hour of your time. All interviews will be recorded via a Dictaphone for transcription purposes only. These recordings will not be available to Cape Mental Health.

The time and place of the interview will be determined by your convenience. As all participant’s live within meeting distance of the researcher, all interviews will be face-to-face and in person. Due to the personal nature of the interview, you may find that the interview covers sensitive topics. Should you feel uncomfortable with a question, you are under no obligation to answer it. If the interview brings up difficult memories or emotions, debriefing and counselling will be offered to you by Cape Mental Health.

How will participating benefit you?

Participation may not have any direct benefit to you at this stage, but sharing your experience may lead to the development of the profession within the practice and an improved service for other patients and family members. You will not be paid for your participation.

What will happen if you withdraw from the study?

Choosing not to participate in the study will in no way jeopardise your relationship with Cape Mental Health.

Who will have access to this information?

Confidentiality will be carefully protected and your name will not be mentioned in this study. The Dictaphone recording will only be heard by the researcher and an independent transcriber, who is bound by confidentiality.

How public will this research be?

As per the Master’s level dissertation procedure at the University of Cape Town, all studies are published on Open Access and therefore available to the general public. The findings of this study will also be shared with the team and management at Cape Mental Health.

Informed Consent of Participant:

I ____

agree to take part in this research study titled "Psychosocial Rehabilitation Programmes in Mental Health: An Explorative Study of Clients' Experiences of a Psychosocial Rehabilitation Programme in Relation to their Mental Illness Recovery."

I agree that:

- I have read all the information provided.
- I understand the information given and it has been written in a language that I understand
- I have been offered an opportunity to ask questions about this research study and my questions have been answered adequately.
- I understand that my participation is voluntary and I have not been forced or pressurised to participate.
- I understand that I can choose to withdraw from this study, or not answer any questions that make me feel uncomfortable. There will be no consequences or prejudice from the researcher.

Signed at: ______________________ on the ______________________ 2019.

______________________ ______________________

Signature of participant Signature of Witness