Acta Scientific Women's Health (ISSN: 2582-3205)

Volume 4 Issue 12 December 2022

Research Article

A Qualitative Analysis of the Kind of Support Needed by Family Members Regarding Reintegration of Male State Patients into their Families in South Africa

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Received: October 17, 2022

Published: November 28, 2022

Abstract

Introduction: State patients are admitted to the psychiatric hospitals according to the Mental Health Care Act, 17 of 2002 after being declared as such by the magistrate courts as a result of not found fit to stand trial for the offence they had committed. Family members of state patients need support regarding reintegration of these patients into their families after successful rehabilitation at the psychiatric hospitals. There is limited information in the literature about the kind of support needed by family members regarding reintegration of state patients back into their families. In light of the limited information, this study seeks to explore and describe the kind of support needed by family members regarding reintegration of male state patients into their families using a qualitative approach.

Purpose: The purpose of the study was to explore and describe the kind of support needed by family members to reintegrate the state patients into their family**.**

Method: A qualitative approach using explorative, descriptive and contextual designs was adopted. In-depth interviews were conducted with 10 family members who were purposefully sampled, and data were thematically analysed using Tech Open Coding method.

Results: During analysis of data three themes emerged regarding the kind of support needed by family members from the hospital, community, and the government.

Conclusion/Recommendations: Data revealed the kind of support family members require from hospitals, community and govern regarding re-integration. The study recommends that a model need to be developed regarding re-integration of state patients into their families.

Keywords: Family; Family Member; State Patient; Support

Introduction

State patients are categories of mentally ill patients who are admitted in the mental health institutions after the magistrate courts had declared them as such after being found not fit to stand trial. State patients are declared as such according to Criminal Procedure Act, No. 51 of 1977, due to their mental illness status at the time of committing an act that constitutes a criminal offence [1]). When state patients are successfully rehabilitated, they need to be discharged and be reintegrated into their families. In South Africa this is supported by Mental Health Care Act, No.17 of 2002,

which lays out the legal framework for a primary health care based mental health system based on human rights. Similarly, the Mental Health Policy Framework and Strategic Plan document emphasises that mentally ill patients including state patients should be cared for in the community. Furthermore, the Mental Health Policy Framework places the reintegration of mental health care into general health services in the primary health care centres [2].

Reintegration of male state patients enables mental hospitals to have admission beds for the new declared state patients from magistrate courts who need care, treatment and rehabilitation as stipulated by the Mental Health Care Act, No. 17 of 2002 [2].

Mental hospitals had put mechanisms in place to ensure that state patients are rehabilitated successfully and be ready for reintegration with their families. However, state patients are rejected either by their families or members of communities and such they remain in the hospital for a very long time. This was affirmed by [3] in Japan who indicated that many families were not willing to live with the mentally ill patients in the community although a small proportion of families want their mentally ill relatives to live independently after discharge from the hospital. Similarly, in United State of America [4] revealed that life of children with mentally ill parents becomes overwhelming, scary, confusing sad leading to these children rejecting their parents.

When mentally patients are admitted for a long time in the hospital, it makes the family of that particular patient to be unstable and sometimes dysfunctional especially when the admitted member of the family is a parent. This is supported by [5] who concluded that that family members experiences of growing up in a dysfunctional home can result in relational issues later in life and that the need for support can persist into adult life. Furthermore, this has implications for clinical practice when encountering these patients.

In South Africa, the National Department of Health (NDoH) annual report of 2021 shows that the demand for forensic mental health services continues to grow. In the financial year 2021-2022, 2007 court referrals for forensic psychiatric evaluations were received, of which, 1309 were concluded [6]. The number of state patients remain high in the mental hospitals due to rejection leading to overcrowding in the hospital wards. In Limpopo Province, the selected hospital is the only mental hospital with a maximum-security ward with a functional infrastructure wherein state patients are admitted. In this selected hospital in 2017 between January and June, Hospital Social Workers' records show that there were 60 state patients who were admitted; whilst only 3 (5%) patients out of 60 were females and 40 (66.6%) were stabilised and ready to be reintegrated with their families. Of these 40 stable male patients, 20 (33.3%) were being rejected by their family members. As a result, the hospital remains with high numbers of stable male state patients who are supposed to be with their families due to this rejection.

The study conducted by [7] focussed on the lived experiences of family members of state patients who were admitted in a psychiatric hospital and not on the support needed by family members when that state patients need to be reintegrated into the families. The study revealed that families need conference meetings to provide an opportunity for feedback that is needed on the status of the condition of their admitted state patient. Additionally, a planned home visit by a social worker or nurse may also meet the need for information and the provision of feedback.

There is a limited evidence on the literature regarding the kind of support needed by family members of state patients regarding reintegration into their families. In South Africa, literature found focussed on support for mentally ill patients in the hospital and not necessarily when the said patients are to be reintegrated into their communities. This is supported by [8] who concluded that although family members of state patients had varied views regarding reintegration, there is a need to investigate on the kind of support needed by family members regarding re-integration of state patients into their families. Furthermore, [8] indicated that family support is essential to successful community based mental health care. This is supported by [9], who posted that in several countries like China, India, Israel, including Palestine, Japan, Mexico, Peru, Spain, Turkey, Uganda, and the United Kingdom, family therapy needed to be conducted in order to support families of mentally ill patients. Similarly, [10] found that mentally ill patients are discharged home to be cared for by their relatives without due considerations of support for either the patient or family's wellbeing, is neither beneficial nor ethical for the patients and their families. There is also a stigma attached to the mentally ill patients and their families hence there is a need for an investigation into the kind of support for these families and their patients. In

light of the consequences of rejection of state patients and paucity of information in the literature regarding support needed by family members during reintegration of state patients, the researcher was prompted to conduct a qualitative study on the kind of support needed by family members of state patients regarding reintegration into their families.

Methods

In this study, a qualitative approach using explorative, descriptive and contextual design was adopted as described in the literature [11-14]. A qualitative approach was used to allow the researchers to explore the kind of support needed by family members as they were able to narrate their lived experiences regarding the support they need to re-integrate male state patients with them. The paper was able to explore the kind of support while family members described the kind of support during in-depth interviews. Inclusion criteria used in this study, included family members with complete contact details and were allocated numbers that were listed and these family members were purposively selected. Those family members without complete contact details were excluded from being participants of the study. Researchers also explored literature extensively during literature control to validate how family members perceive reintegration of male state patients into their families. Descriptive design assisted the researchers to observe, describe and document aspects of a situation as it naturally occurs. In this study, data about the study was gained through in-depth individual interviews where family members described the kind of support they need in order for reintegration of male state patients to happen in their families [15]. Contextual design assisted the researchers to be in the actual setting where the participants spend much of their time, in order to have a deeper understanding of their situation and only focusing on those aspects which are related to the reintegration of male state patients into their families, without the researcher losing focus [12,16]. The study was contextual in that individual interviews were conducted with family members in the Limpopo Province in their homes where they stay with their male state patients. Furthermore, the language that was used during interviews was Tshivenda as the hospital is situated in a region which is predominantly constituted by Venda speaking family members. The paper focused on the reintegration within the context of male state patients. Other forms of reintegration were not entertained and families outside the selected study areas were not included.

Study setting

This study was conducted in the Limpopo Province. Limpopo Province is divided into five districts which are Vhembe, Mopani, Capricorn, Sekhukhune and Waterberg. Limpopo Province is mostly rural except some parts of Capricorn District. This study was conducted in the Vhembe district, among the family members of male state patients at their homes where they stay with these patients although the patients were still admitted at selected hospital when the study was conducted. The selected hospital is the only designated psychiatric health facility with functional maximum-security ward infrastructure which admits male state patients from all the districts of Limpopo Province especially Vhembe, Mopani and some parts of Capricorn District.

Sampling method

A sampling method is described by [13,17] as the process of selecting a sample from the population in order to obtain information regarding a phenomenon in a way that represents the population of interest.

In this study, non- probability purposive sampling was used. Sampling occurred in two stages namely; sampling of a hospital and sampling of participants [8].

Sampling of a hospital

The selected hospital was purposively sampled as it is the only hospital with functional maximum-security ward where male state patients are admitted after being declared as such by magistrate courts in Limpopo Province [8].

Sampling of participants

All Venda speaking family members of male state patients who are admitted at the designated selected hospital were purposively sampled. These family members' names were found in the hospital admission register and only those with complete contact details were allocated numbers that were listed. Those without complete contact details fell off from the list. Only those family members who agreed to participate were included in the sample. Those with cellphone numbers were recruited telephonically contributing to the initial stage of prolonged engagement of family members with the researchers. Researchers recruited 37 family members, 16 family members agreed to participate in the study and only 10 participated in the study owing to data saturation [8].

Sampling size

The actual number of individuals who have been selected by the researcher as the representatives of the target population are referred to as sampling size [15]. The total number of those with complete contact details were 37 and were recruited telephonically. Out of 37 recruited, 16 family members agreed to participate in the study. However due to data saturation, those who participated were 10. Participants' profile is indicated in the figure 1 below.

Profile of participants

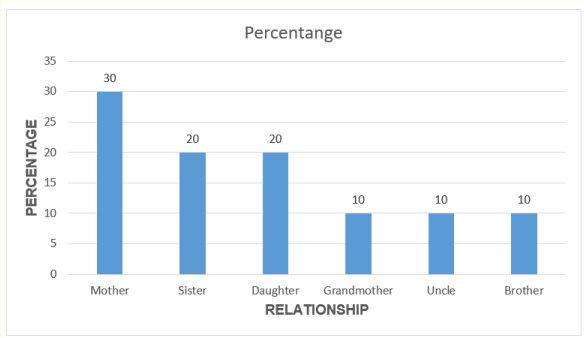

Figure 1: Percentage relationship information of participants and the state patient.

Source: Selected hospital admission register.

Criteria of inclusion

Family members who were selected to form part of the study were those were staying or responsible for providing care to male state patients in their families. Family members ensure that state patients take their treatment as expected and that they go to the psychiatric hospital when they are due for review assessments. This is supported by [11] who indicated that family members expressed moral obligation to care for mentally ill patients at home although this comes with challenges of not empowered to do so. Furthermore, family members also ensure that their state patients' general well-being is taken care off, provision of shelter, food/ basic items for survival, provision of family psychosocial support. All family members resided in Vhembe District. Their names and their contact details were appearing on the register of relatives of male state patients at the selected hospital, and they all who gave consent to participate in the study were included.

Data collection

In preparation for data collection, researchers introduced themselves and explained the study briefly, asked for participant's consent and made an appointment, at their homes where they felt comfortable, and at a time and date that is convenient to them. 10 in-depth interviews were carried out when data saturation has occurred using a semi-structured interview guide consisting of central question, as well as prompts, while allowing for unplanned questions to explore emerging issues raised during each interview. 10 in-depth interviews were carried out when data saturation has occurred using a semi-structured interview guide consisting of central question: "What can be done to make you feel supported for re-integration of the patient who committed a crime into your family", as well as prompts, while allowing for unplanned questions to explore emerging issues raised during each interview". The study interviews lasted about 20–30 minutes each, were conducted in Tshivenda, audio-recorded, transcribed verbatim and then translated in English.

The audio records were transcribed verbatim in Tshivenda, and the Tshivenda transcripts were then used to translate the data into English. An independent translated then transcribed the English version of the transcript into Tshivenda again. This was done to ensure that data does not lose it meaning during the translation process.

Data analysis

Following transcription, the interviews were analysed using qualitative content of Tech open coding method [16]. After collecting data from the family members, the researchers played the voice recorder and transcribed the recorded information verbatim. The researchers read through the transcribed data several times to gain overall meaning of the responses from the family members. After the researchers read through the transcribed data, the data was then arranged into themes and sub-themes and labeled using the actual words and language of the family members. Three themes emerged regarding the kind of support that family members need in order in for reintegration of male state patients to happen. The themes revealed the kind of support needed by family members from the hospital, community and government to reintegrate male state patients into their families. The data analysis process was done manually without the use of analysis software. To ensure

rigour, the four evaluating criteria (credibility, transferability, dependability, and confirmability) of research trustworthiness suggested by [18] have been followed. Credibility was ensured through prolonged engagement and member checks. Rapport was built with the participants prior to the actual data collection process, this assisted in ensuring that there is trust between the researcher and the participants. Engagements with the participants was maintained through telephone and home visits, to prepare the participants for the actual data collection process by providing any study related information. In member checks, after the interviews with the participants the researcher provided a summary of the interview to each participant, awarding them an opportunity to verify if the captured information is correct or not. Transferability was ensured by that all research methods and designs that were applied in the study were explained in detail, this includes the approach, study population, sampling methods and size, setting where the study was conducted, inclusion criteria, data collection instruments that were used, as well as the data analysis approach that was taken. This was done to ensure that the findings of this study can be generalized and to allow other scholars to can be able to replicate the same study in other settings. Dependability was ensured by that a group of experts in researcher focusing on mental health issues had an opportunity to cross check the findings of the study and the methods of analysis that were applied, after this process some of the themes and sub-themes had to be adjusted based on the suggestions made by those experts. Confirmability was ensured by that the researchers ensured that they remain objective throughout the study. The interviews were recorded using a voice recorder and transcribed without any alterations. To further ensure that the findings of the study are neutral, the direct quotes from the participants were used to support the findings. An independent co-coder checked the transcribed data and started coding it. A consensus was reached between the researcher and the independent co-coder about the emerging themes.

Ethical considerations

Ethical clearance to conduct the study was obtained from the University of Venda Research Ethics Committee (ethical clearance number: SHS/18/PDC/06/0905, May 2018), Limpopo Provincial Department of Health and Vhembe district Department of Health, and the selected hospital issued a letter to allow the researchers to have family members' contact details in order to recruit participants from their homes. to stop it for some reason. Participants were recruited telephonically and then appointments were made to visit them at their homes. Only those participants who agreed to take part in the study were visited at their homes at the time that was agreed during telephonic conversations. All participants were provided with the information sheets and consent forms before they participated in the study. Researchers ensured that participants are not physically, emotionally, psychologically harmed during their participation in the study, by avoiding use of sensitive language. Codes were used instead of the participants' real names, in order to protect their identity. Study information was kept away from those who are not part of the study [8].

Results

The results are discussed together with the supporting quotes from participants on the kind of support needed by family members to reintegrate male state patients into their families. Three themes and their sub-themes emerged during data analysis and are discussed below.

Theme 1: Support needed by family members from the hospital regarding reintegration

Most participants indicated their perceptions regarding the kind of support they need from the hospital relating to reintegration which yielded the following sub-themes: the family should be visited by the hospital staff to give them health education, victim's family should be visited by the hospital staff to hear from them regarding reintegration and the mental health care user must be visited by the staff to ensure compliance. This is presented in table 1 below.

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

Table 1: Support needed by family members from the hospital regarding reintegration.

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

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

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

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

Another one said:

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

Another said:

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

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

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

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

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

Most of the participants indicated that there is a need for the MHCU to be visited by hospital staff in order to ensure treatment compliance as depicted by the following quotes:

"…They should check his mind whether he is no longer aggressive as he was during his admission. Also check if he is having records of fighting other patients. They should then determine whether his records influence his release so that the community will not fight us if all these issues are not done properly. If he repeats his aggression, the community may think that he does not trouble us as the family instead they may think that we as the family are the ones who are sending him to trouble them. They will not see that he is causing all the troubles because he is mentally ill. I do not have any other input than the ones I said above…" Sister: Family unit no. 1.

Another one said:

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

Another said:

"…Even when these patients are at home some of them refuse to take treatment that they have been given when they were released from the hospital and as such I see that those nurses from the hospital should come and visit the patient once per week or twice per month to check on how the patient is doing. Those nurses from the hospital should come and visit the patient once per week or

twice per month to check on how the patient is doing…" Daughter: Family no. 10.

Another one said:

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

Theme 2: Family members' kind of support they needed from the community relating to reintegration

Most participants indicated their perceptions regarding the kind of support they need from the community relating to reintegration which yielded the following sub-themes: Traditional leaders should be the ones to instruct family members to accept the mental health care user. The community should agree that the mental health care user should be brought back home. This is presented in table 2 below.

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

Table 2: Family members' kind of support they need from the community relating to reintegration.

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

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

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

"…I think for the patient to come home is difficult as we fear him. I think the hospital should consider visiting the family of the patient to be reintegrated and also the one which is affected by the crime that the patient had committed the hospital should check if the family like the patient and why they do not like the patient and that what should be done to assist. The mind of the patient should be checked. They should also consult the community through vhakoma (village headman) and the civic and even the local chief through the khoro (traditional council). I think if all these efforts are done by the hospital it could help the patient to come back home to the family..." Uncle: Family unit no. 5.

Another one said:

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

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

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

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

Theme 3: Family members' kind of support they needed from the government relating to reintegration

Most participants indicated their perceptions regarding the kind of support they need from the government relating to reintegration which yielded the following sub-themes: government should build a house for mental health care users; mental health care users

must be employed and government should give them a disability grant. This is presented in table 3 below.

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

Table 3: Family members' kind of support they need from the government relating to reintegration.

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

Government should build a house for mental health care users

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

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

Another one said:

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

Mental health care users must be employed

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

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

Another one said:

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

Government should give mental health care users a disability grant

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

"…In order feel supported, the government should offer him mundende (Social grant) that will him financially. Mundende will assist him to get food and that he will be able to wash himself and his clothes. He can also get money to marry a woman. Furthermore, he will also be able to buy water as there is no water in our village we live by buying it. The family will help him to save money…" Uncle: Family unit no. 5.

Discussion

The findings of this study revealed the importance of supporting the family by visiting them at their homes. This is in congruence with [19] who showed that psychiatric patients who had been discharged to be cared for at home, and are visited at home by doctors and nurses have a lower rate of rehospitalisation than those who are only left to be cared for by their family members.

Similarly, [20] concluded that schizophrenia and other severe mental illnesses should receive more attention in both general practice and somatic hospitals. Health professionals from hospital settings should also liaise with those health professionals who are in general practice in the community, to assist with the care of mentally ill patients in the community settings.

On the other hand, [21] found that home visits to mentally ill patients will ensure that family members are educated on the

mental illness that the male state patient is suffering from. This is supported by Tartakovsky [22,23] who also found that one of the strengths of families of mentally ill family members is that they seek education on the mental illness of the family members. If families are provided with educational information and are involved in the treatment process, mentally ill family members experience a reduction in symptoms, hospitalisation days and relapses.

This is in line with [24] who found that there was a need for family education organisations to teach relatives more collaborative strategies for preventing and resolving problematic behaviours by their relatives with psychiatric disorders, so that there were fewer undesired consequences. Furthermore, they recommended the use of a tool called 'Family Limit Setting Scale' (FLSS), as a valuable component of such education. The tool assists families to set limits to their relatives who are mentally ill, in order to modify their uncontrollable behaviours.

The study also highlighted the need for visiting the victim's family in order to get their opinion about the reintegration of their loved ones. Similarly, a case study by [24] indicates that through the journey of therapy, the patient who is cared for in the community regarding his mental status, also developed a more coherent narrative about his life, established a stable sense of self, and became an active agent in the world. This caring of the patient uses three approaches namely: combining metacognition-oriented therapy with elements of cognitive behavioural therapy and psychiatric rehabilitation. This case illustration demonstrates that these three different approaches can be used in a sequential and complementary fashion to foster recovery in the midst of serious physical and mental illness.

The study emphasises the need for supporting the family by visiting the mental health care user after discharge as this might increase treatment compliance. This is in line with [25] who concluded that families utilise external strengths as well as internal strengths, in supporting their mentally-ill family member. Recommendations for nursing practice, nursing education and for further research could be formulated. Psychiatric nurses should acknowledge families' strengths and, together with families, build on these strengths, as well as empower families further through psycho-education and support.

Similarly, [26] identified that the family support on mental health is important. This kind of support needs to be strengthened by health professionals during their visits to the families of mentally ill patients. Family members need knowledge on how to give treatment to patients when they are at home.

On the other hand, [27] in Malawi further support this by providing valuable information about the views of families regarding nursing care of psychiatric patients. In their study, family members indicated that they are involved in the care of mentally ill patients who are admitted to the hospital, although there is lack of effective cooperation between them and nurses. The lack of collaboration with nurses has resulted in families receiving inadequate information about the condition of their mentally ill relative. Therefore, it is imperative that family members receive sufficient support from nurses and other health care professionals so that reintegration of male state patients with them happens smoothly.

Culturally, traditional leaders have influence on the community they lead. Therefore, for the family to accept the mental health care user, the study indicated the influence traditional leaders can make for the family to accept their patients. This is in line with [28] who concluded that community care is emerging globally as an important method of service provision. While obstacles in varying forms remain, the benefits are gradually becoming visible. Mental health services can develop effectively if there is adherence to a principle ethical base, which respects the human rights of individuals living with mental illness within the communities.

Similarly, [29] concluded that there are various ways in which patients can facilitate shared decision making (SDM) and play a more active role in it, with patients emphasising being open and honest and psychiatrists emphasising being active in the consultation. Interventions to increase active patient behaviour may enhance SDM in mental health care in the community.

The study also indicated that the community where the patient comes from, also plays a major role and needs to be considered and their voice be heard regarding acceptance of mental health care user back in the community. because This is in line with [30] whose study revealed that participants who endorsed community-oriented attitudes (rather than hospital/drug-oriented attitudes) about health care for the mentally ill were more likely to show a decreased social distance. Participants who believed that the mentally ill were dangerous had higher scores on the social distance scale.

Similarly, [31] confirmed established knowledge from community settings and indicate that social networks and social support exert differential effects on mental health. They furthermore suggest that the particular type of social support may be important. In contrast, different types of social network appear to impact upon poor mental health in a more uniform way.

On the other hand, [32] found that there is need to educate families about supporting each other and also offer support to the psychiatric state patients. These will help the families to live together in harmony and avoid any psycho-social effects between families. This in turn will encourage harmony in the community in which the MHCU stays.

In agreement further, [33] pointed out that mental health care once labelled as institutionalised care has changed into de-institutionalised and home-based care. Moreover, the rising costs of health care in most countries has led to restrictions of institutionalisation and encouraging community care or family care as it enhances speedy recovery. Furthermore, the impact of having a family member with a major mental illness was similar as perceived among family members who were interviewed. Modern medical interventions and technologies have extended the lives of chronically ill persons, which has increased the responsibility of families for caring for these patients.

This study outlined the family kind of support they need from the government. It revealed that most participants were not working and did not have houses to live in. Therefore, the study noted that it is essential to build houses for mental health care users. This is in congruence with [34] who states that national governments should work collaboratively with international partners. National stakeholders should provide educational information, ascertain acceptable risk levels, and regulate and legislate as necessary regarding mental health. Tackling the root causes of mental ill health is the responsibility of national governments through reducing poverty, unemployment, and economic disparity, including housing needs for the poor. National governments cannot work in isolation and should partner with local authorities, non-governmental organisations and other partners in community.

Unemployment has been identified as a challenge to most of the mental health care users and there is a need for them to be employed. This is in congruence with [35] who states that national governments should work collaboratively with international partners. National stakeholders should provide educational information, ascertain acceptable risk levels, and regulate and legislate as necessary regarding mental health. Tackling the root causes of mental ill health is the responsibility of national governments through reducing poverty, unemployment, and economic disparity including housing needs for the poor. National governments cannot work in isolation and should partner with local authorities, non-governmental organisations and other partners in the community to provide employment for their people.

The other important dimension raised from the findings of this study, was the issue of mental disability which has been identified as another way of supporting the mental health care users and their families. This is in line with [35] who concluded that the issue of ageing with a mental disability was already presenting significant problems for service delivery to this group of people in the New South Wales State and Commonwealth levels. There was consensus across the sector for government, at both State and Commonwealth levels that the implementation of the National Disability Insurance Scheme may be a point at which the State and Commonwealth Government can agree upon the precise mechanisms to support individuals with a mental disability to age in a place without the existing bureaucratic divide. With comprehensive new strategies and support structures underpinning service delivery, both disability and aged-care staff are likely to feel readier to meet the emerging challenges they are confronting on a daily basis. Equally, the individuals and their families who are ageing in rural and remote areas may benefit from services tailored to meet their changing needs.

Family members of male state patients from Vhembe district in South Africa viewed re-integration as positive because they wanted their patients to come back from hospital after rehabilitation. However, they need some kind of support from the hospital, community and government so that reintegration of male state patients could happen successfully. Furthermore, traditional leaders in the community and their members should be educated about the male state patients who are to be reintegrated with their families.

Conclusion

The aim of this study was to determine the kind of family members regarding re-integration of state patients into their

families. Data revealed that family members had varied views on the kind of support family members need regarding re-integration. Some understood and accepted re-integration as an indication of love. However, the majority of families had indicated that the hospital, community and government should provide support to the families so that integration could happen successfully. Therefore, the researchers concluded that reintegration of male state patients need that health professionals consider the kind of support that family members indicated in order to reintegrate male state patients.

Limitations and Recommendations

This study was restricted to Venda speaking relatives of male state patients and one selected hospital in one district only out of the five districts of Limpopo Province. The researcher acknowledges that this study was contextual and that only family members of male state patients were interviewed; the researcher did not get to hear about the perceptions of family members of female state patients. However, the results provide valuable insight and recommendations that can be considered when supporting families with male state patients who are to be reintegrated into their family. The study recommends that based on the kind of support needed by the family members, .there is need to develop a model that would support the reintegration of male state patients into their families.

Acknowledgements

The following are acknowledged by all authors for their contributions to the study: the University of Venda for approval of the study, Limpopo Department of Health and selected mental hospital for the permission to allow the study to be conducted and all participants for sharing their time to participate in this study.

Conflict of Interest

Authors have no financial interest or any conflict of interest to declare.

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