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REHABILITATION OF INDIVIDUALS WITH SCHIZOPHRENIA IN SOUTHWEST NIGERIA: EXPERIENCES AND PRACTICES OF CLIENTS, FAMILIES AND HEALTHCARE PRACTITIONERS

OYEYEMI OLAJUMOKE OYELADE

A thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in fulfilment of the requirement for the degree of Doctor of Philosophy in Nursing

Johannesburg, 2022

DECLARATION

I, Oyeyemi Olajumoke OYELADE, declare this thesis is my original work, solely submitted for the degree of Doctor of Philosophy in Nursing at the University of the Witwatersrand, Johannesburg, South Africa. There has been no submission of this thesis for any degree or examination at this or any other institution.

Signature: 

Date: 24/06/2022

DEDICATION

I dedicate this project to:

- The Almighty God; the indescribable creator of the universe, the author of life and knowledge.
- My late fathers,

  Pa Emmanuel Oyeladun Oyelade (Biological)

  Rev. Dr. Gomba Fortune Oyor (Spiritual)

  You desired to see me start the Ph.D., but you could not witness it. I knew If you were alive, your excitement would have been without measure. Sleep on in the bosom of your saviour.
- The individuals with mental illness who have lived their lives and now buried in the hospital premises, having little or no chance of rehabilitation. The society missed the opportunity to learn directly from your stories, but your tombs are there as history.

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ABSTRACT

Background: schizophrenia is the most chronic form of mental illness. It is a non-communicable disease of the mind that affects the thoughts, feelings, moods, and behaviour of an individual. A person with schizophrenia presents with features such as hallucinations and delusions that reduce social desirability, career or employment sustainability. Moreover, schizophrenia-like other mental illnesses cause stigma due to the person's behaviour, which is supposedly unpredictable, invariably reducing the productivity and self-care of the individual; these put a burden on the family who must care for the clients who are unable to care for themselves. To increase the social relevance and productivity of individuals with mental illness (schizophrenia), the World Health Organization recommended psychosocial rehabilitation(PSR) as the best method of post-recovery care, which also helps to assume productive functioning.

Problem statement: PSR, although recommended, has an unclear mode of execution in some countries like Nigeria. The WHO emphasises that PSR should be a contextually relevant practice in each country. Over the decades, high-income countries have managed to implement context-specific PSR; however, almost all African countries, Nigeria included, have no practice guide for PSR, except for South Africa and Botswana. It is therefore a concern how Nigeria practices PSR.

Purpose: The purpose of the study is to improve the care of people living with schizophrenia in Southwest Nigeria with the development of a context-specific practice guide for PSR of individuals with schizophrenia.

Methods and design: This study followed a multi-method; qualitative descriptive design, scoping review of literature on PSR in Sub-Sahara Africa, and used semi-structured interviews with the clients, families, and health care practitioners(HCPs).

Result: The study revealed that clients experience dictatorship from families and professionals except those who have been abandoned by families and are just within hospital facilities for accomodation. Preferences of clients are self autonomy. Families desire recruitment of more rehabilitation experts into skills acquisition while professionals desire improved human and material resources.

Conclusion: This study concludes that individuals with schizophrenia can have more effective rehabilitation if the HCPs are equipped in terms of training on rehabilitation alongside the developed practice guide.

PUBLICATIONS AND PRESENTATIONS ARISING FROM THIS STUDY

Publications

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ACRONYMS AND ABBREVIATIONS

CARTA	Consortium for Advanced Research Training in Africa
HCP	Health Care Practitioners
IRB	Institutional Review Board
NGO	Non-Governmental Organisation
OAU	Obafemi Awolowo University
OT	Occupational Therapy
PSR	Psychosocial Rehabilitation
SW	Southwest
UKZN	University of KwaZulu-Natal
WAPR	World Association for Psychosocial Rehabilitation
WITS	University of the Witwatersrand
WHO	World Health Organization

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CHAPTER ONE: ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Mental illness is a sudden or transient change in behaviour that adversely affects the social functions and disposition of an individual (Bolton, 2013; Caper, 2018). It is the most stigmatised illness that subjects an individual and their families to reduced social desirability (Cullen et al., 2017; Lucas et al., 2018). Mental illness constitutes 14% of the global burden of disease and 30% of the non-communicable diseases (Kessler et al., 2009; Funk, 2016) with schizophrenia being the most chronic form of the illness, contributing about 7% to the global burden (Alphs et al., 2018). The rate of the global burden of mental illness is significant since it has the highest rate of disabling effects (regarding low or no productivity) on the individuals (WHO, 2004; 2018).

Specifically, in Africa, mental illness accounts for 18% of a life lived with the disability (WHO 2012), meaning if an individual has a mental illness for 10 years, the person will be utterly dependent for 730 days (2 years) of his/her life. Moreover, there is a 40-60% chance of premature death in people with schizophrenia (WHO, 2014). To provide an overview of schizophrenia, Uys and Middleton (2020) state that schizophrenia symptoms are divided into two groups. Group one is the positive symptoms (function distorted, which involves perception, inferential thinking, thought /language, behavioural monitoring), while Group two is the negative symptoms (function diminished, which involves fluency of speech/thought, emotional expression, volition, and drive, inability to experience pleasure and capacity). It is important to note that it is the negative symptoms that impair the client's ability to function in daily life; most people with schizophrenia are unable to hold down a job in the open labour market, to form deep friendships, or have meaningful intimate or family relationships (Marder & Galderisi, 2017).

The disabling effect of schizophrenia not only affects the individuals but also their families and health care practitioners(HCP). The burden for the family emanates from monitoring the personal hygiene of the client, the use of medication, comportment at a social gathering, follow-up care, and having to deal with the mood changes (Villalobos et al., 2017; Lee et al., 2018; Sharma et al., 2018). Gharavi et al. (2018) report that the burden of care for a family with mental illness causes emotional distress to family members and increases their chances of developing psychological disorders. The burden of schizophrenia on HCPs relate to the scarcity of human resources, which the World Health Organization (2013) declared as a

significant requirement for quality care in mental health. HCP engage in different patterns of mental healthcare to achieve recovery, involving pharmacological (anti-psychotics) and non-pharmacological, such as family therapy, individual therapy, group therapy, occupational therapy, etc. (Sibeko et al., 2017; Forma et al., 2018) which helps with recovery but does not reduce burden in the absence of PSR (WHO, 2002).

Psychosocial rehabilitation (PSR) is described as a set of approaches aimed at assisting an individual to achieve restoration from a state of dependency caused by schizophrenia (or other mental illnesses) to a state of an independent decision-maker (Allen, 2010; Lucky et al., 2016). It encompasses promoting quality of life and is the most significant healthcare action for facilitating and sustaining the recovery of persons with mental illness, including schizophrenia (Thornicroft & Tansella, 2013; WHO, 2013; Adebowale et al., 2014; Lucky et al., 2016). PSR promotes the holistic view of the person by providing vocational, educational, residential, social/recreational, and personal adjustments services (WHO, 2013; Ringeisen et al., 2017; Corrigan et al., 2018; McKay et al., 2018). Evidence from global research shows that between 251 and 261 mental illness disabilities (DALYS p.a./1 million pop.) may be averted through PSR interventions compared 149 to 160 averted DALYs (Disability Adjusted Life in Years) from medication alone (WHO, 2004, 2012, 2013; Murray et al., 2013). With schizophrenia, clients expressed a feeling of life restoration by the non-restrictive approaches of PSR (Brooke-Sumner et al., 2017). The WHO (2002) emphasises quality and ingenuity of approach in their recommendation that each country should develop a suitable contextual guideline for PSR. Quality PSR is suitable for a specific community, promoting rehabilitation and empowerment for individuals with chronic mental illness (Schizophrenia) (WHO, 2013; World Association for Psychosocial Rehabilitation (WAPR), 2013).

Despite all the evidence about the effectiveness of PSR, there seems to be a dearth of literature and implementation of PSR in Africa (Adebowale et al., 2014; Lucky et al., 2016; Akinsulure-Smith et al., 2017). Global studies reveal only two (Botswana and South Africa) African countries that have the standard PSR practice guide (WHO, 2013; World Association of Psychosocial Rehabilitation, WAPR, 2013). The scarcity of PSR guidelines is due to the lack of policy, shortage of specialised personnel, and the widespread civil crisis in other African countries (WHO, 2013; WAPR, 2013). Moreover, Nigeria, a sub-Saharan African country, has no mental health policy that guides HCP on the management of mental health illness; in general, they are still guided by the Lunatic Act of 1958 (Westbrook, 2011; WHO, 2013; Gureje et al., 2015).

1.2 PROBLEM STATEMENT

The research problem pertains to the rehabilitation of people living with schizophrenia in Southwest Nigeria. The WHO (2013), through the Mental Health Action Plan 2013-2020, has made a standpoint on the need for increased service coverage through integrated and responsive rehabilitation. Currently, in Southwest Nigeria, HCPs who published on PSR expressed a lack of understanding of such (Adebowale et al., 2014; Lucky et al., 2016). Akinsulure-Smith (2017) refers to PSR as inclient psychiatric care in a community-based psychiatric institution that has the capacity for continued hospitalisation. The WHO (2013) discourages unnecessarily prolonged institutionalisation but accentuates PSR at a non-confined environment (natural setting/community). Specifically, in Southwest Nigeria, there are no records of community-based rehabilitation, and the two tertiary health institutions in which schizophrenia is managed also expressed a lack of understanding of PSR, yet they report providing it (Adebowale et al., 2014; Lucky et al., 2016). To date, the findings of this study are the only available scientific research published reporting on the experiences of clients with schizophrenia about PSR or their families in Southwest Nigeria (Oyelade & Nkosi-Mafutha, 2021a: 2021b).

Increased rate of relapse, social neglect, abandonment by family, and increased medication dependency occur when there is no rehabilitation of clients with schizophrenia (Loh, 2018). Community members fear seeing vagrant, un-rehabilitated schizophrenic clients in case they are unpredictable (Gloria et al., 2018), which consequently increases the stigma attached to mental illness and social isolation (Loh, 2018); conversely, however, it causes reduced productivity (WHO, 2004:2012). This is significant on the country's productivity when the statistics of major mental illness, such as schizophrenia, are high (WHO, 2012). Although Nigeria lacks statistics for schizophrenia, the challenges (widespread civil and religious crisis) within the country cause chronic mental illness (WAPR, 2016). Moreover, lack of rehabilitation may result in overutilisation of the already overburdened healthcare system in Nigeria (Balogun et al., 2018), thus, the rationale for this study.

1.3 CLARIFICATION OF CONCEPTS

- **Health care practitioners (HCP):** The WHO (2010) describes HCPs as individuals who actively engage in illness prevention, disease management, and restorative or rehabilitative care. In the context of this study, HCPs are regarded as medical team members who directly participate in psychiatric rehabilitation and include nurses, doctors, psychologists, social workers, and occupational therapists.

- **Sub-Saharan Africa:** This is the part of Africa situated to the south of the Sahara. There are 47 countries, including Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo (Brazzaville), Congo (Democratic Republic), Côte d'Ivoire, Djibouti, Equatorial, Guinea, Eritrea, Ethiopia, Gabon, The Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Réunion, Rwanda, South Africa, Sao Tome and Principe, and Senegal.

- **Negative symptoms:** Uys and Middleton (2020) state that schizophrenia symptoms are divided into two groups. Group one is the positive symptoms (function distorted, which involves perception, inferential thinking, thought/language, behavioural monitoring). Group two is the negative symptoms (function diminished, which involves fluency of speech/thought, emotional expression, volition and drive, inability to experience pleasure and capacity). It is important to note that it is the negative symptoms that impair the client's ability to function in daily life; most people with schizophrenia are unable to hold down a job in the open labour market, to form deep friendships, or have meaningful intimate or family relationships (Marder & Galderisi, 2017).

- **Stability:** Stability is the extent of self-awareness and complexity of symptoms (Borsboom, 2017). It is a function of the extent to which an individual is aware of the negative symptoms and the rate of their presence. In the context of this study, stability is the confirmation from clients' records after 3 months of discharge, and confirmed stable after 3 months of being without negative symptoms recorded in their files; this is because research evidence shows the risk of relapse is usually high between 1 to 3 months of discharge (Rossi et al., 2018).

- **Schizophrenia:** "This is a disturbance of the core self in its immediate relation to the world and descriptions from the third-person perspective which characterize and individualize a person and which easily lend themselves to linguistic self-description" (Parnas & Zandersen, 2018).

- **Practice guide:** This is from two words which are practice and guide. Practice can be expressed as act of doing while guide can be regarded as a road map, manual or instructional booklets that aids an individual's method of carrying out a task, procedure or project (Albakri, et al., 2021)

- **Families**: These are individuals who are related by blood (Melvin, 2021), but in the context of this study, a family is whoever cares for an individual with schizophrenia and whom such individuals regard as their next of kin.

- **Healthcare facilities:** These are places (hospitals and clinics) where healthcare is rendered, but contextualised in this study as hospitals and their community centres that offer mental healthcare.

1.4 THE SIGNIFICANCE OF THE STUDY

The significance can be divided into three ways:

- **Clinical practice**

  To the best of our knowledge, this is the first attempt of inquiry on clients' and families' experiences and expectations; also, HCPs' practice and expectations on rehabilitation. Therefore, the hope is that this study will improve health outcomes for people diagnosed and living with schizophrenia and their families. The inquiries from clients, families, and HCPs will also serve as feedback and has the potential to improve practice.

- **Nursing Education**

  Having established a lack of rehabilitation practice guide, this is the first attempt of developing a practice guide on PSR in Nigeria and this has the potential to improve the teaching of rehabilitation in the context-based environment. It is of particular importance to nursing education because nurses are at the forefront of clinical practice, and given the dearth of human resources for rehabilitation, using nurses for community-based rehabilitation may be the only available way out, which may require academic preparation before engagement with such a task.

- **Nursing Research**

  This study tends to stimulate further studies on rehabilitation in other geopolitical zones in Nigeria, and Africa in general. There could be the adoption of the practice guide in in-house research and studies in other parts of Africa. This study may also stimulate further inquiry on how nurses rehabilitate clients who could not afford rehabilitation services of the hospital.

1.5 RESEARCH QUESTION

How are the clients living with schizophrenia, in two tertiary health institutions in Southwest Nigeria, rehabilitated, and how can they be better rehabilitated?

1.6 PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of the study was to improve the care of people living with schizophrenia in South west Nigeria through the development of a context-specific practice guide for PSR.

The objectives were to:

- Review the literature to determine the work conducted on PSR in Sub-Sahara Africa. (Phase 1)
- Describe the experiences of clients living with schizophrenia as well as their expectations of PSR. (Phase 2)
- Describe the experiences of families of clients living with schizophrenia as well as their expectations of PSR. (Phase 2)
- Describe the current practices of HCPs on PSR and describe their constraints and suggestions for effective PSR in their context. (Phase 2)
- Develop a context-specific practice guide for PSR that HCPs could use for rehabilitation of clients with Schizophrenia in Southwest Nigeria. (Phase 3)

1.7 THEORETICAL FRAMEWORK

Underpinning this study was the compensatory theory of recovery, as proposed by John Hughling Jackson who described recovery as the use of a compensatory mechanism (York et al., 1995). Compensation can be adapted in different ways and from different perspectives. Generally speaking, compensation is what something is done for an individual who was deprived or feel cheated to alleviate the feeling of subjugation. Likewise, compemsation can be applied when an individual's service is terminated unjustly or justly but untimely from an employment. Compensation also applies when an individual is renumerated for occupational hazard or injury resulting to hospitalisation, loss of body part or chemical burns and the likes. In regards to mental illness, compensation is adapted as assisting individuals to regain time lost to the disabiling effect of mental illness or aiding shiting of focus of family and society from what the person is incapable of doing to the uniqueness of the person in what he or she is capable of doing. The author of compensation theory is a renowned scholar who

conceptualised that a defective area of the brain resulting in mental illness can be compensated for with the uniqueness of the functional part.

He, John Hughling Jackson, expressed it in the form of neurological compensation for a defective part of the human system with a functional part. This study, therefore, adopted the theory into the PSR of individuals with schizophrenia. Meaning, a compensatory appraisal of the non-acceptable attributes of individuals with schizophrenia by an appraisal of the area of strength through which an individual can maximally function. This was adapted as compensatory rehabilitation in this study, to appraise the area of strength of individuals with schizophrenia and overlook the areas of weakness. The rationale for clients' denial post community re-integration has been traced to the lack of integrating family and individuals with schizophrenia into the rehabilitation plan (Lim et al., 2017), and due to social bias about such individuals. This study took the stance that if individuals with schizophrenia can maximise their potential in areas of strength, the areas of weakness may not constitute barriers to rehabilitation.

In summary, this study adopted the compensation theory to mean appraising the area of strength of individuals with schizophrenia, with less focus on the mental illness morbidity symptoms. This has the potential to help the individual's productivity in the areas where their strength lies. By extension, this means the practice of the HCPs was assessed based on the extent to which they focus on the area of strength of an individual. Thus, this form the rationale for the pattern of the research inquiry on the professional practice of rehabilitation in Southwest Nigeria.

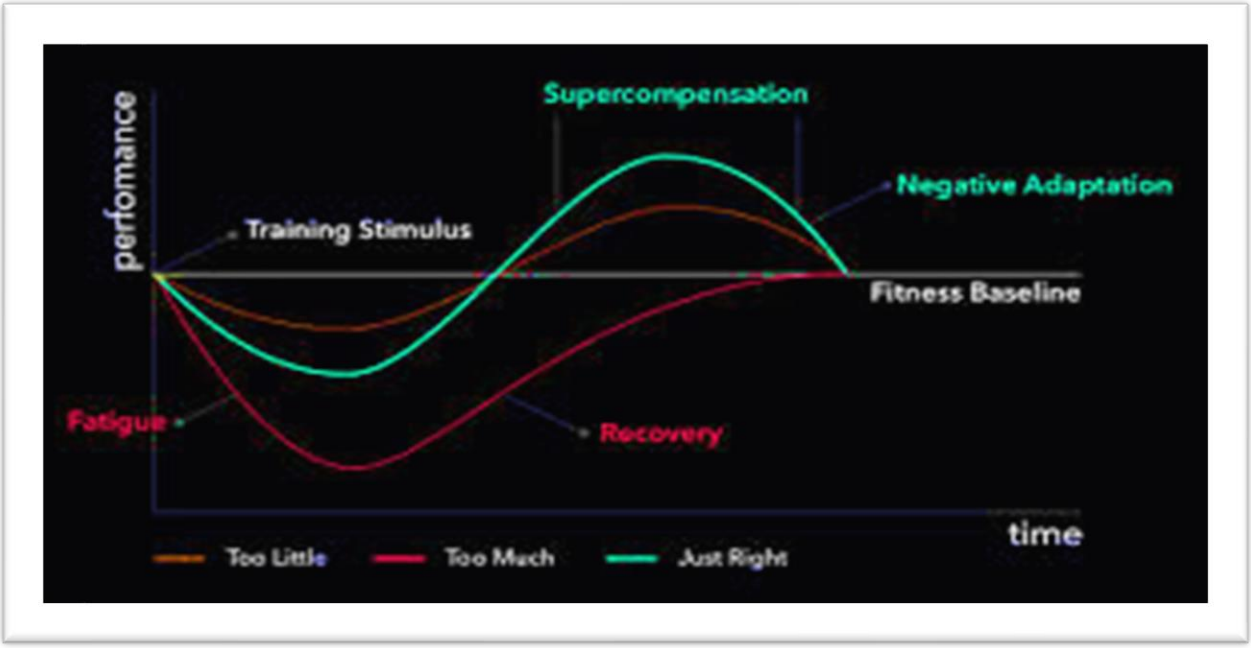

Figure 1.1: The theory of compensation (https://medium.com/@GoRocketBody/fatigue-recovery-and-supercompensation-f71538de18)

1.8 RESEARCH METHODS

This study adopted a multi-method of inquiry, which involves individual interviews with mental HCPs, families, and individuals living with schizophrenia in Southwest Nigeria. The practice guide was developed through information gathered from the interview and the review (literature and scoping review). Chapter Three discusses further details on the methodology and the context (Southwest Nigeria).

1.9 SUMMARY

This chapter introduced the entire study. It presents the background, the research problem that necessitated the conducting of this study, the concepts and their interpretations, the theoretical underpinnings, and the research methods adopted.

1.10 CONCLUSION

This chapter concludes that improvement of the care of people living with schizophrenia in Southwest Nigeria, by the development of a context-specific practice guide for PSR, is the focus of this study. The following chapter presents the review of the literature.

CHAPTER TWO: LITERATURE REVIEW

Chapter one focused on the introduction to the study, problem statements, clarification of concepts, significance of the study, purpose, and objectives, research methods, and theoretical framework. This chapter presents the review of the literature with a focus on the study's objectives.

2.1 INTRODUCTION

The literature searches in this study used the following search phrases: a global perspective of rehabilitation, rehabilitation in high-income countries, rehabilitation in Africa/Sub-Sahara Africa/Nigeria. Rehabilitation in mental healthcare settings, HCPs' methods of rehabilitation, knowledge of rehabilitation among HCPs, barriers to rehabilitation, training need of rehabilitation, resources available for rehabilitation.

Search engines used included ProQuest, PsycINFO (Psychological Information), Pub MED, Sabinet, Science direct, and Google scholar, with the parameter; year of publication (maximum of five years), the context of the study (hospital, community, home-based and traditional setting), and focus of the study (rehabilitation, practice, experience, expectation, constraint).

This chapter explored the concept of schizophrenia, the description of schizophrenia in Sub-Sahara Africa, and the approaches to the management of such. The concept of rehabilitation and practice of rehabilitation, the experiences of rehabilitation by service users, and the alternatives to rehabilitation. Other therapies in mental healthcare and their relationship with PSR. Also discussed are the challenges HCPs encounter with rehabilitation, the procedure guides HCPs adopt in the discharge of rehabilitation services, family view of rehabilitation and available support systems.

2.2 SCHIZOPHRENIA AND REHABILITATION

Mental illness is a disease of the mind (Dobrow, 2017). The intensity of the symptoms varies, and the most chronic form of mental illness is schizophrenia (Ashwini et al., 2017). A person with schizophrenia presents with features such as hallucinations and delusions that reduce social desirability, career, and employment sustainability (Ashwini et al., 2017). Moreover, schizophrenia, like other mental illnesses, attracts stigma, invariably reducing the productivity and social acceptance of the individual (Thonon & Larøi, 2017). Surprisingly, healthcare HCPs reportedly exhibit the same, and sometimes worse, stigmatising attitudes than the public towards individuals with mental illness (Yuan et al., 2017). This implies that medical care does

not guarantee acceptance or reduction in the stigma of mental illness. However, care geared towards productive living and evidence-based community service for individuals with mental illness reduce the stigma of all forms (Stefanovics et al., 2016). This implies that beyond hospital management, programmes geared at aiding productivity are necessary for individuals with mental illness.

The institution of rehabilitation, through the incorporation of lay community members, has multiple advantages, which include evidence-based reduction of the stigma (Mueller et al., 2018; Rai et al., 2018). In addition to the wide coverage of care, rehabilitation ensures continuity of care and reduces the family burden through the active involvement of people in the community (Rai et al., 2018).

Given the effectiveness of rehabilitation, the World Health Organization encourages each country to develop a context-specific guide for the rehabilitation of individuals with mental illness (WHO, 2002). High-income countries have guides for rehabilitation that are effective in channeling the strategy of care, whereas a big gap in rehabilitation exists in Sub-Saharan Africa. The defining of the Sub-Saharan African gap is in terms of the dearth of literature, lack of practice guidelines, and implementation of PSR in Sub-Saharan Africa (Adebowale et al., 2014; Lucky et al., 2016; Akinsulure-Smith et al., 2017). The study, therefore, discusses the opportunities for recovery of individuals with schizophrenia, the advent of HCPs' roles, and the peculiarities of Sub-Saharan Africa/Nigeria.

2.3 SCHIZOPHRENIA AND SUB- SAHARA AFRICA SPECIFICITY

Severity of schizophrenia is in terms of prognosis and reduced responsiveness to medication, while chronicity is a function of attributes and disposition (Kayi et al., 2018). The pathology of schizophrenia has attracted different descriptions from different authors. Berkovitch et al. (2018) report that in schizophrenia, the impulse for conscious stimulus is deformed, which brings about cognitive impairment and disorganisation syndrome.

Similarly, Koethe et al. (2018) reported cerebrospinal challenges in schizophrenia, which manifests by the increased cerebrospinal space of the fatty acid neurotransmitter within the central nervous system, resulting in physiological dysfunction. Conversely, Sekar et al. (2016) declared schizophrenia as a hereditary illness that has unknown aetiology, with diagnostic symptoms majorly arising from significant depletion in grey matter. Sejar et al. (2016) also state that schizophrenia is difficult to define and that the treatment is majorly palliative and neither preventive nor curative. Despite all these disabilities and views, studies have reported that rehabilitation towards productivity, as evidence-based, reduces the burden and stigma of schizophrenia (mental illnesses) in high-income countries (Asher et al., 2018; Villotti et al., 2018; Kohrt et al., 2018; Vita & Barlati, 2019). However, rehabilitation and scientific

approaches to mental healthcare are still struggling for acceptance in Sub-Saharan Africa (Kohrt, et al., 2018; Robertson, 2019; Cooper, et al., 2020).

There are various factors identified as combating rehabilitation in Sub-Saharan Africa. These factors are interwoven but grouped as the contextual definition of schizophrenia, culture, perception, and knowledge (Abbo et al., 2019). Further to the generally accepted definition of schizophrenia, it is worthy to note that there are different ways in which Sub-Saharan Africans define schizophrenia compared to the global conceptualisation (Kometsi et al., 2019). Kometsi et al. (2019) further state that in Sub-Saharan Africa the definition of mental illnesses is not diagnosis-specific, meaning Sub-Saharan Africa does not have a definite definition for each kind of mental illness but defines them according to the different groups, and regards schizophrenia as most stigmatised. In addition, schizophrenia is seen as a mental illness that outweighs orthodox intervention. Despite the existence of orthodox medicine and the scientific definition of mental illness, research shows that Sub-Saharan African traditionalists believe orthodox therapies cannot treat schizophrenia (Schierenbeck et al., 2018). Kometsi and colleagues further report that Sub-Saharan Africans generally regard individuals with mental illness as demonic and that the definition is culturally construed (Kometsi et al., 2019).

Oyelade et al. (2017) further assert that the perception of demonisation of an individual with schizophrenia gives room for abuse in Sub-Saharan Africa. Furthermore, Abbo et al. (2019) report that Sub-Saharan Africa still patronises traditionalists who believe that individuals with mental illness are demon-possessed, while Parle (2019) reports that in psychiatric institutions in Sub-Saharan Africa, where core scientific management is expected, the care sits alongside demonological belief and treatment. Nortje and colleagues describe traditional management as involving, starving, giving concussions, and incision (Nortje et al., 2016), while Oyelade et al. (2017) report that brutal treatment of individuals with schizophrenia and other mental illnesses occurs in institutions. In addition, the first line of care families adopt for individuals with mental illness in Sub-Saharan Africa is communal overpowering and tying the individuals down to prevent absconding (Nortje et al., 2016; Jegede, 2017). The communal and traditional approaches pose the threat of injury, development of infections, and critical illness for the individuals.

Schierenbeck et al. (2018) report that medical management is the last result for mental health care in Sub-Saharan Africa, and considered after all other efforts fail. This explains the rationale of mental illness chronicity in Sub-Saharan Africa, and further aggravates the stigma, which is worse in this region than in any other part of the world. Kimotho (2018), in their report, declare Sub-Saharan Africa stigma of mental illness arises from misconception. Although the feature of mental illness is similar everywhere, the management differs. Whilst some symptoms are referred to as psychosocial disabilities, both the psychosocial and psychotic

symptoms have peculiar modes of management in Sub-Saharan Africa; the psychotic and the psychosocial symptoms may differ, but they both attract negative reactions from society.

2.4 PSYCHOSOCIAL, PSYCHOTIC DISABILITIES IN SCHIZOPHRENIA AND SUB-SAHARAN AFRICA INTERPRETATION

Schizophrenia, attributed to a lack of social cognition, is characterised by a lack of appropriate response to social needs and emotional issues, which requires empathy or sympathy for others (Sekar et al., 2016). This justifies the reason for flat affects in schizophrenia and inappropriate or contrary reactions to emotional issues. Schmidt and Mirnics (2015) regard such features as negative (social) symptoms, and go on to describe two other symptoms of schizophrenia, cognitive symptoms, and positive (psychotic) symptoms. The cognitive symptoms affect information retention and attention span, which is usually low in schizophrenia (Schmidt & Mirnics, 2015) which Misiak et al. (2016) describe as affective and anxiety symptoms.

Sub-Saharan African reports show that some psychosocial disabilities are attributed to witchcraft and such individuals who exhibit such traits are killed mercilessly (Atata, 2019).

Verginer & Juen (2019) stated that community members in Sub-Saharan Africa associate displays of psychosocial disability as a bad omen that can attract evil to the community. Etindele-Sosso (2017), conversely, stated that Sub-Saharan African communities view individuals with a psychosocial disability as sent by the devil to inflict pain on the populace. This shows that the conceptualisation of psychosocial disability in Sub-Saharan Africa is such that individuals have little or no chance to live within the community. Conversely, individuals with schizophrenia in Sub-Saharan Africa also believe they are ill because the community wishes them so (Chidarikire et al., 2020).

The attitude of Sub-Saharan Africans to psychotic symptoms is however milder and not as grievous in their attitude to psychosocial disabilities; however, negative attitudes against psychotic symptoms do exist. The Psychotic symptoms of schizophrenia vary, such as hallucinations and delusion, with different subtypes that predispose them to different cognitive features (Goghari & Harrow, 2016). Goghari & Harrow (2016) describe hallucination as a form of a psychotic feature in schizophrenia underpinned by both cognitive disorder and emotional trauma. The names of the types are according to the sensory function affected; auditory, tactile, visual, gustatory and olfactory hallucination.

According to Misiak et al. (2016), childhood trauma is a significant determinant of the intensity of hallucination, and the trauma ranges from sexual abuse, physical injury and emotional

upset. Childhood trauma can increase the tendency of hallucination two-fold more than in someone with schizophrenia but without a history of childhood trauma (Misiak et al., 2016). Audiovisual hallucination is common in the history of childhood trauma in schizophrenia, and manifests as thought amplifier, third-person audition, and persistent commentary voices (Misiak et al., 2016). In its description, Goghari & Harrow (2016) state that olfactory hallucination is more common in other types of mental illness than schizophrenia and varying forms of hallucination peak between 5 and 10 years of diagnosis of schizophrenia. In addition, auditory hallucinations are more common in an individual with schizophrenia than visual (Goghari & Harrow, 2016). Unlike olfactory hallucination, delusion is more common in schizophrenia and is one of the signs that manifests at the onset, which tends to impede recovery if a recovery goal is not instituted early (Goghari & Harrow,2016). The recovery goal, with the view of symptom improvement, is best achievable in the early stage of diagnosis, or in schizophrenia, between 5 and 10 years (Goghari, & Harrow, 2016).

Delusion manifests through strict adherence to unreliable convictions (Baker et al., 2019); it does not respond to medication, and is confirmed higher in individuals with the high socio-economic class (Baker et al., 2019). Delusion is less severe and remission lower in females than males (de Vos et al., 2019). Delusion manifest in different ways, including the delusion of persecution, grandiose delusion, thought broadcasting, and nihilistic delusion. According to Iwashiro et al. (2019), persecutory delusion arises from co-morbidity of depression with schizophrenia. Iwashiro et al. (2019) further assert that for an individual with schizophrenia to have depression, there must be an attributable emotional disturbance, which sometimes interferes with hearing and speech. Likewise, Wu et al. (2018) declare speech impairment and inconsistency as a standard feature of schizophrenia, which is attributable to delusion. Sakakibara (2018) reports that delusion is a feature of all forms of mental illness, but the kind of delusion in schizophrenia is complex and complicated by delusional symptoms called thought broadcasting (Bott et al., 2016; Kilicaslan et al.,2016).

Sakakibara (2018) describes thought podcasting as a situation when a client believes people around him are reading what is in his mind and saying it aloud. Cermolacce et al. (2018) state that although delusions are only false to the observers of the individuals with schizophrenia, the person exhibiting believes it to be true. Delusions have their roots in hallucinations or intuitions, and this makes it fixed and difficult to remove (Cermolacce et al., 2018). Nihilistic delusion is another type of delusion where individuals exhibit fixed beliefs about the loss of a body part or their existence (Bott et al., 2016). In addition to the general psychosocial disabilities (delusion and hallucinations), some disabilities are peculiar to different types of schizophrenia. Uys and Middleton Lyn (2020) state the types of schizophrenia as hebephrenic, catatonic, undifferentiated and schizoaffective disorder. The psychosocial disability of

hebephrenic is the hoarding of rubbish (Chiu et al., 2003). Individuals with hebephrenic schizophrenia usually keep waste materials in an untidy manner, which has an impact on personal hygiene and social outlook (Chiu et al., 2003). Catatonic schizophrenia is characterised with fixed gait and maintaining a particular position for a particular period (Zuchowski & Kirkpatrick, 2016). Despite the variations in the psychotic disabilities of mental illness, scientists have adopted different management, which in turn becomes treatment. However, globally available treatments have different approaches in Sub-Saharan Africa, and a description of these approaches and variations follows.

2.5 TREATMENT APPROACH AND SUB-SAHARA AFRICAN METHODOLOGY

Scholars have reported different treatment modalities that range from medication, electroconvulsive therapy, psychosocial therapy, family therapy and PSR as follows;

2.5.1 Medication: Administration of medications to reduce psychotic features in schizophrenia is one of the first lines of action in the illness' treatment (Karson et al., 2016). Early commencement of antipsychotics in the first episode of schizophrenia has evidenced-based confirmation of remission of symptoms and frequency of relapse, but it does not guarantee prevention of chronicity (Karson et al., 2016). The antipsychotics vary, as there are changes in type or improvement in dose. However, the changes in type and dosage lead to drug dependency and chronicity (Karson et al., 2016). Beck et al. (2016) reveal there are numerous antipsychotics suitable for the treatment of schizophrenia; however, individuals with schizophrenia are prone to resistance from long-term use. Carpenter and Buchanan (2015) argue that the root of administration affects the potency of antipsychotics, but the root may not be significant in the case of resistance (Sreeraj et al., 2017). There are several medications for the treatment of schizophrenia, but Gillespie et al. (2017) believe clozapine is the only effective medication for the treatment of antipsychotics for clients with treatment resistance.

Clozapine falls within the group of atypical antipsychotics, and has reduced extrapyramidal side effects because it has little antagonism towards dopamine (Gillespie et al., (2017). Elkis & Buckley (2016) support this assertion but with a further declaration that the emergence of resistance to schizophrenia may necessitate a non-drug therapy as the last resort for schizophrenia management. There is an acceptance globally and in Sub-Saharan Africa of the use of medication, but the peculiarity of Sub-Saharan African medication is forceful administration (Beyero, 2018). In Sub-Saharan African institutions, there are conventional drugs with specific dosage, whereas Sub-Saharan African traditional settings lack dosage, however both settings engage in forceful medication (Ajala et al., 2019). This is different from globally accepted standards. The WHO (2018) encourages active client participation in the

choice of their treatment and emphasises the right of an individual with mental illness to make a choice of antipsychotics. There are various therapies available globally and adopted in Sub-Saharan Africa, but other places have better strategies. One of those therapies is electro-convulsive therapy.

2.5.2 Electroconvulsive therapy(ECT): This is the use of the regulated convulsion through the electric current to treat mental illness (Rasmussen, 2020). The need for electroconvulsive therapy arises from the frustrations of resistance to medications, which is a function of symptom remission after the prolonged use of an antipsychotic (Elkis & Buckley, 2016). In some cases, clients with treatment-resistance schizophrenia are unable to use schizophrenia medication due to its side effects, such as drowsiness and constipation, and non–compatibility with some medications in individuals who have other co-morbidities with schizophrenia (Zheng et al., 2016). In such groups of individuals with treatment-resistant schizophrenia and contraindication to clozapine, other groups of antipsychotics with electroconvulsive therapy are advised (Zheng et al., 2016). Lally et al. (2016) also report that electroconvulsive therapy can augment clozapine to achieve symptoms remission in treatment-resistant schizophrenia. ECT is the most effective when rapid symptoms remission is required, and most especially in cases of catatonic schizophrenia (Thomann et al., 2017).

Essali et al. (2015) describe two variations of ECT as unilateral and bilateral, with the difference being in the placement of nodes; in unilateral, the nodes are on one side of the lobes and on two sides in bilateral. The two forms of ECT have the same effectiveness, but unilateral has the added advantage of reducing the tendency of post ECT memory impairment (Essali et al., 2015). ECT is globally accepted, and the recommendation is to use anaesthesia to minimise risk, but the administration of ECT without anaesthesia still occurs in Sub-Saharan Africa (Ibrahim, 2017). Kadiyala et al. (2017) report that ECT without anaesthesia results in diverse muscular-skeletal injuries. This invariably infers that administration of ECT without anaesthesia increases the risk of complication despite its importance. Apart from the active treatment with the use of medication and ECT, some treatments that serve as reintegration strategies accompany psychiatric treatment, such as psychosocial therapy, which encompasses family therapy and occupational therapy.

2.5.3 Psychosocial therapy: Psychosocial therapy are social pre-integration strategies that involve restoring the methods of effective socialisation in individuals with mental illness (Jones, et al., 2018). According to Essali et al. (2015), psychotherapy is as essential as other therapies and both become more effective in recovery when combined for management of schizophrenia. These therapies are effective in aiding the productivity of an individual with mental illness. The therapies include occupational therapy. Occupational therapy is a

treatment strategy of the building or re-building the vocational life of an individual with mental illness (Linkie et al., 2017). With schizophrenia specifically, Lystad et al. (2017) reported challenges with occupational therapy, especially when aimed at restoration to a particular vocation. In the situation where occupational skills training was effective, clients complained that the type of training was elementary (Noyes et al., 2018). Although some skills in occupational therapy have evidenced-based effectiveness, they may not continue if the client feels they are not necessary at that moment (Lystad et al., 2017; Noyes et al., 2018). In some situations, therapy for individual clients is usually in a group, but therapy that will sustainably achieve recovery must be individualised and based on what clients feel are needed, not by dictatorship (Välimäki & Lantta, 2019). Occupational therapy is easily available for individuals with mental illness globally, but in Sub-Saharan Africa, only those who can afford it access it (Ned et al., 2020). Another form of psychosocial therapy is group therapy. It is effective in the rehabilitation of individuals with addiction or conscious behavioural challenges (Irabli & Wood, 2018). However, in the case of schizophrenia, the recovery goal has to be individualistic for effectiveness (dos Santos et al., 2018) and therefore, group therapy goes in line with cognitive behavioural therapy. The active treatment and the reintegration strategies are not complete in achieving holistic recuperation, thus the advent of PSR.

2.6 PSYCHOSOCIAL REHABILITATION

Different therapies, such as medication, are effective in the remission of psychiatric symptoms, but there is no medication found for recovery of social cognition and productive living (Green, 2016). This makes medication much less significant in achieving recovery goals (Green, 2016). One can describe psychiatric care as a medical intervention targeted towards remission of symptoms, while recovery is the effort of assisting an individual to gain insight into the sick state and developing a self-care goal. Care is vital, because lack of care has the potential to reduce chances of recovery and lead to chronicity (Palaniyappan et al., 2016). The care model focuses on remission of symptoms, while the recovery model focuses on improving social relevance. The traditional conceptualisation of recovery is remission from psychiatric symptoms (Mueser et al., 2018). However, the current trend of recovery of individuals with mental illness is moving toward the model of positive health (Mueser et al., 2018).

The description of positive health is being hopeful and focusing on areas of strength during an illness, which aids recovery (Van Cappellen et al., 2018), however, recovery emphasises restoration or stimulation of productive life and living (Mueser et al., 2018). Schizophrenia has a poor prognosis, high mortality, with over 90% incidence of suicide, high co-morbidity, heart diseases, respiratory, pancreatic and malignant diseases (Charlson et al., 2018). But the level of chronicity of an individual with mental illness should not hinder recovery and productivity (Byrne et al., 2018). Bryne and his colleagues stated that recovery only becomes difficult when

the person sees no possibility in himself and when the community views the individual as undesirable (Byrne et al., 2018).

The community view is necessary in recovery because productivity is associated with giving to and taking back from the community (Kohrt et al., 2018). The process of giving and taking back is broad and depends on the needs, which entail product and services, friendship and relationship, merchandise and sales (Wewiorski & Gorman, 2018). In the situation where an individual is unaccepted in the community, productivity becomes difficult (Byrne et al., 2018: Allman et al., 2018). The inherent challenges of rehabilitation in Sub-Saharan Africa are culture and knowledge. This study believes if the approach of educating the populace in Sub-Saharan Africa is towards compensation for the loss in mental illness, treatment and rehabilitation, there may be a new outlook in Sub- Saharan Africa. This write-up considers schizophrenia rehabilitation in Sub-Saharan Africa as best suited in the compensation theory of recovery.

2.7 SUMMARY

Sustainable recovery is only achievable through psychosocial rehabilitation (PSR), which requires incorporation of clinical services into the expanded scope of PSR (WHO, 2013; WAPR, 2013). The incorporation of clinical practice and PSR is a significant yardstick for the attainment of a balanced care model for global mental health (Collins et al., 2013; Uribe-Restrepo et al., 2017). Additionally, the extension of the scope of PR in the care of the individuals with mental illness, which has gone beyond reintegration into the community to instituting support, is a significant mark in the progression of its approach (Luciano et al., 2014).

2.8. CONCLUSION

This chapter concludes there is a different conception of care in Sub-Saharan African setting with misunderstanding of rehabilitation. Information dissemination on the benefit of rehabilitation and community participation in rehabilitation has potential to stimulate for positive change.

CHAPTER THREE: RESEARCH METHODS

3.1 INTRODUCTION

Chapter two presented the literature review section, which comprised the definition and description of schizophrenia and rehabilitation, Sub-Saharan African description of schizophrenia, psychosocial, psychotic disabilities in schizophrenia and Sub-Saharan African interpretation, and general description of PSR. This current chapter is the methodology chapter and comprises the description of the research location and the approach to conducting the study.

3.2 RESEARCH SETTING

This study took place in Nigeria, specifically Southwest.

Nigeria has a wide geographical coverage (923,770 sq. km) divided into six geopolitical regions, namely Northeast, Northwest, North central, Southeast, Southwest, South-south. Psychiatric care is available in tertiary institutions in Nigeria, with one psychiatric institution in each geopolitical region, and two in the Southwest, Neuropsychiatric hospital Yaba, Lagos and Neuropsychiatric hospital Aro, Abeokuta, and this is where the research occurred. Southwest was the most suitable for this study for the following reasons:

- The researcher is from Southwest, which is a requirement for context-based studies that are not ethnographic, like this study (Allen et al., 2019; Garrison et al., 2019).
- Neuropsychiatric hospital Aro, is the only World Health Organization-affiliated centre for psychiatric research and training in Nigeria. It is also the first psychiatric institution in Nigeria and serves as the global point of reference for psychiatric care in the country.
- Articles on psychosocial rehabilitation, in which there was a lack of understanding expressed, were generated from the southwest Nigerian institutions; there were no articles from other regions, except one from the Southeast with a similar report.

Currently, mental health services and treatment care are available in the two tertiary psychiatric institutions through direct client's interaction and care are by psychiatric nurses, psychiatrist, psychologist, social workers, and occupational therapist (Falola et al., 2018). Two primary health centres are affiliated to the the first tertiary institution, Neuropsychiatric hospital Aro. The primary health care facilities serve as follow up centre for discharged clients who consider it close to their residence.

Therefore, the two tertiary health institutions and the primary health centres affiliated to Aro constitute the setting of this study (Yaba has no affiliated primary health centre).

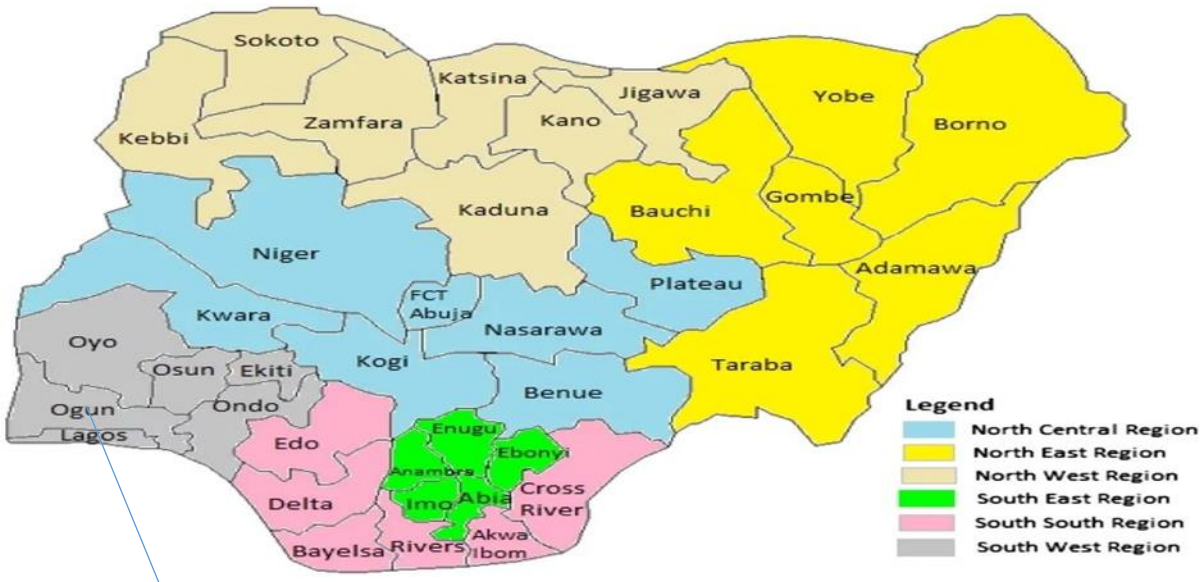

Figure 3.1: Map of Nigeria showing southwest region

Location of Research settings.



Figure 3.2: Location of research settings

Source:ttps://www.google.com/search?client=firefoxd&q=Lagos+and+Ogun+location+in+South+West

3.3 RESEARCH DESIGN

This study adopted a multi-method approach (Creswell, 2012), which involves a scoping review (Phase 1) and qualitative description (Phase 2). Multi-method design, is when two or more research projects are steered, each complete in itself, to address research questions and/or hypotheses, a topic, or a program (Driessnack, Sousa & Mendes, 2007).

3.3.1 Phase 1: Conceptualization (scoping review)

Scoping reviews is a form of aggregating of scientific evidence through systematic and explicit processes (Tricco et al., 2018). It involves defining the area under study, searching for the studies within the area, assessing the quality of the studies retrieved and analysing the findings (Peters et al., 2015). This scoping review explored the past literature on PSR in Sub-Saharan Africa. Specifically, within the context of this study, the scoping review is the most appropriate due to the need to identify and map the existing literature on psychosocial rehabilitation with guidance of Tricco et al's (2018) PRISMA guideline for scoping review.

3.3.2. Scoping review design

The PRISMA review framework for the conduction of reviews, as explained by PRISMA (2018), guided the methodology of this study. It entails five sequential stages which involves;

1. Setting the research question
2. Identifying the relevant studies
3. Selection of study participants by inclusion and exclusion criterion
4. Data charting
5. Collation, summary generation, and report writing

3.3.3. Scoping review methods

Scoping review question and objectives

What literature is there in terms of the PSR of people living with schizophrenia in Sub-Saharan Africa during the period between 2000 and 2018 (Though, preliminary literature searches show publication output on schizophrenia rehabilitation in Sub-Saharan Africa started in 2009. The global advocacy of mental health burden and rehabilitation started in 2000 (WHO, 2002).

The objectives of the scoping review were to:

1. Identify trends of PSR
2. Assess the outcomes, limitations, and challenges of PSR
3. Assess the methodology of PSR
4. Assess the research output on the concept of PSR
5. Summarise main findings
6. Identify relevant focus for future research

3.3.4 Data collection and analysis of the scoping review

3.3.4.1 Search strategy

Sorted for review was primary data that addressed the research question and published in a peer-reviewed journal or grey literature. The searches for published literatures were performed

using the online bibliographic LibGuides and six databases: PubMed, PROQUEST, PsycINFO (Psychological Information, SCOPUS, SABINET; however, the search was extended to one additional broad database, EBSCO Host (Academic Search Complete, ERIC, Health Source, Psychology and Behavioral Sciences Collection), due to the limitations discovered in SABINET

The following sites were consulted for unpublished literature: Google, Google Scholar, African Journals Online, and HINARI. In addition to the electronic search of databases, the search approach included checking the references of included studies and related reviews. The search terms included psychosocial rehabilitation AND rehabilitation AND schizophrenia AND Sub-Saharan Africa. Three library experts from three different countries were consulted. One was a medical school librarian, and two were librarians from schools of public health to guide search terms for “schizophrenia”, “rehabilitation” and “Sub-Saharan Africa” (the full list of variations on the search strategy is available in the search sample below). According to reports of library experts, schizophrenia can also be conceptualized as a chronic mental illness, while rehabilitation is conceptualized as productivity. In alternate words, Sub-Saharan Africa is also regarded as Black Africa. The variant terms were also considered in the study. Duplicates were removed, and the eligibility criteria applied to select studies that were reviewed in the study. Based on the search terms, articles featuring eligibility criteria and limited settings were exported into the END Note library; duplicates were removed. Further scrutiny of the abstract, which involved a search for the context of Sub-Saharan, Africa was applied.

3.3.4.2 Eligibility criteria (Inclusion and Exclusion)

The guide for the search strategy for this review was specific duration; specifically, articles from 2000-2018 were included, specifically studies conducted in Sub-Saharan Africa. Accessibility to full text was proposed but was not a limitation. The articles not available through the South African interuniversity library system were found with the assistance of research fellows in the research institute of the Consortium for Advanced Research Training in Africa (CARTA); therefore, there were no articles excluded due to the constraint of access to the full text. There was also consideration given to the context of the articles; excluded were articles generated outside Sub-Saharan Africa. Article available in English language was proposed but those written in other languages with available English version were included. A data extraction sheet was developed, and only articles that met the inclusion criteria were analysed using content analysis (Sandelowski, 2000). To prevent bias, the researcher extracted the data and the supervisor reviewed it, a meeting followed to determine consensus; where they could not reach consensus, they asked a third academic to evaluate the article (Comprehensive details of the scoping review is in chapter four of this study).

3.3.2 Phase 2: Interviews (Clients, families, health care practitioners).

This phase used a qualitative descriptive design for the descriptive qualitative inquiry (interview). The researcher adopted a descriptive qualitative design to describe the future of mental health nursing education and training as perceived by stakeholders and international literature. Descriptive qualitative design aims to describe the essential findings in a rigorous way that is free from distortion and prejudice but discover new meaning, describe what currently exists, and categorize the information (Lambert & Lambert, 2012). Rationale for qualitative description and the phillosophical underpinnings are described as follows:

3.3.2.1 Phillosophical underpinnings

- **Ontology:** A descriptive qualitative approach (constructivist paradigm) underpins the study. The basis for the ontological perspective of this paradigm is the belief that reality is subjective and multiple (Brink et al., 2012). This study takes the stance that reality about PSR in SW Nigeria is subjective and contextually constructed over time. Specifically, within this study, the construction of reality about PSR is through interaction with clients, family and HCPs. Clients have a subjective interpretation of the experiences, the family have theirs and HCPs have a subjective interpretation of the care rendered. Protocol introduces client and family to the process of PSR, and serves as a guide for HCPs discharging the duty of care, they (clients, family and HCPs) construct their own reality and ideology about the process. It is important to know their ideology about it before developing a protocol of care for use for and by them (clients, family and HCPs).

- **Epistemology:** how can one know reality, is within the constructivist paradigm through the interpretation of knowledge of the "knower" (Brink et al., 2012). The reinforcing of the epistemological premise is the belief that as far as PSR protocol is concerned, there are different streams of knowledge that span from published articles, the HCPs and the researcher. From the published articles it was clear that there is no contextual protocol that guides PSR in Nigerian practice. What is unknown is the mode of PSR in Nigeria, while the researcher knows that bringing the resources together will help to fill the missing gaps that are the protocol for practice guidelines. However, the exploration into the streams of HCPs' knowledge and practice will be from the institutions and their community health facilities.

- **Methodological interpretation** is the process the researcher took to collect valid and reliable data from the research participants (Brink et al., 2012). The narrative inquiry

described PSR experiences and expectations from clients and family. Qualitative inquiry is the most appropriate method of inquiry from clients and family because of its benefit of aiding the flow of thought with minimal interruptions (Schewandt, 2014; Stolz et al., 2017). From HCPs, exploration descriptive approach and published resources through scoping review guided the researcher. The exploration descriptive helped to engage in in-depth inquiry and at the same time aided extensive clarifications (Polit & Beck, 2014; Harrison et al., 2017). While the scoping review gave a broad view of the literature on the concept, context and the contextual findings (Munn et al., 2018). The inclusion of these sources was considered vital in the development of the PSR practice guide in southwest Nigeria.

3.3.2.2 Population for the descriptive qualitative inquiry

Study population is the number of individuals who are eligible for participation in the study not necessarily those who are recruited but all those who are qualified to be recruited into the study. This can be by group classisfication or religion or location (Stratton, 2021). Specifcally in this study, schizophrenia is the focus of attention. Thus the population are individuals who are directly or indirectly link with an individual who is diagnosed of schizophrenia. This can either by care provision, family relationship or such individuals themselves.

The population consisted of:

- **Client population**: All clients diagnosed and treated in the two tertiary hospitals (there are about 2000 clients in each facility seen and treated yearly, and approximately 50 clients follow up cases seen monthly at the outpatient (follow up clinic, community clinics and occupational therapy clinics) and rehabilitation units; out of the eligible 50, 21 clients refused to give consent, therefore the interviews were with the 29 who consented).
- **Family population**: This consist of individuals whom the clients considered closely involved in their care (determined based on the selected client numbers and on clients' recommendation); 21 participants gave consent and were interviewed.
- HCPs**'** **population**: psychiatric nurses (18), psychiatrists (4), psychologists (4), occupational therapists (7), social workers (3) employed at the institutions where the study was conducted were interviewed, resulting in 36 HCPs interviewed.

3.3.2.3 Sample and sampling methods for the descriptive qualitative inquiry (interviews).

Table 3.1 describes the sample and sampling criteria.

Table 3.1: Sample and sampling methods in the qualitative inquiry

Sample	Sampling method
Client	Both institutions see about 50 outpatients with schizophrenia. The first selection criteria were profile assessment to determine which client to select based on the inclusion criteria basis of stability. This started from the record of clients discharged not earlier than 3 months. This is because research evidence shows risk of relapse is usually high between 1 to 3months of discharge (Rossi et al., 2018). Purposive sampling selected participants based on the following inclusion criteria:

	using the outpatient hospital record book, the clients with the diagnosis of schizophrenia in each of the institutions were selected, their files reviewed base on the following inclusion criteria: • Diagnosis of schizophrenia in the past two years, the two-year duration is vital for the feasibility of tracing and the possibility of commitment to follow up (Schöttle et al. 2018) • Post 3 months discharged and confirmed stable from clinical records which is indicated by 3 months of being without negative symptoms in their files, has no history of debilitating co-morbidity (such as head injury, cerebral cancer, poorly managed diabetes with injuries or wounds), affective co-morbidity like depression and mania • Lives within the location of research setting (Abeokuta or Lagos) • Above 18 years
Family member	Purposively selected from clients' files, snowballing as referred by clients mentioning them as the people caring for them Inclusion criteria: • Closely involved in clients' care, lives within Abeokuta or Lagos
Health professional	Purposively selected based on inclusion criteria: • Permanent staff of the two tertiary institutions • Directly involved with clients' care, HCPs such as psychiatric nurses, psychiatrists, psychologists, social workers, occupational therapists, community health officers • The number of participants was determined by data saturation; in each institution after each health professional was interviewed, data was analysed and stopped at saturation of information, the researcher moved to the next institution and did the same

3.3.2.4 Data collection procedure

- The details of the study (Information leaflet and verbal consent: Annexure B (Study Information Sheet for clients), C (Study information sheet the clients' family member), D (Study information sheet for HCPs) and Consent Annexure E (Participant consent sheet) was explained by the researcher, telephonically (verbal consent).
- Written consent was taken on the first physical contact (Annexure E: Participant consent sheet), F (Consent form for an audio recording of study participation).
- The preferred venue and time for interview was discussed on the day the physical consent was taken from each client and family.
- The interview with the clients was outside their clinic days to avoid the divided attention that may arise from a pre-clinic interview or over weariness from the interview after long hours of a hospital appointment.
- In cases where the preferred venue requires clients taking transport, the researcher bore the travelling costs of the clients and family. There were separate interviews with clients and the family to enhance free expression and confidentiality.
- There was an explanation of the information about the study, as outlined in the information leaflet. Interviews with the HCPs were at a time suitable for the health professional. Data collection for them was on their off-duty days'/break period, as they preferred.

3.3.2.5 Interview guide for the descriptive qualitative inquiry (interviews).

The demographic profile (Annexure A) of the clients was collected. Semi-structured interviews conducted as guided by the instrument in Annexure H (Interview guide for clients), Annexure I (Interview guide for families), Annexure J (Interview Guide for HCPs), and audio recording of the interviews. There could be an expansion of the interview guide if the need arose based on the findings of the scoping review, but there was no need for such.

The objectives of the study achieved through the phases presented in Figure 3.3.

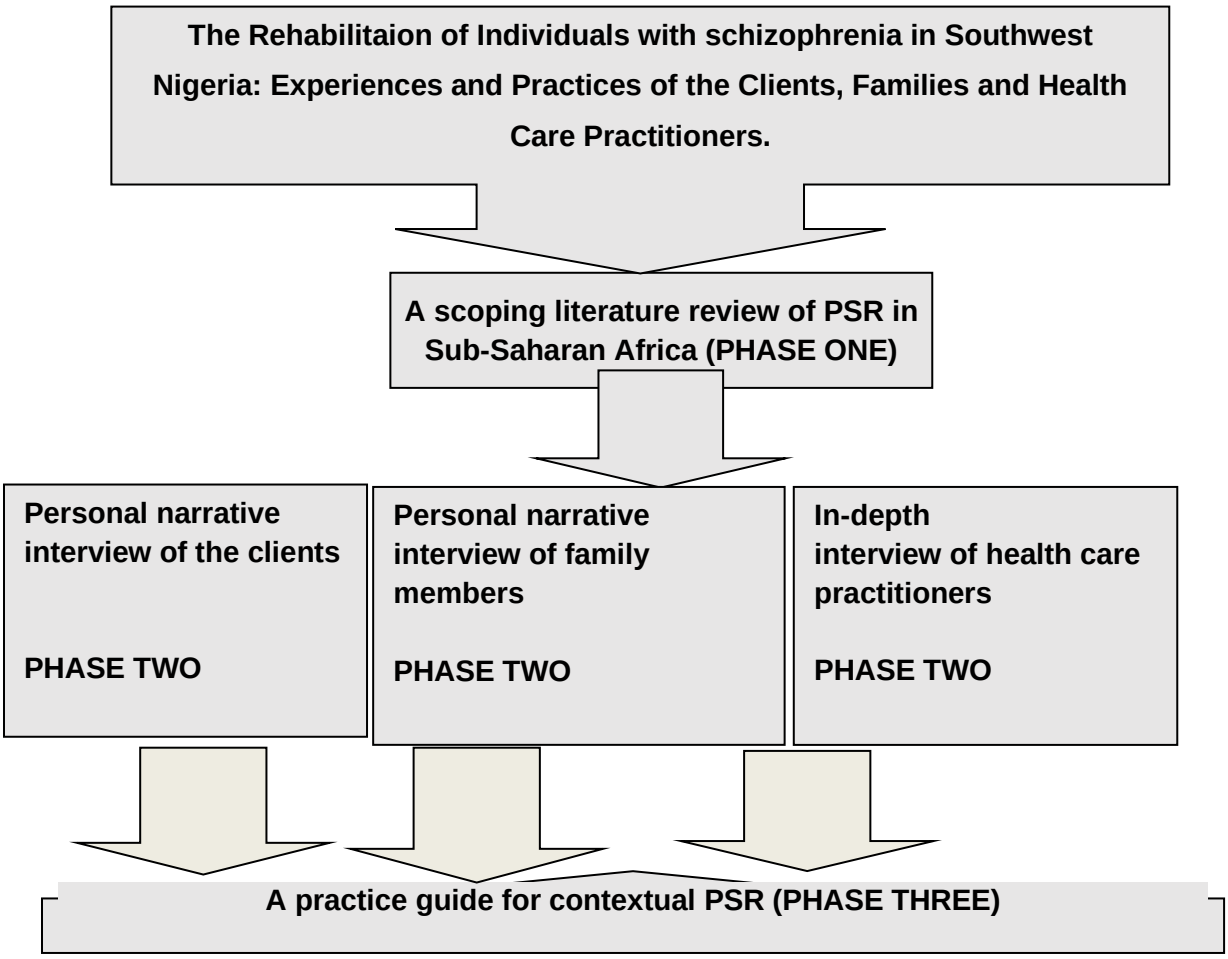

Figure 3.3: Phases of the study

3.3.2.6 DATA ANALYSIS FOR THE DESCRIPTIVE QUALITATIVE INQUIRY (INTERVIEWS)

This study adopted the Sandelowski (2000) and Elo and Kyngäs (2008) approach of content analysis for the data analysis. The stages described by these authors can be summarised into three phases: Preparation, collation and report.

- ***Preparation****:* The audio recorded interviews underwent transcription into written scripts, followed by the researcher repeatedly reading them until well acquainted with the content.
- ***Collation****:* Coding was the first stage started (open coding), followed by categorisation and abstracting the core contents. Open coding started with underlining keywords within the transcripts; this involves structured (unconstrained) categorisation matrix, which implies grouping the relevant information until the set objectives is gathered together, the categorised data was reviewed for congruence, and corresponding categories each received a code. The codes generated are the meaning unit/content unit (the generating of the codes was from the keywords of the participants' categorised responses (condensation). These were transcribed verbatim onto coding sheets, and themes and categories generated.
- ***Reporting:*** This involves the analysis of process and the results, the data collected was used solely for this study. All recordings were labelled using participants' pseudonyms and dates, and downloaded on a personal computer with a protected password known only to the researcher. At each stage of data analysis completion with the participants, there was a data confirmation section.

3.4 RESEARCH RIGOUR

Research rigour is the effort the researcher uses to ensure quality research. In qualitative research, known as trustworthiness.

3.4.1 TRUSTWORTHINESS

Achieving trustworthiness is convincing the reader about the truthfulness of every stage of the research, and the way it coincides with the research objectives (Holloway & Wheeler 2013). Attaining this is through the principles of credibility, confirmability and dependability (Holloway & Wheeler, 2013). The following paragraphs present the application of each.

3.4.1.1 Credibility: Research credibility means the extent to which the process of the study is right and worthwhile (Hansson & Polk, 2018). This study achieved credibility as follows:

- **Authenticity**: This can be described as the extent to which a research process is effective (Yusoff, 2019). To validate the appropriateness, clarity and level of congruence of the

content of the presentation with the set objectives, the research was presented at departmental level to the lecturers before it went to the assessors at faculty level, and the corrections effected and confirmed by the assessors.

- **Supervisor and the researcher**: The research supervisor is an advanced psychiatric nurse specialist, experienced researcher and an educator. The researcher is an indigene of Southwest Nigeria, a psychiatric nurse specialist, pursuing a doctoral degree.
- **Sample selection**: An equal mix of clients' gender in ratio 1:1 was proposed, but not feasible. Snowball sampling allows the researcher to access relevant family members as participants. The unit managers guided the selection of experienced HCPs.

3.4.1.2 Progress briefing: This is an explicit report of each stage and process of research or field experience to the higher authority, as the research engages with the process of acquiring data (Hansson & Polk, 2018). During the process of data collection, the researcher ensured continuous briefing of the research supervisor on each stage of research, the distance barrier (the supervisor being in South Africa during data collection and the study setting being Nigeria) handled through electronic media of video-chat, and debriefing through video-chat till the data collection is finalised.

3.4.1.3 Confirmability: This is the process of verification or cross validation information gathered in research (Kyngäs et al., 2020). Member checking occurred with the participants after each data transcription. In addition, the supervisor received the transcriptions to co-code and check the researcher's data analysis process and themes identified.

3.4.1.4 Dependability: This is the level of appropriateness and reliability of the research process (Speziale et al., 2011). The interview was conducted in English or Youruba as preffered by the participants. English is a widely used official language in Nigeria while Yoruba is the central local dialect in Southwest Nigeria. There was back-to-back translation of the interviews conducted in Yoruba by the research. These (language choice and translation method) preserved the richness of data and allowed the participants to express themselves freely in the language of their choice. The interviews were audio-recorded to avoid the researcher's misinterpretation of the participants' words. The researcher documented all transcriptions of the interview into hard copies.

3.4.1.5 Transferability: This is the extent to which a study can be replicated in another setting (Speziale et al. 2011). To enable readers from other contexts to decide if the study findings are suitable for them to adopt in their own setting, the researcher ensured a detailed expression of all the stages of the study, which included all research process stages without

exempting accomplishments and limitations encountered at any level of the research execution or data collection (Speziale et al., 2011).

3.5 ETHICAL CONSIDERATIONS

Ethical procedures in research start with the researcher's plan being reviewed by the IRB of a University to ensure the enforcement of federal regulations that protect research participants (Creswell, 2012). Therefore, the following ethical procedures and considerations guided this research:

3.5.1 Review: Conducted by the Department of Nursing Education, School of Therapeutic Sciences, Faculty of Health Sciences Postgraduate Committee, University of the Witwatersrand. Permission (Annexure K, L) and Ethical Clearance were sought from Wits Human Research Ethics Committee. The Ethics Committee of the two tertiary health institutions. The first institution, Aro, ethics approval covers affliated institutions. The research therefore needed not apply for separate ethics from Aro primary health centres but permission to collect data was obtained from the unit heads (Annexure L).

3.5.2 Beneficence: Beneficence was promoted in this study, as there were no physical risks. Being a vulnerable population, there was protection of the clients' rights by strictly adhering to the inquiry of this study. The inclusion criteria also considered clients' vulnerability when determining those eligible to participate, part of which was clinical stability of 3 months, the evidence of which was confirmed through the follow-up report. Excluded were clients with co-morbidities with an affective disorder that increases the tendency of emotional breakdown to minimise the emotional risk. This study posed no harm, although recounting experiences can bring about emotional reaction in clients despite the consideration of that for exclusion. In the event of this, the researcher, prior to commencement of the research, liaised with the psychology unit of the hospital to enable any clients who experienced emotional break down during the data collection to be referred at the researcher's cost. This is because clients pay for this service, and the section would be discontinued with the client (Annexure G); fortunately, no client had an emotional breakdown throughout the period of the study.

3.5.3 Respect for human dignity: To ensure respect for human dignity, the researcher provided all the information to help the participants make an informed consent, and advised that participation in the study was voluntary and that they could withdraw anytime they chose.

3.5.4 Confidentiality and anonymity: Codes represented participants' identities and the name of the hospital, and only the researcher and the supervisor could trace participants; the use of these codes was during transcription and publications from this research.

3.6 SUMMARY

This chapter shows the details of how this study was conducted using multi-methods, which included scoping review, interviews, triangulation of interviews, reviews and development of practice guide for rehabilitation of individuals with mental illness in Southwest Nigeria.

3.7 CONCLUSION

This chapter concludes that the adherence to the phase-by-phase execution of the methodology helped in the conduction of the study and achievement of the set goals.
The chapter precedes the scoping review chapter of this study.

PHASE ONE

CHAPTER FOUR: SCOPING REVIEW

Foreword: The review protocol of this study has been published in the systematic review (BMC). Oyelade, O.O. and Nkosi-Mafutha, N.G. (2022) Psychosocial Rehabilitation of individuals with schizophrenia: A scoping review protocol. Systematic Reviews (BMC). 00, 1-9.DOI: https://DOI: 10.1186/s13643-022-01901-y (Annexure R)

The previous Chapter presented the research methods of the study in detail, this Chapter presents phase one of the study, the scoping review.

4.1 INTRODUCTION

This scoping review aimed to examine the literature on the conducting of rehabilitation for people living with schizophrenia in Sub-Sahara Africa. It is vital to be able to assess the existing programmes for possible replication in other settings in Sub-Saharan Africa, given the fact, there are no existing protocols that guide the practice of rehabilitation of people living with schizophrenia in Sub-Saharan Africa. A scoping review is a suitable strategy to achieve this aim because of its explicit description as "the process of mapping the existing literature or scientific evidence (Armstrong et al., 2011).

4.2 DESIGN AND METHODS

The PRISMA review framework for the conduction of reviews, as explained by PRISMA (2018), guided the methodology of this study as described under scoping review design and methods in chapter 3.

4.3 SETTING THE RESEARCH QUESTION

The underpinning of the review is the question; what work has been done in terms of the rehabilitation of people living with schizophrenia in Sub-Saharan Africa?

4.3.1 Eligibility of the research question

The study Population Concept and Context (PCC) by Arksey and O'Malley (2005), as adopted in Table 4.1, determined the eligibility of the research question.

Table 4.1: PCC framework

Criteria	Determinants		
	Main concept	**Alternate keywords**	**Subject headings**
Population	Schizophrenia (Individuals with schizophrenic disorders)	Chronic mental illness OR chronic psychiatric illness OR chronic insanity OR chronic mental disorder OR dementia praecox OR Schizophrenic psychosis OR schizophrenic disorder OR schizophreniform disorder OR schizoaffective disorder	Individuals with schizophrenic disorders
Concept	Rehabilitation	Productivity OR re-integration OR reformation OR rehabilitation OR recovery functioning OR halfway housing OR re-establishment OR occupational skills OR vocational skills OR independent living skills OR reclamation OR improvement	Psychosocial rehabilitation
Context	Sub-Saharan Africa	Sahara Africa OR Black Africa OR Southern Africa OR Africa OR south of the Sahara OR Africa OR developing countries OR low economies countries OR third world countries OR Low-income countries	Africa
	Sub-Saharan African Countries	Angola, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Comoros, Congo, Dem. Rep., Congo, Rep., Cote d'Ivoire, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, South Sudan, Sudan, Tanzania, Togo, Uganda, Zambia, Zimbabwe	Sub-Saharan Africa

4.4 IDENTIFICATION OF THE RELEVANT STUDIES

This was discussed under search strategy in chapter 3.

4.5 SELECTION OF STUDY

The eligibility criteria (Inclusion and Exclusion) are described in chapter 3.

4.6 SEARCH STRATEGY

The search strategy for this review was in three phases

4.6.1 Phase 1: This phase occurred at the protocol development stage as pilot testing. Table 4.3 indicates the search terms piloted to ascertain their appropriateness.

Table 4.2: Piloted database search results

Date of search	Keywords	Database	Publication retrieved	Link	Search terms
11 July 2018	Schizophrenia AND Rehabilitation AND Sub-Sahara	PubMed	640	https://pubmed.ncbi.nlm.nih.gov/?term=long query2ebce740c3d8f7d790ea&filter=dates.2000-2018	(Schizophrenia OR "chronic mental illness" OR "chronic psychiatric illness" OR "chronic insanity" OR "chronic mental disorder" OR "Schizophrenic disorders" OR "dementia praecox" OR "Schizophrenic psychosis" OR "schizophreniform disorder" OR " schizoaffective disorder") AND (rehabilitation OR productivity OR re-integration OR reformation OR rehabilitation OR "recovery functioning" OR "halfway housing" OR re-establishment OR "occupational skills" OR "vocational skills" OR "independent living skills" OR reclamation OR improvement) AND ("Sub-Sahara Africa" OR "Black Africa" OR "southern Africa" OR "Sahara Africa" OR Africa OR "south of the Sahara" OR "developing countries" OR "low economies countries" OR "third world countries" OR "low income countries" OR Angola* OR Benin* OR Botswana* OR "Burkina Faso*" OR Burundi* OR "Cabo Verde*" OR Cameroon* OR "Central African Republic*" OR Chad* OR Comoros* OR Congo * OR "Democratic Republic of Congo*" OR "Republic of Cote d'Ivoire*" OR "Equatorial Guinea*" OR Eritrea* OR Swaziland* OR Ethiopia * OR Gabon * OR Gambia * OR Ghana* OR Guinea* OR "Guinea-Bissau *" OR Kenya * OR Lesotho* OR Liberia* OR Madagascar* OR Malawi * OR Mali* OR Mauritania* OR Mauritius* OR Mozambique* OR Namibia * OR Niger* OR Nigeria* OR Rwanda* OR "Sao Tome and Principe*" OR Senegal*OR Seychelles* OR "Sierra Leone*" OR Somalia* OR "South Africa*" OR "South Sudan*" OR Sudan* OR Tanzania* OR Togo* OR Uganda* OR Zambia* OR Zimbabwe*)

4.6.2 Phase 2: This involved the title screening of the articles from each database. Table 4.3 displays the slotting of the keywords into each database without modification for consistency of search terms. The principal investigator assessed the titles of the resultant pool of articles one by one. After selecting the title with the population (schizophrenia) and concept (Rehabilitation) of the stud, it went into the new EndNote library, created solely for the review, for a definite record of screening without a mix of articles from other write-ups. Table 4.3 documents the record of title screening, while the entire search strategy followed a systematic process of PRISMA Flow-chart, as indicated in Figure 4.8.

Table 4:3: Electronic record of title screening

22-07-2018	PubMed	Schizophrenia AND Rehabilitation AND Sub-Saharan Africa	640	56	**133References Retained**
23-07-2018	ProQuest	Schizophrenia and Rehabilitation AND Sub-Saharan Africa	5,534	22	
24-07-2018	PSYC INFO (Psychological Information)	Schizophrenia and Rehabilitation AND Sub-Saharan Africa	2,273	150	
25-07-2018	Scopus	Schizophrenia and Rehabilitation AND Sub-Saharan Africa	1625	3	
26-07-2018	SABINET	Schizophrenia and Rehabilitation AND Sub-Saharan Africa	359	2	
27-07-2018	EBSCO Host	Schizophrenia and Rehabilitation AND Sub-sahara Africa	5,300	9	
	Total		15,731	242	
SORTING (BY ENDNOTE DIRECT)					
	TOTAL ARTICLES	=	242		
	DUPLICATES	=	109		
	NET TOTAL		133		

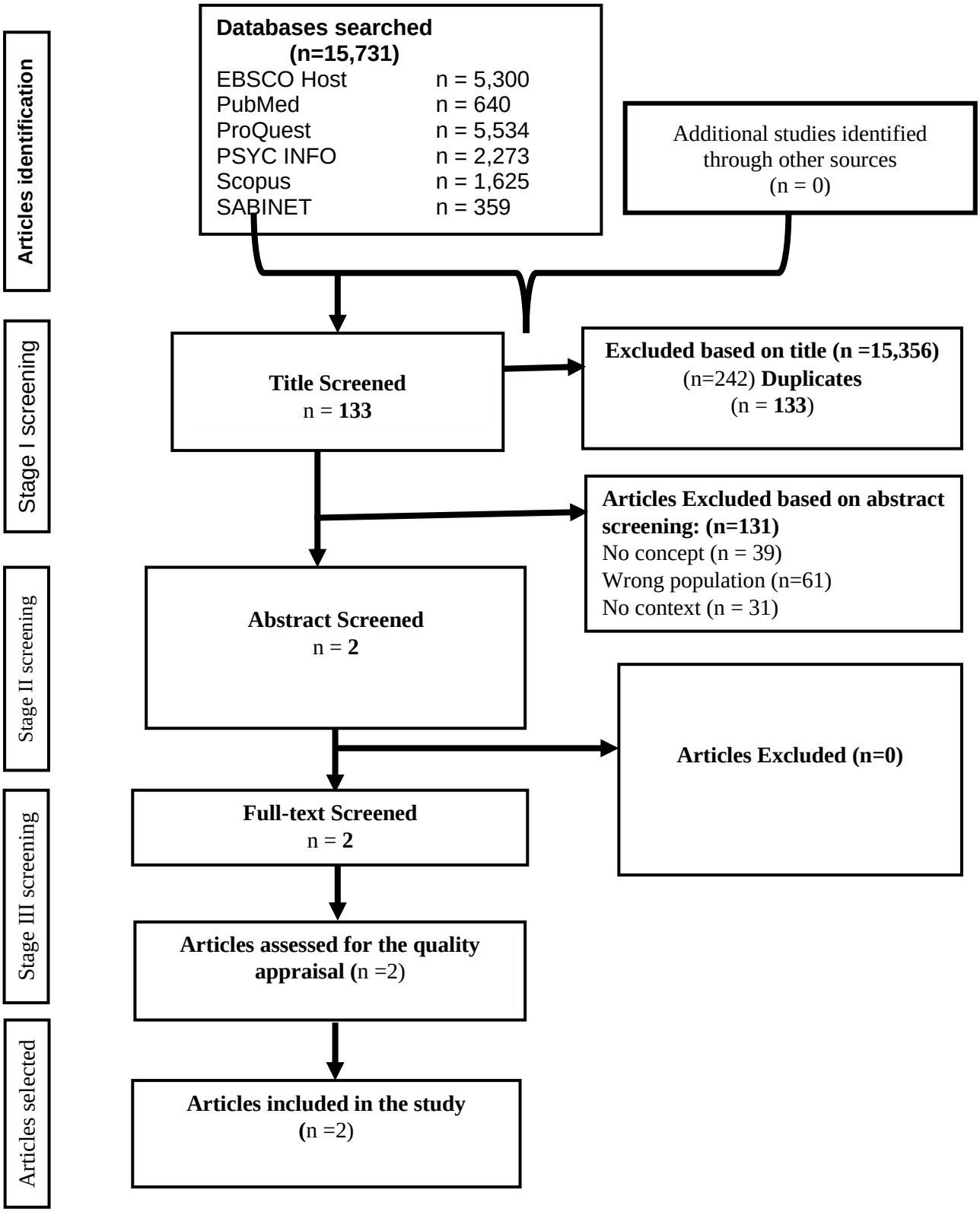

Figure 4.1: PRISMA FLOW

4.6.3 Phase 3: This involves abstract and full article screening. Two screeners undertook the abstract and full-text screening screeners (the principal investigator and a co-screener, M.A). The two reviewers conducted an independent screening of the abstract and the full text and compared the result. The new Endnote library, generated by the principal investigator during title screening, was shared with the co-reviewer for co-screening. The belief was there would be a resolving of discrepancies between the two screeners by a critical assessment of the differences for resolution, but for the abstract screening, there were no discrepancies. There was a small discrepancy in full article screening due to differences in the interpretation of a screening question. The two screeners agreed to retain the discrepancy as it was and calculated the level of agreement. KAPPA statistics assessed the level of agreement of the full article screening between the two screeners, as featured in Table 4.8.3.

TABLE 4.6.3: KAPPA STATISTICS

<table>
<tr><th>Author Name and date</th><td>Question 1</td><td>Question 2</td><td>Question 3</td><td>Question 4</td><th>Total</th></tr>
<tr><td>Article A (Asher et al., 2018)
Reviewer 1(O.O)+Positive</td><td>1</td><td>7</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>Reviewer 1(O.O)
-Negative</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Reviewer 2(M.A)+Positive</td><td>1</td><td>7</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>Reviewer
2(M.A)-Negative</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Article B (Brooke-sumner et al., 2017)
Reviewer 1(O.O) +Positive</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Reviewer1(O.O) -Negative</td><td>1</td><td>7</td><td>1</td><td>1</td><td>10</td></tr>
<tr><td>Reviewer 2(M.A)+Positive</td><td>0</td><td>1</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>Reviewer 2(M.A)- Negative</td><td>1</td><td>6</td><td>1</td><td>1</td><td>9</td></tr>
<tr><td colspan="6">KAPPA Calculation step table and result</td></tr>
<tr><td>P_o</td><td colspan="2">Pe</td><td colspan="3">KAPPA (K)
LEVEL OF AGREEMENT</td></tr>
<tr><td></td><td>Positive Response</td><td>Negative Response</td><td colspan="3"></td></tr>
<tr><td>Aggrement= 4+5 (the other settings) =9 in percentage =90%

Negative from O.O=10
Negative from M.A=9</td><td>Positive answer of Reviewer O.O=0/100=0
Positive answer of Reviewer M.A=1/100=0.01
Multiplication of the two =0</td><td>The Negative answer of Reviewer O.O=10/100=0.1
The Negative answer of Reviewer M.A=9/100=0.09
Multiply the two=0.009</td><td colspan="3">KAPPA (K)=Po-Pe÷1-Pe

=0.9-0.009=0.891
0.891÷1=0.891
0.891-0.009=0.882 (Almost perfect agreement)
Based on the KAPPA Agreement scale, there is almost perfect agreement.</td></tr>
<tr><td>P_o =90(%)</td><td colspan="2">Pe = 0+0.009= 0.009</td><td colspan="3">K=0.882</td></tr>
</table>

4.7 RESULTS

The databases generated 15,731 articles from search terms Rehabilitation AND Schizophrenia. The inclusion of limit setting (by excluding, articles earlier than the year 2000 and later than 2021, studies conducted outside Sub-Saharan Africa, case illustrations) reduced it to 375 articles. Two hundred and forth two (242) out of 375 articles were duplicates in other databases, leaving 133. One hundred and thirty-one (131) out of the 133 articles had no context, Sub-Saharan Africa, leaving two articles eligible for full article screening. Out of the two articles and fit the data extraction criteria in the study, as displayed in Figure 4.1.

4.7.1 Charting of data

The data charting form, as indicated in Table 4.4, assessed the basic information in each of the articles, while the content displayed is the details of the article eligible for this study.

Table 4.4: Data charting form

ARTICLE A	
Author and date of publication	Asher, L., Hanlon, C., Birhane, R., Habtamu, A., Eaton, J., Weiss, H. A., ... & De Silva, M. (2018)
Title of the study	Community-based rehabilitation intervention for people with schizophrenia in Ethiopia (RISE): a 12-month mixed-methods pilot study. *BMC Psychiatry*, *18*(1), 250
The aim of the study	Assessment of the most suitable and acceptable strategies of rehabilitation of an individual with schizophrenia
Country of the study/Location	Ethiopia (Sodo district)
Method/Methodology/Study design	Mixed-method
Population	Individuals with schizophrenia, Family, Rehabilitation facilitators, supervisors, Community leaders
Research question/objective	Testing the acceptability and the suitable of the rehabilitation programme
Study setting/context	Community
Data collection methods	The questionnaire, interview, focus group discussion
Study limitation/challenges	Study impact measurement was considered not feasible, but a mixed-method approach increased the generalisability
Study outcome/result	The effectiveness of rehabilitation is vested in the collaborative effort of family and community
ARTICLE B	
Author and date of publication	Brooke-Sumner, C., Lund, C., Selohilwe, O., & Petersen, I. (2017).
Title of the study	Community-based psychosocial rehabilitation for schizophrenia service users in the north west province of South Africa: a formative study. *Social Work in Mental Health*, *15*(3), 249-283.
The aim of the study	The aim of the study was to develop programme manual for the rehabilitation of individuals with mental illness
Country of the study/Location	South Africa
Method/Methodology/Study design	Qualitative design/Indept interview
Population	Volunteered facilitators from the community and auxiliary social workers
Research question/objective	Task approcaches and challenges of rehabilitation
Study setting/context	A selected community in South Africa
Data collection methods	Indept interviews
Study limitation/challenges	Limited in scope(a community in south Africa)
Study outcome/result	The study showed the advantages of rehabilitation of individuals with mental illness

4.8 COLLATION, SUMMARY GENERATION, AND REPORT WRITING

The article screened for study inclusion was collated in NVIVO. The content analysis approach analysed the article in the NVIVO. There are thematic derivations from the categories of meaning units in the article. The study analysis revealed three themes: Satisfactions from rehabilitation, Expectations from rehabilitation, Context-specific request resolution for

rehabilitation. The themes derivation evolved from the meaning units in each category; this guides the discussion and informs the conclusion and recommendations of this review.

4.9 QUALITY APPRAISAL

The Mixed Method Appraisal Tool (MMAT) version 2018 assessed the quality of the articles. The tool serves as a scientific assessment instrument for checking the rigour of the qualitative methodologies, the validity of the quantitative instrument, suitability of the methodology, and the appropriateness of the mixed method approaches. The principal investigator and a co-screener (W.M,) used the tool to assess the designs, data collection methods, analytical approaches, and its suitability. The reviewers independently scored the article with MMAT and arrived at a score of 26 and 20 respectively. Both reviewers' scores fell within the range of high quality, which affirms the high quality of the study as displayed in Table 4.5. The principal investigator and a co-screener (M.A.) calculated the article for suitability for the review and achieved a high agreement level of K0.882, as displayed in Table 4.5.

TABLE 4.5: MMAT (QUALITY ASSESSMENT)

S/N	Section	Number of questions	Marks per section	Grading style	Marks obtained in the result of Reviewer 1(0.0)	Marks obtained in the result of Reviewer 2(W.M)
1	Section one (All types)	2	2	Yes=1	2	**2**
2	Section two (Qualitative)	5	5	No=0	5	**5**
3	Section Three (Quantitative randomized control trial)	5	5	Can't tell =0	4	**1**
4	Section Four (Quantitative non-randomised)	5	5	**Grade** 0-9 = Low quality	5	**3**
5	Section Five (Quantitative descriptive)	5	5	10-18 = Medium quality	5	**4**
6	Section Six (Mixed methods)	5	5	19-27 = High quality	5	**5**
7	**Total**	**27**	**27**		**26**	**20**

4.10 DISCUSSION

The discussion focuses on the findings of the review itself and the themes generated from the selected article. Findings from this review show there were only two available articles on rehabilitation of individuals with schizophrenia, out of the 39 countries that make up Sub-Saharan Africa, generated from a district in South Africa and Ethiopia. (Though Botswana was declared to have a guide, no evidence of rehabilitation was found in our search). Of note, these

two articles appeared in 2017 and 2018, which reveals that before 2018, there was possibly no evidence of rehabilitation for individuals with schizophrenia, in any Sub-Saharan African country. This finding is in congruence with the justification of the World Psychosocial Association for registering only two African countries in Southern Africa as embracing psychosocial rehabilitation (WAPR, 2012). This also supports the declaration that PSR is an approach just acquiring recognition in Africa (Ned et al., 2017). This is unlike the occurrence in the western world, were 96.99% (129 out of 133) of the articles initially generated in this review came from, with study year cutting across the year limit of the review search (2000-2018). This shows research on the rehabilitation of individuals with schizophrenia has a long-standing inquiry report, with a continuous update on recent studies in the western world.

Conversely, Sub-Saharan Africa may appear behind and maybe incomparable with other parts of the world when comparing the level of engagement with the rehabilitation of schizophrenia. However, the article that emanated from Sub-Saharan Africa shows a promising future as far as rehabilitation of individuals with schizophrenia is concerned. The quality of the studies from South Africa and Ethiopia is a good reference point for other researchers in settings within Sub-Saharan Africa, and the rest of the world, where the research is replicable. Asher and his colleagues conducted the study in a region called Sodo in Ethiopia. These researchers trained volunteers in the community to serve as rehabilitation facilitators while they served as supervisors. Likewise, Brooke-summer in South Africa. The work of the facilitators was to moderate rehabilitation, while the supervisors received feedback from them. The only selection criteria for inclusion in rehabilitation was for the individual to be diagnosed of schizophrenia, while exclusion criteria were lack of consent from individuals with schizophrenia and families, or the decision to discontinue participation. The difference between Asher and Brooke-Summer's work is the development of training manual by Brooke-Summer. However, in both studies, community members, family members, and stakeholders were involved through individual contact and mobilisation. Individuals with schizophrenia had the opportunity of goal setting and assisted in making an informed decision. There was some basic life support provided, such as housing and a small grant for business. There were similar things in the two studies by with areas of differences. Themes generated form Asher et al., (2018) and Brooke-sumner et al., 2017 were satisfaction from rehabilitation, expectation from rehabilitation, and context-specific request for rehabilitation, as discussed below.

4.10.1 Satisfaction from rehabilitation: The facilitators expressed their excitement about the opportunity to relate with individuals living with schizophrenia because it reduced their bias about their potential to harm (Asher et al., 2017; Brooke-summer et al., 2018). The training received by the facilitators also helped them to recognise signs of relapse, and people living with schizophrenia who exhibit signs of relapse received a referral to clinics or follow-up (Asher et al., 2017; Brooke-summer et al., 2018). This was a more effective way of management as

it helped to institute timely intervention according to the HCPs (Asher et al., 2017); the HCPs also found this effective in reducing the need for hospitalisation and its frequency, which reduced job burnout among HCPs (Asher et al., 2017). The willingness of HCPs in Brooke-summer et al., (2017) findings contradicts the findings of the study in Asher et al., (2018), where the HCPs felt threatened by the training of non-skilled personnel and were unwilling to collaborate with them. Practitioners in Asher et al., (2018) also found in challenging that clients dictate their preferences.

Asher et al., (2018) and Brooke-summer et al., (2017) findings further reveal that, incorporation of the community members and leaders was to assist with mobilisation. The leaders expressed their excitement about the improvement of individuals with schizophrenia in their community (Asher et al., 2018; Brooke-summer et al., 2017), and offered some of the grants for starting a small business (Asher et al., 2018). The family members of individuals living with schizophrenia expressed excitement about having someone talk to their relative and make them understand the situation better (Asher et al., 2018; Brooke-summer et al., 2017). People living with schizophrenia expressed a feeling of freedom in working and moving without strict control, which restored a sense of being a normal human being (Asher et al., 2018; Brooke-summer et al., 2017). This is consistent with the findings that rehabilitation can reduce the burden and stigma of schizophrenia (Lucksted et al., 2016).

4.10.2 Expectations from rehabilitation: The facilitators expressed a desire to have a support system for personal safety during a home visit and in case of violence (Asher et al., 2018). This is consistent with the recommendation of Parker and colleagues, who suggested support teams for facilitators during therapy (Parker et al., 2017). There was also a request for training of (community) region-based facilitators due to constraints with reaching those people living with schizophrenia, who lived far from the facilitators, and who were sometimes unreachable via telephone due to network problems (Asher et al., 2018). People living with schizophrenia expressed their displeasure with facilitators and their emphasis on the use of too much medication; this aligns with facilitators' complaints that people living with schizophrenia sometimes neglect their counsel, which necessitated re-training of facilitators by the supervisors (Asher et al., 2018). The decision to retrain facilitators was a vital step since rehabilitation does not allow dictatorship, but rather assists individuals in making informed decisions (Lim et al., 2017). People living with schizophrenia believe the rehabilitation approach to be too monotonous and volatile and expressed a desire for various jotters or pamphlets of programmes (Asher et al., 2018). There are different concerns about the venue of rehabilitation, some consider the home visit appropriate, while others found it stigmatising (Asher et al., 2018). Visiting the workplace was stimulating for some, while others found it disturbing (Asher et al., 2018). This is consistent with the findings of Brooke-Sumner et al.,

(2017), where the venue was a significant challenge. However, rehabilitation does not require a formal site, it is best suited in neutral areas where there can be freedom of participation without fear or prejudice (McKay et al., 2018).

There is also disappointment about the lack of financial support for all the people living with schizophrenia (Asher et al., 2018). This is consistent with the findings of Uribe-Restrepo that evidenced-based rehabilitation tends to place context-based demands on facilitators, such as shelter and financial aid, depending on the needs of the people living with schizophrenia (Uribe-Restrepo, 2017). Contrastingly, Parker and colleagues believe proper enlightenment of family and clients on the scope of rehabilitation will reduce the burden of demands on facilitators (Parker et al., 2017).

4.10.3 Context-specific request for rehabilitation: The supervisors in the study adopted different strategies to find a possible solution to the complaints and expectations of participants. The introduction of various approaches to rehabilitation, such as film shows, group discussions, and quizzes, was to resolve the challenges of boredom (Asher et al., 2018). Mobilisation of support systems, such as medication waivers and a business loan, were available for individuals living with schizophrenia (Asher et al., 2018). Training on occupational skills and entrepreneurial activities, advocacy for employment for minimal labour or household support were helpful as empowerment strategies (Asher et al., 2018). Achieving a housing system and basic need support for vagrant individuals was with the support of community members and stakeholders (Asher et al., 2018). Brooke-sumner et al., (2018) advocates for increased family involvement with the report that some families exhibit non-challant attitude towards the rehabilitation of their relatives with mental illness). Brooke-sumner et al., (2018) also report challenges of poor integration of mental health care into primary health care, with explaination that clients who are properly rehabilitated had challeneges continuous medical care (prescribed medications) at the community.

4.11 LIMITATION

This study is a traditional scoping review and focused only on peer-reviewed articles. It is possible that there were some research articles on PSR in African countries done in the last 18years (2000-2018), but not published or disseminated in any form.

4.12 RECOMMENDATION

This study recommends the utilisation of the available resources for the implementation of rehabilitation in Sub-Saharan Africa. Also vital, is the development of a contextual protocol for the conduction of the programme and training of the staff for effective conduction of the programme.

4.13 SUMMARY

Restoration of a meaningful life through rehabilitation is evidence-based in reducing the burden and stigma of schizophrenia. The report of the evidence on the rehabilitation of schizophrenia emanates from western countries, where rehabilitation is embraced and practised. Rehabilitation has the potential to minimise the consequences of the diagnosis of schizophrenia in individuals, and bring about a positive impact for Sub-Saharan Africa, especially it's economy. However, there seems to be a dearth of literature regarding the rehabilitation of individuals with schizophrenia in Sub-Saharan Africa. It is therefore imperative to review the resources from Sub-Saharan Africa for situational analysis, appraisal, recommendation, and possibly adaptation by settings that are without rehabilitation programmes for individuals with schizophrenia. Arsey and O'Malley's scoping review framework guided the article search and compilation in this review. Articles included passed through three stages of screening, title, abstract and full article screening. The principal investigator alone conducted the title screening, while the principal investigator and a co-screener conducted the abstract and article screening.

The Mixed Method Appraisal tool assessed the quality of the articles, while KAPPA statistics assessed the level of agreement between the article screeners. Both reviewers used a data charting form for screening, while the Endnote library tracked screening records. The content analysis of the screened articles used NVIVO.

There were two articles found on the rehabilitation of people living with schizophrenia from Sub-Saharan Africa. The Mixed Method Appraisal Tool (MMAT) calculation showed the articles quality was high and the KAPPA statistics showed an almost perfect level of agreement between the screeners. The articles show that rehabilitation has a high potential to reduce stigma and increase social desirability for individuals living with schizophrenia in Sub-Saharan Africa. Rehabilitation also has the potential to reduce the burden of care on HCPs, caregivers, families, society, and the burden of financial assistance. Moreover, it boosts the self-morale of individuals living with schizophrenia.

Schizophrenia is a chronic mental illness, and the most stigmatised, however, strategies for rehabilitation have a high potential to improve the standard of living of individuals living with the illness because the negative symptoms that do not respond to medication respond to rehabilitation.

4.14 CONCLUSION

The discussion of the rehabilitation of individuals living with schizophrenia, the constraints in this study, and the contextual strategies for resolution of constraints provided answers to the first, second, and sixth objective of the study, which was to identify the trends, outcomes, and

challenges of rehabilitation; this is also considered vital for other studies that will emanate from Sub-Saharan Africa for possible adoption. These studies showed that Sub-Saharan Africans share the same belief with the WHO declaration on the effectiveness of PSR and follow the recommended global standard; this answered the third objective on the methodology of rehabilitation. These studies also established the fact there are a shortage of community (human and structural) resources for effective conduction of PSR in Sub-Saharan Africa. This may not be a grievous challenge, as the WHO (2018) recommends PSR in a natural setting and not necessarily in a structure, however, the contextual peculiarity of the Sub-Saharan African environment and weather may necessitate this, and this serves as an answer to objective five on main findings. The fact that two articles were found in Sub-Saharan Africa and discussed in this study is an answer to objective four on research output in Sub-Saharan Africa. The conclusion is therefore that further context-specific studies on rehabilitation are required in Sub-Saharan Africa.The review in this study revealed much still needs doing about rehabilitation in African settings, specifically Sub-Saharan Africa. This chapter is Phase One of the study, Phase Two follows in Chapter Five.

PHASE TWO

CHAPTER FIVE- CLIENTS INTERVIEW DATA PRESENTATION

Foreword: The findings in this section (interviews with clients) have been published with Health Expectation (Wiley). Oyelade, O. O., & Nkosi-Mafutha, N. G. (2021). Living Beyond the limitation: Rehabilitation, life and productivity of individuals with schizophrenia in Southwest Nigeria. *Health Expectations. 24(2)*:198-208. https://doi.org/10.1111/hex.13139(Annexure P).

5.1 INTRODUCTION

The previous chapter was the scoping review section. Chapter Five responds to objective 3 of the study and presents the clients' demographic data, the processes of data analysis, and the interpretation of the analysed data at the two research facilities where the data was collected. There were 29 mental health service users interviewed, and Table 5.1 presents the demographic description of these participants.

Table 5.1: Description of clients' characteristics

S/N	Unit	Age	Gender	Diagnosis	Y O E	YOER
1	Psychogeriatric	60	F	Schizophrenia	18	18
2	Psychogeriatric	61	F	Schizophrenia	20	20
3	Psychogeriatric	73	F	Schizophrenia	40	2
4	Psychogeriatric	59	F	Schizophrenia	20	5
5	Psychogeriatric	70	F	Schizophrenia	50	20
6	Psychogeriatric	60	F	Schizophrenia	10	6
7	Rehabilitation	64	M	Schizophrenia	24	10
8	Rehabilitation	69	M	Schizophrenia	15	10
9	Rehabilitation	64	M	Schizophrenia	12	9
10	Rehabilitation	50	M	Schizophrenia	10	10
11.	Rehabilitation	70	M	Paranoid Schizophrenia (PS)	35	30
12	Rehabilitation	71	M	PS	42	41
13	Hope Villa	63	M	PS	15	19
14	Hope villa	64	F	Schizophrenia	30	4
15	Rehabilitation	43	F	Schizophrenia	15	5
16	Rehabilitation	22	F	Schizophrenia	6	6
17	Occupational Therapy(OT)	48	F	Schizophrenia	20	20
18	OT	60	M	Schizophrenia	20	15
19	OT	59	F	Schizophrenia	30	29
20	OT	35	M	Schizophrenia	32	32
21	OT	34	M	Schizophrenia	22	22
22	OT	57	M	Schizophrenia	40	37
23	OT	42	M	Schizophrenia	10	2
24	OT	37	M	Schizophrenia	32	32
25	OT	35	M	Schizophrenia	10	9
26	OT	61	M	Schizophrenia	22	10
27	General outpatient (G.O)	56	F	Schizophrenia	10	7
28	G.O	27	M	Schizophrenia	5	2
29	Primary health centre	28	M	Schizo-affective disorder	15	1

Key: YOE is Years of experience with schizophrenia

YOER is Years of experience with rehabilitation

Table 5.1 presents an overview of the participants' demographics, which reveals there were 17 males and 12 females, which is consistent with the fact that more men are living with schizophrenia than women, as declared by Lim (2017). This is also consistent with the declaration of Seeman (2018) in a review study, which discovered schizophrenia is more common in men than in women because male and female DNA has exposure to different environmental input that differentiates the level of predisposition to schizophrenia. In summary, participants' average length of experience of living with schizophrenia in this setting is 15 years, (me_t/n) n=total number of mental health service users, experience in years. Table 5.2 depicts the themes and the categories of the findings. To ensure anonymity, there are code numbers used when presenting direct quotes from participants.

It is worthy of note that the facilities run different outpatient's units, some of which are residential for individuals who are rejected by family and community but work, pay for the accomodation and fend for themselves from their renumeration. The is what unit refers to.

Further details on units and population is described in chapter three under unit **3.3.2.2 Population for the descriptive qualitative inquiry**

5.2 DERIVATION OF THEMES

Table 5.2: Presentation of themes and corresponding categories of clients' interview

Theme	Category
Self-perception	· Worthlessness/acceptance of fate · Lack of insight/the wrong diagnosis · Hopeful/ changes
Expectation	· Re-integration into communal and social life · Rehabilitation to the previous functioning · Preferred skills
Barriers to rehabilitation	· Physical barrier · Psychological barrier · Social barrier
Rehabilitation interventions/ Outcomes	· Self-mastery cum Independence · Dependent · Alternative therapy

As displayed in Table 5.2, the data yielded four themes and 12 categories.

5.2.1 Theme 1: Self-perception

The theme of self-perception arose from the participants' self-description and consisted of three categories, worthlessness/ acceptance of fate, hopeful/ change, and lack of insight/ the wrong diagnosis.

5.2.1.1 Worthlessness/ acceptance of fate

The researcher during data collection observed that some of the participants had a feeling of worthlessness:

> *C4Ag* shook her head, hissed, and said……. – *"I cannot even do anything, not even clean the house, just there sitting down. When I try to wash the toilet, I will see many things that made me sick; I see different things."*

> C*3Ar* expressed the feeling she is not accepted with a gesture of displeasure and the way she opened her hands, as if she wanted to throw something away and said…… - *"My mother does not want me again…Nobody asks me. They abandoned me……they got rid of me."*

> *C2L* seemed to think that the feeling of worthlessness disappeared due to his ability to do something with his life, *"It has been difficult passing through this road. I have an idea, but staying at home and doing nothing, taking medication, eating, sleeping and all that" …. "Right now, I am in order, doing well, now at the Occupational therapy unit, I am into knitting, so as I progress further…. I no longer feel idle as I used to feel before I started coming here."*

Acceptance of fate is another category under self perception: Participant expressed acceptance of their condition on the premise that they have no alternative or choice.

A participant node her head as she said:

> I have to accept this condition, If I do not, what can I do……..I have no choice (C*3Ar)*.

Another participant recounted as she expressed herself with a retorical question as thus;

> What can one do in a situation you find yourself and feel helpless?, no choice than to accept the condition(C7Av)

5.2.1.2 Lack of insight/ the wrong diagnosis

Some participants felt their self-perception was a product of how others viewed them, which also made them deny their illness and perceive themselves to be a victim of how people perceived them before they received treatment.

> *C11Ar* looked away as he said – *"They said we are sick and want us to believe that we are sick, so we are here now receiving treatment because they said we are sick."*
> "*I was at my duty post when the co-workers took me to a health centre and it is the nurses at the health centre that brought me here. They said I am sick. My family came for a while, and later they stopped coming."*

C1Av believes he has an incorrect diagnosis and said with a tone of firmness – *"I have malaria, not a mental illness."* This client further explained*; "I was referred from a private hospital, where I was diagnosed with malaria, the first time I came, the referral letter was sealed and what I was told is where I was referred to and that I should never open the letter but give it to the health providers there, they told me I would be better managed."*

Sharing in the same belief of the wrong diagnosis*, C10Ar said…- "I have a problem of bird heart." He continued saying "I have a problem with the heart; I told you my heart is like that of a bird."*

5.2.1.3 Hopeful/change

Amid the uncertainty, some participants experienced hope and change. Hope is conceptualised in terms of expectation for signifiacnt improvement in their productive life while change is described as actual improvements experienced and not mere expectation. The description of participants depicting hope/change is as follows;

A participant expressed how the illness affected his schooling but inspite of that he further explained how he overcame idleness as thus-

> *"When I was diagnosed with this illness, I had to stop school and had to stay at home doing nothing … not being active is worse than the illness. I felt like dying then … but with this rehabilitation that I am undergoing, I am now in order, doing well, now at OT. I am into knitting, so as I progress further … I no longer feel idle, and I know I will be well settled after completing the training."* (C2L)

Another said; particiapnt talked about how his nature change from being timid to be outspoken from rehabilitation experience as follows;

> *"I have been gaining a lot because I am an introvert. So, I don't relate because I don't talk that much, but since I came in now, I have been able to come out of that attitude of being an introvert … I talk to people and relate well. No longer shy. I know I will go back fully to my work when I am very okay and can relate very well."* (C8L)

5.2.2 Theme 2: Expectations

The expectations of participants are what they wished to do with their life. This theme consists of three categories: Reintegration to communal and social life, Rehabilitation to the previous functioning, and Preferred skills.

5.2.2.1 Re-integration to communal and social life

The participants described Rehabilitation to communal and social life accordingly.

In the bid to rehabilitate C1Av, who is one of the participants who reside in the hospital's private lodge, Hope Villa, the hospital employed him as a cleaner, and he sold recharge cards. However, he said he feels like he is in bondage, confined to the hospital due to neglect by family. He has a passion for singing but lacks opportunities, *"Music is the only other thing I could think of, I like singing, and I loved to go to the studio and record the songs I have composed, but I have nobody to help me. I also sing in church. I have composed many songs, but nobody has helped me."*

When asked to sing, participant C1Av sang one of his tracks titled; There are many people in bondage. He sang so beautifully that the researcher, during the data collection, had to be aware of her emotions and only just managed not to cry. The song was so melodious, emotion-provoking, and educative. He spoke about his experiences and life history succinctly and appealingly. An excerpt from his song goes thus:

> *"There are many people in the bondage……....they never wish to be in bondage, many see them afar and judge them…...not knowing that they have their story……...*
> *Each individual has a story……. You can only know if you ask them or care to know…...*
> *Their story may not be known if you do not ask……*
> *They never also want to be in bondage……. They have a story to tell but ask them.*
> *Do not just judge people from far, but ask them……. Ask them to know about their story. Not judge from afar."*

C9Ar wants to go home *"I have been here for a long time. My relatives no longer come. The boss here, the ward manager, did not tell me the plan for me. Our boss here, she never tells me when I will be discharged and go home."*

5.2.2.2 Rehabilitation to the previous functioning

The participants described Rehabilitation to the previous functioning accordingly.

Some participants that stayed in the hospital residence said their utmost desire was to go home to stay in their previous domain and resume their previous functions.

C7Av lives in Hope Villa, the hospital's private lodge, and manages a stock shop owned by the hospital, but desires to go home. C7Av said it is taboo to die outside your domain by stating, *"Well, you know it is not good for someone to go without coming home. May we not die in a foreign land……I will also resurcitate my petty trade business at home"*

Another participant, C12Ar, mentioned that he also resides in the hospital inpatient-outpatient ward, and is employed as a hospital cleaner; all he wants is to go home*, "They should make an effort to assist me to return home when my people come. so I can resume my carpentary work"*

5.2.2.3 Preferred skills

Three outpatient participants who access rehabilitation services at the hospital occupational therapy unit expressed desires different from the facility pursuit for them.

Participant C6L, who attends occupational therapy expressed her desire in a low voice and looking down as she said*,*

"I am learning to tailor here, but what I want is for them to help me to achieve going back to my school and graduating, and after, I will have some work to do." This client did not think the vocation taught to her was helpful, as she wanted an education.

This participant further explained: *"I stopped at 300 level as a pharmacy student."*

Participant C9L, also attending O.T., declared similar views,

"*I am into the barbing here, learning to be a barber, but my aspiration in life is to become an administrative person, working for the government. I studied business administration at university and that's what I want to do. I like meeting people."*

He was asked if he had received assistance concerning his desire, and his response was

"*No. No assistance. I am doing it myself. I also want to establish a business and I want to go back to school. I want to go and do my master's postgraduate……"*

C5L describes how others decided the choice of career for him:

"*Actually, when I came, I was directed to the tailoring section by former H.O.D. I worked there for about three years. There I couldn't, I was not able to pass thread into the needle. So I had to go for an eye test. So I was recommended a pair of glasses. Later on…, my colleagues in the tailoring section, inform me that I should go for computer training. I have been here for about 6 years. Here I learnt how to make use of computers especially, Corel draw, Microsoft Word, Microsoft Excel, and so on."*

The researcher asked the participant why they asked him to go for a computer, but he said,

"*I do not know the reason they gave, but they said I should go there, just to conclude my rehabilitation.*"

He, further said,

"*At this computer age, I would like to be a computer analyst, because it is a thing of…….. ehn……... a thing of……computer age."*

Another participant, C7L, said he was told to learn computers, however, the researcher observed he looked uninterested,

"*I was told I have to come here and be learning somethings. So……* "

The participant did not conclude the statement, but the researcher asked, So what? He continued and said, *"So I learnt it. "*

5.2.3 Theme 3: Barriers to rehabilitation

The barriers related by the participants were physical, structural (housing), and psychological.

5.2.3.1 Physical barriers

In terms of physical barriers, the participants recounted there are barriers to their functioning. During data collection, the researcher observed that one participant was shaking during the process of the discussion.

C15Ag complained about the shaking of her hands as a physical barrier to her productivity by saying*, "My hands always shake; I don't know; maybe the medication I am using" …*she progressed to say *"I do not want my children to give their children to a nanny" …….. "So I can care for their children, but my hands shake. My hand is always shaking."*

On another occasion, the researcher, on her way to the field one particular day, stopped at a shop to buy toiletries, but on arriving at the hospital house the person who served her at the stock shop was the same person introduced as one of the individuals living in the hospital facility and diagnosed with schizophrenia. The researcher deliberated as to why the individual was still in the hospital house.

During the interview, C7Av expressed her lack of a physical structure (home)

"I was brought back to the hospital by the social workers when the house I was to be discharged to is dilapidated. There is no kitchen; there is no toilet; there is no water. I don't even think anyone stays there anymore."

This participant experienced the challenge of housing, where she could go even after functional rehabilitation. This could lead to stress.

5.2.3.2 Psychological barrier

Another barrier was psychological, as expressed by participants.

C15Ag said,

"*My sister from the same parent was dating my husband after I came down with mental illness……. We divorced after that, but I want us to come together again, but my sister wishes me dead."*

She expressed that with a blunt affect, but her words sound weighty. She further said*, "My sister, the same father, the same mother."*

When asked if she needed support, she responded*, "It was so difficult, but my mother is supportive, my mother is always there to support me."*

The psychological distress this participant experienced seems to hinder her will to rehabilitate.

5.2.3.3 Social barrier

Linked to the psychological barrier is the social undesirability (social barrier) by people in the community, as expressed by these participants with a history of murder.

C13Ar, murder case,

> *"I mistakenly killed my father" …, "I have changed, but they do not want me at home. I have been here for 38 years."*

After further inquiry with C13Ar, he revealed that he is also biased that they can kill him at home,

> *"There was a time I was discharged to my cousin's house, so many families don't want me."*

C13Ar further recounted that the hospital social workers went back home with him,

> "*The social workers went home with me, to the family house where I was rejected, but they told them frankly that they can't help me*, *they said they could not accommodate me there, that they are aware of my murder case. If I decided to stay there by force, they could kill me.*"

Another participant, C1Av, reported-

> "*Ehm…. I had some domestic problems that involved my Dad and my mother and the rival of my mother. They all created the problem that resulted in me murdering my father."* He further said*, "I took a knife and stabbed my father three times from the back, and he collapsed."*

In his recount, C1Av *stated "I have been there since…… I came here in 1985 from prison. I was given amnesty by the governor of the state in 2007 on October 10" "They do not want me at home."*

These participants would face a significant barrier in rehabilitation to the community, especially with their families. Without trust and a sense of belonging, it would be a challenge that the HCPs would need to work towards as a goal for rehabilitation.

5.2.4 Theme 4: Rehabilitation interventions / outcomes

These are the intervention services the individuals with schizophrenia receive to enable them to live an independent and productive life

5.2.4.1 Self- mastery/ independence

The description C15Ag gave of her activities revealed that she gained self-mastery through self-initiated (internal) motivation. She said:

"*We sell provisions, eggs, beverages, toiletries, I share the same shop with my mother.*"

In her account, C16Ag reported how she had been living an independent life,

"*I am living alone in my room, I do everything myself, and I use my medication as prescribed, one tablet in the morning and once at night. I come to the clinic alone*."

Another participant, C12Ar, who lives in the hospital residence stated,

"*I have been here doing one thing or the other. I have been doing a menial job. I barb (shave people's hair) and do all those small chores*." He stated, "*I go out very well. The goods I sell; once sold, I go out to buy more stock myself*". "*I go to buy things I sell, I buy medications from the sales I make and any little amount that I get, I will add to it. That is how I have been managing myself*."

C12Ar further said he sells sachet water,

"*I also sell pure water using the hospital fridge. I put it in the hospital fridge*."

C1Av who left the inclient ward and now resides in a hospital residential house said

"*I Left this place since 2010. I stay at Hope Villa…. I have just come here to do business*". He also said*, "I sell cell-phone recharge cards to the nurses and the doctors."*

CR12Ao is another participant, and in her report, she said the only way the illness affected her was that she could not multi-task as she used to*,*

"I retained or continued the same job I was doing. I am a fashion designer, and that is the same thing I have been doing until now." She further stated*, "The only thing is that I wanted to start a water supply business, but I could not cope because I need to wake up early morning for supplies, one day I dose off and lose my wallet, so I stopped and faced tailoring squarely."*

Some participants reported hospital intervention in two ways: through menial jobs or training. The participants who had a menial job in the hospital are those living within the premises, while those trained come from home and could afford the cost of the training.

The participants doing the menial jobs for the hospital reported as follows:

C8Ar said*,*

"The hospital gives us a menial job, we clean windows and sweep the floor every morning."

C9Ar- reported;

"I just……..... We work at the secretariat there. We use to go there every morning, and we come back early, around 10 or 11, we will return from work."

C11Ar stated*,*

"We wash the floor. We sweep the floor. The authority employed us as cleaners."

C13Ar in his account said*,*

"For now, they got a particular job for us to help us." When asked what kind of job and he replied, "*Cleaning Job. We clean the offices. That is what we do."*

C1Av- said,

"I clean office. I also clean wards."

C3Ar stated,

"*Every day after we sweep they give us money from the hospital bank.*"

C2Ar said,

"I am into cleaning, cleaning, and dusting."

One participant, C3Ar, reported how she gets extra money,

"I also wash clothes for people" she further said, *"I can wash car, clothes, plates and I can also sweep the floor."*

C13Ar talked about the salary,

"*It is this salary that we use to maintain ourselves. It's 200naira per day (R8 O.5/USD).*"

Conversely, one participant reported that she also renders a service to the hospital, but she is not on salary. C7Av stated,

"*I pay for my expenses through pension money*". In her further explanation, C7Av seem unhappy about the fact that she was not paid as she further said; "*Ah…….. We get there before 9 am and close by 5 pm, what is not good is that we make good sales, but not paid any salary."* She went to say, *"Others that work for the hospital are paid, but we are not that is not good enough, but I am praying about it."*

The trained participants reported their training experience in two categories (Self-mastery, Dependent). Some said they chose what to learn by themselves and they were happy doing it (Self-mastery).

C6L said*,*

"I have been receiving training in the tailoring section. I prefer tailoring. I was the one that chose the tailoring." C6L further said she had passed through many sections, "*I think they have been helping me so much in the O.T. that I have been attending…the exercises. The sections, the kitchen rehabilitation…ehn…….all those……..and the computer, the salon, the hair salon. The tailoring section and the catering section, where I have been. I have passed through all of them. I think the way they are helping is that they have been training me towards my future goal."*

When asked about her future goal, she said it was to have a tailoring firm.

5.2.4.2 Dependent

Those whose choice of vocation was decided by HCPs or their family members,
but, they had a different agenda, which was personal indicated dependence.

C9L said,

> "*Ahm……..….. in the department what I am into is barbing, they suggested it for me. I desired to become an administrative person. So, since I am here, I have no choice. That is, it."*

C1L said,

> "*I am into tailoring, I have learnt measurement, I have learnt to spread, but it remains to sew.".*

5.2.4.3 Alternative therapy

Some participants, in their description of the first line of family intervention, said they went to traditional houses where they experienced abuse of all kinds.

The report of C12Ar *stated,*

> *"My father took me to the house of an herbalist when I was supposed to come for the second appointment, even though I told him to bring me to the hospital, but he said I should remain there. They tie me on the floor to a tree in the bush. They killed fowl and goats. They killed many animals for sacrifice. It was during that second episode of relapse that I injured someone, and the person died."*

C13Ar shared a similar experience,

> *"It was once I came before. Before then, I did not know about this place. I was only here for once. This is my second time. After the first time, they had no money to bring me back to this place, so they carried me to the herbalist's house because my people are poor and they tied me down there doing many things. After that, I had a misunderstanding with my father during which I mistakenly killed him."*

5.3 DISCUSSION PER THEME

5.3.1 Theme 1: Self-perception:

Self-perception, according to Nehrlich et al. (2019), is a product of what an individual think about himself, what society thinks he is, and what close associates say he is. Self-perception affects morale, while morale affects social function (Moritz & Roberts, 2018). The findings of the study reveal that participant's perceived themselves as worthless when inactive, and this inactivity aggravated feelings of ill-health in individuals with schizophrenia. This is consistent with the findings of Askari (2018), that inactivity is a potential and actual cause of mortality in schizophrenia.

Another finding of self-perception in this study is the feeling of uselessness through rejection or abandonment in the hospital. According to Loh (2018), Hasan & Adil (2019), and Moorkath et al. (2019), this is one of the reactions individuals with schizophrenia experience from family.

Moorkath et al., (2019) revealed that the family abandons relatives with schizophrenia for many reasons, ranging from avoidance of labelling of the family name to burden of care and feeling of hopelessness. In support, Hasan & Adil (2019) state families abandon people with schizophrenia to protect the social outlook and financial status of the family. In the view of Loh (2018), from a study conducted on developing countries, schizophrenia constitutes a cause of attention and family distress, and families abandon such individuals to reduce the stress and burden. This study takes the stance that the cause of abandonment of others is traceable to the burden and stigma (Loh, 2018; Moorkath, et al., 2019).

Of note in this study is the defective insight of some of the participants about their diagnosis. Lack of insight, according to de Jong et al. (2019), can impede productivity, and achievement of insight should be the first step towards rehabilitation. Supportively, Sánchez et al. (2019) declared that disability acceptance is a major determinant of individual productivity and social functioning. Gerretsen et al. (2015) reported that schizophrenia is one of the illnesses that come with denial or impaired illness awareness, which can be due to defence mechanisms or lack of knowledge. Lack of knowledge of the diagnosis is consistent with the clients' reports in this current study, where one participant reported his diagnosis was malaria, but the referral letter remained secret. This is consistent with Amsalem et al's (2018) findings that the attitude of HCPs towards disclosure of schizophrenia diagnosis had an impact on the acceptance of the diagnosis by both service users and their relatives.

5.3.2 Theme 2: Expectations

Participants in this study expect that they have freedom of choice of career and live within the community, but this study revealed the participants' passion is entirely different from the training they received. Souraya et al. (2018) revealed that giving individuals with schizophrenia liberty to make informed decisions is vital in goal-oriented rehabilitation. The findings of the study conducted by Lempp et al. (2018) reveal that the service users in mental healthcare have amazing benefits from the correct channeling of mental health programmes. Rai et al. (2018) reported another benefit of service users' involvement in rehabilitation by declaring that service users' co-facilitated training reduces the stigma of mental illness. A three-year peer support service among individuals with mental illness in China also revealed that involving the active participation of mental health service users was therapeutic use for one another and as a role model for the new assessors of recovery goals and rehabilitation service (Fan et al., 2018). This study takes the stance that the involvement of non-skilled HCPs in rehabilitation should be encouraged to reduce the problem of hierarchy in rehabilitation service delivery between service users and participants.

5.3.4 Theme 3: Barriers to rehabilitation

About the barriers to rehabilitation, there were financial constraints to meet daily needs and cope in the community expressed in this study. However, in a study conducted on rehabilitation of individuals with schizophrenia, by Asher and colleagues (2018), it was noted that support strategies in the form of incentives to set up small-scale businesses were helpful for service users to get back to their feet. Asher et al. (2018) further noted that rehabilitation and empowerment go hand in hand, without which training efforts may end in futility. This study attributed medication reaction by participants to be a physical barrier. However, the WHO (2013) encourages informed decisions and collaboration with clients in prescription. In a self-reported study, Son (2018) declared that individuals post-acute phase of psychosis do not necessarily have to be on regimented medication before recovery is achieved; the author further noted that appraisal of individuals' needs for recovery is evidence-based and outweighs the use of medication. Flore et al. (2019) also expressed that the use of antipsychotics produces different narratives in different individuals is highly subjective and should be taken as such. This study, therefore, takes the stance that physical challenges that result from medications are avoidable, or better coped with if the service users have the opportunity to make choices in the medication preference and adhere to the choice.

Some participants in this study reported that the family and social undesirability was due to the crime they had previously committed, and that serves as a barrier to the community rehabilitation; this is consistent with findings of Chen et al. (2018), that the public feel threatened by the presence of individuals with a history of schizophrenia coupled with violence. Jovanovic et al. (2019) also reported that most cases of suicide and homicide occur in paranoid schizophrenia, which is consistent with the findings of this study. This study takes the stance that individuals experiencing rejection of any type need psychological support to be able to cope with the challenges they face, and re-invest their energy into productive activities.

5.3.5 Theme 4: Interventions

The interventions in this study are apparent in the tasks in which the participants engage, and the different levels of activity range from basic to skill acquisition activities.

Firth (2017) states the activity level of individuals with schizophrenia is insignificant compared to the activity level of the general population. Firth (2017) further states that self-reported activities are unreliable in an individual with schizophrenia, except there is reportable evidence. Thus; this authenticates the values of this study as a qualitative approach during which there is a view of the clients, and their activities, in their natural state. The study also

shows that some participants felt compelled to do some activities, which does not yield a positive result; however, those who have a sense of productivity through self-initiated activity are excited and expressed feelings of productivity. This is consistent with the findings of Corbière et al. (2019) that dictatorship can serve as a major constraint to the productivity of individuals with psychiatric disabilities.

This study further reveals that the cases of murder in this report are traceable to a sense of abuse. Those who reported cases of abuse at the traditional home, such as being chained to a tree in the bush and beating, also reported they became more aggressive after their release. This is consistent with the report of Oyelade and Ayandiran (2018), that aggression breeds aggression, but the victim of the retaliated aggression may not necessarily be the perpetrator. Of note, is that those whom these individuals kill is not necessarily those who tied and bit them. This study, therefore, takes the stance that abuse against individuals with mental illness is not permissible, and should attract sanctions.

5.4 SUMMARY

The purpose of the clients' interview was to describe the experience of individuals with schizophrenia on rehabilitation and describe their desire and expectation. This study managed to achieve this by finding out their experiences in the acquisition of vocational skills, employment in a hospital facility, entrepreneurial activities, and family dependence. It also identified the need of rehabilitating individuals with self-initiated and collaborative goals with mental healthcare service users and also cultivate their capability to be independent as individuals living with schizophrenia, because through the study we find that those who are not dependent on HCPs can live independent, regardless of the illness.

5.5 CONCLUSION

This chapter concludes that individuals neglected by relatives and confined to hospitals expressed high decision-making capacity and could pursue their desires compared to individuals who have support services from families. Those individuals who assess rehabilitation practices on an outpatient basis face dictatorship from family members and/or HCPs. The constraints generally expressed are funds for business establishment. Those confined to the hospital also desire reintegration into the community. Conversely, those who have family support declared that what they need from society is support in areas where they expressed needs. About the HCPs ' interventions, this study noted wide variations in the approaches of intervention and recommends a practice guide for uniformity of practice.

PHASE TWO

CHAPTER SIX: FAMILIES INTERVIEW DATA PRESENTATION

Foreword: The findings in this section (interviews with families) have been published with *Health & Social Care in the Community* (Wiley). Oyelade, O.O., & Nkosi-Mafutha, N. G. (2021) "Expectations and experiences of family members regarding the rehabilitation of relatives with schizophrenia in Southwest Nigeria." *Health & Social Care in the Community*. 00, 1–10. https://doi.org/10.1111/hsc.13617(Annexure Q).

6.1 INTRODUCTION

The previous chapter described the findings of the client's interviews. This chapter includes the presentation of families' demographic data, the process of data analysis, and interpretation of the analysed data from the two research facilities where data collection occurred. In total, there were 21 families, recorded as next of kin, in the case note, to individuals with schizophrenia, interviewed. Table 6.1 depicts the demographic description of the participants.

Table 6.1 Demographic profile of the participants' family members

S/N	Gender	Age	Experience With rehabilitation	Relationship
1.	F	35	18	Daughter
2.	F	40	20	Daughter
3.	M	45	1	Brother
4.	F	73	2	Mother
5.	M	39	1	Son
6.	F	35	1	Elder sister
7.	M	51	10	Elder brother
8.	M	28	1	Elder brother
9.	F	48	1	Wife
10.	M	40	5	Son
11.	M	40	2	Clergy (Client's pastor)
12.	F	56	7	Mother
13.	F	28	2	Wife
14.	F	63	20	Mother
15.	F	45	20	Younger Sister
16.	F	65	35	Elder sister
17.	F	46	5	Formal Caregiver
18.	F	36	2	Formal caregiver
19.	F	46	2	Formal Caregiver
20.	M	45	30	Formal Caregiver
21.	M	69	20	Cousin
	Female = 13	Mean		
	Male = 8	46	10	

Table 6.1 presents an overview of the participants' demographics, which revealed there were eight males (8) and 13 females, which is consistent with the fact that female family members care for individuals with mental illness more than males (Mulud & McCarthy, 2017). Interestingly, a pastor represented a client as next of kin in the study. Table 6.2 depicts the themes and the categories of the findings.

6.2 DERIVATION OF THEMES

Table 6.2: Presentation of themes and corresponding categories of families' interview

Theme	Category
Functionality and Productivity	· Effective functionality/ constraint · The productive activities
Feelings about rehabilitation practices	· Satisfaction · Dissatisfaction
Ideal family rehabilitation	· Finance/ general support · Relief from care burden · Self-accountability

Based on Table 6.2, there were three main themes with eight categories, as presented below. Table 6.2 presents the results in themes and categories.

6.2.1 Theme 1: Functionality/ Productivity

The theme Functionality cum Productivity emerged from responses on how the family views their relatives diagnosed with schizophrenia, concerning their activities. They expressed the level of releave of such individuals from idleness and not just finding something to do but also explained how productive they are in whatever they are doing. The functionality/ productivity is categorised into two: effective functionality and constraints and productive activities.

6.2.1.1 Effective functionality/ constraints

Effective functionality and Constraints is the first perception noted from participants' responses, which emerged from responses on the description of the client's rehabilitation activities and productivity. Some of the participant's family members, expressed their clients are active while some reported their relatives with schizophrenia are a source of burden to them and exhibit some traits which make it difficult to rehabilitate them effectively. These traits also make them burdensome.

One participant, CR4Ag, expressed that her client was a burden to the family and that she was unable to interact with the outside world meaningfully due to some attributes she exhibits; for these reasons, she also described the client as unable to maximise efforts at rehabilitating her. The attributes mentioned by CR4Ag were inactivity, irrational talk, and fighting.

CR4Ag quotes,

> *"She is just a burden to us, even the grandchildren always wonder what is wrong with grandma. You know she can't relate with the outside world meaningfully ……It is very pathetic. It's not a good sight for my children. We can't send her out of the house, she can't do anything. Not even cleaning. She also complains about everything. She talks irrationally. The children are always confused asking what is wrong with grandma, why is she talking rubbish. She will be fighting the children pursuing each other……..*
> "*It just seems difficult to rehabilitate her. She is there doing nothing. Not even helping*

us with anything in the house, at least if she can't sell things or engage in any business, she should at least be able to help us care for our children or clean the house, but she can't do anything. She says a lot of rubbish."

CR5Ag, in the description of their relative's functionality, expressed that she engages in sales of household items, but with the support of a sales representative because she sometimes frustrates family and customers when she decides to be selectively mute.

CR5Ag quotes,

"The problem with her is that sometimes she doesn't respond when people are asking her questions, that's how she used to behave. That can be frustrating and affects her effective rehabilitation. Though she makes sales that is with the help of a sales representative."

Another participant, C76Ao, in his account said his sister was active and efforts at rehabilitating her have helped to resuscitate her hairdressing business. However, that stopped due to her wandering tendencies and fights with customers.

He stated,

"*Sincerely speaking, the only issue that affects her functioning is that she wanders away, she has missed before for about 2 years, we even thought she had died until we learnt some people found her and took her to the hospital, we have to monitor her movement…. we can't leave her alone now, or else she will get missing again. Another issue is that she is short-tempered."*

CR14Ao said lack of finance and frequent relapses were the constraints to her son's rehabilitation, and this made him dependent on her, as the mother, and the siblings.

"He was a mechanic as I told you, but since the illness started over 20years ago, he is not doing anything. It is his older siblings and me who take care of him. We combine our efforts to take care of him. They provide funds while I monitor him. ……he is completely dependent. No income, no work, no wife, nothing. ……...I am tired of the situation myself. He also relapses frequently and that has not helped in his rehabilitation and makes him dependent on me. This is not good for me, I am his mother and I am getting hold. Like this time yesterday I was in the hospital because I was seriously sick, but today again I have to be on the road to bring him here. That is the problem. "We cover a distance of about five hours to and fro. That is the challenge we are facing. We don't even know when the burden will be reduced."

Some relatives' expressions of their perception about their family living with schizophrenia revealed a level of engagement in the productive task.

CR5Ag describes her mother as a retired and active person:

> *"Now she is retired, she was a typist, but retired 4years ago and she is at home. She opened a shop at home at the front of the house. She opened a shop at the front of the house where she sells foodstuff. Though retired, she is still very active and well rehabilitated into productive living."*

CR6Ac1 in his account said his brother was a farmer and his illness does not affect his work.

> *"What I can say is the work he does is as he used to and not affected by the illness. He is independent and does his work on his own. The only clause is when he feels weak, we hire a vehicle to convey him to the farm and he works well with ploughing, sewing, and all aspects of his farming business."*

Conversely, CR11Ao said his brother was a pharmacist but stopped working after the illness because he hallucinates and sometimes is aggressive, for those reasons customers no longer trust his judgment in dispensing the right medication; he lost patronage for this reason and changed to peasant farming.

> "*Usually he does little things like cleaning the surroundings and cutting the grasses. Those are the daily activities he engages in for now and I consider that as sufficient for now. My joy is that he uses his drug and daily activities without monitoring. He goes to the mosque on his own and comes back, we open he will resume work when we get much better."*

CR13Ao said her husband was a hairdresser and continues his hairdressing business except that he does not work actively as he used to before the illness.

> "*He is a hairdresser. He has just been working skeletally since the illness started. The shop is in his father's house. At the side of the house. Despite the closeness of the shop to the house, he sometimes complains of tiredness and sometimes doesn't go to work for that reason, when he was hallucinating, the shop was completely closed, but now he has resumed work skeletally."*

6.2.1.2 The Productive activities

Some participants reported productive activities in which their relatives were productive but dependent in the sense they still need close monitoring.

CRIL said,

> "*She is active and selling recharge cards, but we still monitor her because she has been missing on about 3 occasions. We don't want a repeat of that. If we cannot find her, it is more torturous for us than for when she is no more. At least, then we know she is no more, but if we cannot find her, we don't know what is going on, we don't know who has her. That torture alone is great. That is the reason why she is here and why we monitor her. We were bringing her, picking her up, but now she comes herself and she goes home herself. When we started we engaged someone here to say please*

help her cross the road, so she can take up the transport, but now she does it herself. So that's why I said we are seeing improvement. We can leave her alone and that's why we monitor her because we don't want to take any action that we will eventually regret."

CR6Ao-

"*Truthfully, there is no source of concern about the service here, but the only issue is the burden of his care, because we can't leave her alone now, or else he will get missing.*"

She is well rehabilitated and into teaching, but we still monitor her.

CR3L said

"*She is independent and active, she is well rehabilitated and stable, but* as *the caregiver, whenever she is coming here to work, I usually come with her and come to pick her up in the afternoon, but I didn't stay with her. Just to drop her and go back*. *That is the instruction I have from the family*.'

CR4L-

"*What I feel he needs now is close monitoring. He has improved significantly and acquired skills. What is left now is for someone to monitor his spending. He is well rehabilitated and works, but he spends lavishly.*"

6.2.2 Theme 2: Feelings about rehabilitation practices

The theme, feelings about rehabilitation practices emerged from the description of the participants' experiences with the rehabilitation of their clients. These are in two categories, satisfaction, and dissatisfaction.

6.2.2.1 Satisfaction

The participants' expression of satisfaction is as follows:

Participant CR5L said,

"*There is a lot of improvement because by the time we brought him here, I mean before he started rehabilitation therapy, he used to relapse in two weeks' intervals, but now that he is in rehabilitation, he doesn't relapse, he is occupied and engaged. He now learns hairdressing, is more active and he no longer exhibits the trait of loss of memory that he used to exhibit before."*

Another participant, CR1L, reported,

"*Hum! Well!!!! Let me start with when the whole thing started. Ahm….it started I think about 20years ago, 1999 and she came into this facility in 2001 as an inclient, but he recently started undergoing rehabilitation, that was 2years ago.…that she started this rehabilitation at the occupational department. As I said, she's been in and out. …and I*

will say that to the glory of God…so far so good, we have seen a lot of improvement of …and……she is more aware of herself, meaning that the treatment that she is getting has been helpful and… we see that …. all our efforts by the grace of God has not been washed down the drain. …...in the area of skill…... She is learning here. she …. entered into a fashion school of which she graduated and also she has gone into a computer school, she has done a bit of teaching as well even during this period of her illness."

CR6L said,

"*If not for them, the health care* practitioners *here, at least this is the only facility that could help him like nobody would have been able to understand his situation better than they do. So that is one of the things. If not for them, they are the ones helping at managing him, and in that respect, they are doing well.*"

6.2.2.3 Dissatisfaction

The responses that depict dissatisfaction are mainly a lack of understanding of psychopathology and the prognosis.

CR4L said,

"*They need an individual that is experienced. The people training them here are not experts, they just acquire basic knowledge of different vocations and with such elementary training, they can survive the competitive society where we are at the moment."*

CR2L also reported the same concern,

"*The training is not thorough…... He started with hairdressing …later he changed to computer because he did computer when he was schooling in the U.S., the first of all learnt computer here, we buy materials he needed, but nobody is teaching him. The guy collected some things from him, but he didn't teach him. I even came by myself to come and meet the guy and tell him, but no difference. They also need to include things like exercising, like gymnastics, you see the way he is…. We are planning that sooner or later, he will go back to the U. S to finish up in the U. S, not to stay here, because there is nothing in Nigeria, but the activities exercise aspect has to be included so you people can improve on that."*

CR5L said,

"*There is a need for improvement of this place. The place is too stuffy. It is just too stuffy. Even if the client sweats a lot and his shirt will be smelling, there are not enough fans there. Even the toilet is not O.K. for them, that is the only thing.*"

CRIL reported the same,

"*One cannot expect much in a public service facility like this. It is not all the psychiatric hospitals that have this kind of facility, because we have been to a few, but I just feels that a facility like this, the government can go all out to have private partnerships. Cough…. When you have a private partnership, they can give back to society by making this facility more comfortable. Equipping it with all the necessary equipment that is necessary. To the glory of God, I have been to facilities outside Nigeria. You see what happens, it's like a home away from home, but you can't say that here. But when you bring in private participation, they can improve on …...whatever equipment they are using there. Maybe the equipment people don't even use anymore, maybe you don't even expect to see those kinds of things here and you come here, you see it. Now if you are training people with these kinds of equipment, when they go out they get stacked because they are going into an environment where what they are seeing is strange to them, but if you can have private participation, you know…by going to other facilities…seeing what obtains there and by saying I covet what I see in this facility here, speak to a private organisation, it will go a long way.*"

6.2.3 Theme 3: Ideal family rehabilitation

Participants expressed the desire to be relieved from the burden of care of the relatives and financial support as ideal for rehabilitation; they will be relieved, and the person accountable to himself with minimal family monitoring.

Some requested additional support.

6.2.3.1 Finance/ general support

The participants in description of finance explained how they source for funds to before they can afford rehabilitationa and expressed that financial constraints which sometimes limit the extent to which they would have wished to engage their relatives in relabilitation. General support is described in terms of waver for rehabilitation or subcidy.

CR11Ao said,

"*As I earlier told you, we found him on the street, we don't know him, but we are the ones taking money from our pocket to take care of him. There is nobody that comes with any form of support since he has been with us since early this year and we are in the eighth month of the year now. There is nobody till now.*"

Another participant, CR4L, said,

"*They need materials to work with and then they need an individual that is experienced. You know there is a difference between a hairdresser and a hairdresser, let me use it that way. If you want this person to, because you are going to push this person to the community, you will want this person to function at the rate at which the community*

level is, so we need to also brush this person up in other aspects of hairdressing so that this person will be able to blend."

CR6L said,

"*As I said, basically what I just noticed is that ah…. there is a need for support. No financial support. Many of our administrators have gone outside, go to other facilities in the developed world and they see what is in place. I think good things could be emulated and be placed here. The fact that we are Africans doesn't mean things should be done haphazardly. At least the standard that is in operation elsewhere could be copied and established here. Many staff here are handicapped. They can only work here with the little they were given, but if the administrators have been going out to see what is in operation in other places and bring it here. It will make things better.*"

6.2.3.2 Relief from care burden

Relief: This is another request expressed by participants as a feature of ideal rehabilitation.

CR4Ag said,

"*It has not been easy at all. I don't know if in this place when they have cases like this, maybe they should make it such a way that the facility will take over the care of cases like this. I don't know if they have old people's homes or something. There should be something like that here. This hospital should have something like that for people that after the whole thing, you know for people like this…. there should be something. You can imagine what she said now, we have been battling with this issue for 18years. Please deduct 18years from my age, so you can imagine how small I was when this problem started. We want where we can live so we can be relieved of the burden.*"

CR7Ao also said,

"*If there is such an opportunity for her to be admitted within this facility, we will be glad. She was missing for more than 10years. It was a church that brought her to this place and we have to monitor her. We also have our family. She is the only one that is not married and she is 40years."*

6.2.3.3 Self-accountability

Self-accountability: This is also a feature of ideal rehabilitation as expressed by the participants.

Some families reported a level of self-independence by their relatives.

CR5Ag said,

"*She is alone, she does it alone herself, but if we are at home we assist."*

CR17Ag reported,

> "*Well! Before she wasn't able to go out, but now, she goes out on a visit to her friends and younger sister. Sometimes ago she slumped and sustained an injury to the wrist. That is why she cannot cook anymore. Though she lives alone, we employed a cook for her."*

CR2L said–

> "*No one lives with him. He does things herself*."

6.3 DISCUSSION PER THEME

6.3.1Theme 1: Functionality and Productivity

Family members wish their relatives to be independent and self-accountable, but also to achieve a level of monitoring. Caqueo-Urízar et al. (2015) support this assertion when declaring that family monitoring and care are important in the face of scarce human resources in mental health rehabilitation. Similarity exists in the declaration of Caqueo-Urízar et al. (2015) and the family wishes in this study, in the sense that Caqueo-Urízar is also concerned about the holistic functioning of the individuals with mental illness. However, the definition of monitoring by the author is the assessment of clients for any stressor, while the participants in this study desired continuous monitoring from the fear that their relatives could go missing, which they validated with their previous experience. According to the findings of Asher et al. (2018), individuals with schizophrenia detest monitoring, as described by the participants of this study; however, a Malaysian and German study by Ayass (2015) and Anwar et al. (2016) declared vagrancy as a function of socio-economic factors and results from street begging to the extent that individuals miss their way in unfamiliar areas. This study, therefore, takes the stance that there is a need for a context-specific study on vagrancy and its cause in the mental illness from clients' and relatives' perspectives.

6.3.2 Theme 2: Feelings about rehabilitation practices

There was satisfaction derived from the fact that clients were learning a trade and became engaged or productive through that process. This is consistent with an Ethiopian study, where the relatives and the community members expressed their excitement about the productivity of individuals with schizophrenia (Asher et al., 2018). Dissatisfaction in this study arose from the fact that the training such individuals received was not thorough, physical exercise was not part of the training, the environment was not conducive, and the cost of receiving rehabilitation care was a burden for those who could ill afford it. This is in line with the findings of a study conducted in Latin America, where insufficient funds were the barrier to full implementation of rehabilitation to the ever-growing population of individuals with mental illness (Uribe-Restrepo et al., 2017).

6.3.3 Theme 3: Ideal family rehabilitation

Families in this study regard ideal rehabilitation as that which will earn them relief from the burden of care. This is consistent with the findings of a study conducted in China, where the author (Yu et al. 2017) reported family members expressed various forms of the burden of care for individuals with schizophrenia, ranging from financial as the highest-burden and family interaction disruption as the least. This study also noted the forms of burden found in the study by Yu et al. (2017), however, the factor disruption of family interaction, which the China study expressed as being least, was expressed as a critical point of concern in this study. The variation in the utmost burden may arise from cultural differences within the two settings. In another study conducted by Inogbo et al. (2017), in Southeast Nigeria, the inactivity of an individual with schizophrenia reportedly increased the burden of the family and gives the family a feeling of un-wellness. This is consistent with the findings of this study as the family reported their client as “useless” in their description of their burden and desire for relief.

6.4 SUMMARY

This chapter revealed the expectations and experiences of families with the rehabilitation of their family members diagnosed with schizophrenia and revealed that the family view of rehabilitation has diverse dimensions, as shown in the description.

6.5 CONCLUSION

The family of clients who engage in one productive activity expressed their joy about their relatives’ independence and expressed no form of burden whatsoever. This study, therefore, takes the stance that supportive activity is vital for effective rehabilitation and reduction of the burden of care for individuals with schizophrenia.,

PHASE TWO

CHAPTER SEVEN: HCPs INTERVIEW DATA PRESENTATION

Foreword: The findings in this section (interviews with HCPs) has been submitted for publication to Journal of Service Research and are under review.

7.1 INTRODUCTION

The previous chapter described the findings of the families' interviews. This chapter includes a presentation of HCPs' demographic data and the interpretation of the analysed data from the research facilities where data collection occurred.

There were 36 HCPs interviewed. Table 7.1 presents the demographic description of the participants.

Table 7.1: Demographic characteristics of HCPs

S/N	Code	Health Professional	Gender
1.	D1	Medical doctor	Male
2.	D1L	Medical doctor	Male
3.	D2L	Medical doctor	Male
4.	D3L	Medical doctor	Male
5.	N11Ac	Nurse	Male
6.	N10Ac	Nurse	Female
7.	N11Ac	Nurse	Female
8.	N12As	Nurse	Male
9.	N1Aw	Nurse	Male
10.	N1L	Nurse	Female
11.	N2Aw	Nurse	Female
12.	N2L	Nurse	Female
13.	N3Aw	Nurse	Male
14.	N3L	Nurse	Female
15.	N4	Nurse	Female
16.	N4Aw	Nurse	Male
17.	N5Aw	Nurse	Female
18.	N5L	Nurse	Female
19.	N6Aw	Nurse	Female
20.	N6L	Nurse	Female
21.	N8Ac	Nurse	Female
22.	N9Ac	Nurse	Female
23.	OT1A	Occupational therapist	Male
24.	OT2A	Occupational therapist	Female
25.	T1	Occupational therapist	Female
26.	T2	Occupational therapist	Male
27.	T3L	Occupational therapist	Male
28.	T5L	Occupational therapist	Female
29.	T6L	Occupational therapist	Female
30.	P1	Psychologist	Female
31.	P2L	Psychologist	Male
32.	P3L	Psychologist	Female
33.	P4L	Psychologist	Female
34.	S1	Medical social worker	Male
35.	S2L	Medical social worker	Male
36.	S3	Medical social worker	Male

7.2 DERIVATION OF THEME

Themes and categories

From the content analysis carried out on the data, three themes and 22 categories emerged, See Table7.2.

Table 7.2: Presentation of themes and corresponding categories of HCPs**' interview.**

Theme	Category
Psychosocial Rehabilitation Practices	Running of rehabilitation centres *(Support services, Half way homes & Referral for rehabilitation)* Assessment of clients Psychotherapy Community rehabilitation services Collaborations with stakeholders Occupational therapy Multidisciplinary mental healthcare
Psychosocial Rehabilitation Constraints	Lack of facilities Financial constraints Stigma Poor family commitment No mental health legislation Lack of material resources Referral challenges Inadequate staff
Suggestions for Improvement in Psychosocial Rehabilitation	Provision of resources Government-sponsored rehabilitation Capacity building Public education on mental health Enactment of mental health law Collaboration with other stakeholders Community care

As depicted in Table 7.2, the main themes and categories were Psychosocial rehabilitation practices (Running of rehabilitation Centre's; Psychotherapy; Community care; Collaborations for effective care; Occupational therapy; Multidisciplinary mental health care; Assessment of clients), Psychosocial rehabilitation constraints (Lack of facilities; Financial constraints; Stigma; Poor family commitment; No mental health legislation; Lack of material resources; Referral challenges; Inadequate staff), and Suggestions for improvement in psychosocial rehabilitation (Provision of resources; Government-sponsored rehabilitation; Capacity building; Public education on mental health; Enactment of mental health law; Collaboration; Community care).

7.2.1 psychosocial rehabilitation practices

Under the theme of psychosocial rehabilitation practices, HCPs described various approaches to rehabilitation of people living with schizophrenia in Nigeria. The rehabilitation of clients with schizophrenia undertaken by HCPs included treatments at rehabilitation centres, general assessment of clients with schizophrenia, the provision of psychotherapy and occupational therapy, and extended to include community rehabilitation services, involving a multidisciplinary health care team and collaborating with stakeholders to ensure effective rehabilitation for people living with schizophrenia. Seven categories under current psychosocial rehabilitation practices emerged from the data. These include Running rehabilitation centres, Psychotherapy, Community care, Collaboration for effective care, Occupational therapy, Multidisciplinary mental healthcare, and Assessment of clients.

7.2.1.1 Running of rehabilitation centres

Rehabilitation centres mainly serve as places where people living with schizophrenia assimilate for proper integration into society. Some of these centres provide support in terms of financial support, halfway homes, and referral to the communities.

- **Financial support**

This includes the provision of treatment on credit and direct financial assistance to clients under treatment at the rehabilitation centre, as narrated below:

> *'… sometimes most clients, when they come here, we find a way to help them by giving them treatment on credit … so that when they come for review, they bring the money…. it shows that we are giving support.' (N12As)*

> *'We solicit money from donations for the less privileged. We do this to cater for the cost of treatment and rehabilitation for poor people. … Because of their poor financial status and lack of social support when they come for hospital appointments, they don't even have the means to buy their medicines.' (S1)*

One hospital had funds allocated for catering for the rehabilitation of impoverished clients; this helps them to provide total funding for the cost of care of these clients.

> *'Some of them are staying in the hospital for many years and are funded by the hospital. We have funds called- Alaanu funds, which a lot of people access although it is not enough. … As much as possible, the hospital tries to avoid taking responsibility for the cost of rehabilitating the clients except in case of neglect. That is when they are*

assisted through Alaanu funds. Besides that, we levy the family to pay the cost of rehabilitation.' (P2L)

One medical doctor explained that the provision of financial support services was because most of the clients seen are impoverished.

'Most of the clients we see are poor indigent clients.' (D1)

Other financial support services provided in the rehabilitation of people with schizophrenia include subsidisation for the cost of medication by the facility.

'We don't have support facilities. The people who can afford the service are the ones we provide it for.' (D1)

- **Halfway homes**

As part of rehabilitation, clients go to places called halfway homes, where they are at will to do their normal activities of daily living. This serves as a home away from home. They can go in and come out freely, such as going to work or school and returning by the close of the day.

'There is a place we call halfway- home villa. So, some of them that do not have the support of their relatives and they are fully recovered with rehabilitation, we try to let them be there. There is one client presented here, she is waiting to go to that home. We want them to feel as if they are in their home. It is home for them.' (N4Aw)

'Yeah, yeah……we have. There is a place we call Hope Villa. Hope Villa is a place whereby a client who is not able to go back home lives under our supervision. For like 6 months, the client will be there. Going out and coming back by himself. Doing the normal activities of daily living.' (OT1A)

- **Referral for rehabilitation**

Referral for rehabilitation was a common practice among treatment and rehabilitation centres. Instead of rehabilitating individuals with schizophrenia, some HCPs refer the clients to other centres for rehabilitation. This is how one medical doctor and two nurses described the practice:

'Unfortunately, this facility only takes care of outpatient cases. So, when we need rehabilitation of individuals with schizophrenia, we refer them to the neuropsychiatric hospital, Aro.' (D1)

'We only take care of clients on an out-client basis. If there is any admission, we advise them to take the client back to Aro for admission for treatment and rehabilitation.' (N11Ac)

'In some secondary health care facilities that are closer to the clients, there is a psychiatrist and a few psychiatric nurses. However, social workers and clinical psychologists are very rare. To refer clients to them formally is quite different, we don't often do that except when the client asks for that. So, he can continue to have treatment and rehabilitation in those facilities. But to tertiary centers like us, yes, we refer clients. We refer clients to them for rehabilitation because we are confident that they have the full range of the mental health team to rehabilitate the client.' (D1L)

7.2.1.2 Assessment of clients

Client assessment is part of rehabilitating persons with schizophrenia; this is either as a means of establishing a diagnosis or determining the progress of treatment. The assessment also informs decisions on suitable and appropriate options for the treatment and rehabilitation of the client. It includes the assessment of clients during admission, assessments by the occupational therapist, and psychological assessment in general.

- **Assessment during admission**

Assessment takes place on admission and is an ongoing process throughout treatment and rehabilitation. Nurses are the first point of contact in the assessment during the initial stages, while doctors, medical social workers, and occupational therapists also assess the client. This multidisciplinary approach helps to understand the client's problem and inform intervention strategies suitable for the client; they explained this process as:

'*When they come for the first time, they see our assessment officer, the nurses, and if it's a psychiatric case, they are registered and allowed to see the doctor.'* (D1)

'*Once they are admitted, we start engaging with them. We take the history, family history to assess them.'* (N2L)

'*So, there are stringent measures of assessment that are put in place to ensure that if the client is going to be admitted we know right from the beginning, we try our best to ensure that such client will not be abandoned.*' (D1L)

The assessment helps the nurses, occupational therapists, and medical social workers to know if the client has insight and can start occupational therapy. It also helps to understand the client's strengths and weaknesses and the care required. This helps the team to realise the type of rehabilitation suitable for the client.

'*When receiving a client, we conduct an initial assessment to determine if the client has insight into his or her condition so that we will know if the client will be able to start going for occupational therapy.*' (N3L)

'So, when they send them to the occupational therapy department, they are assessed for their area of strength after which they refer back to us. We now counsel the relations and the clients before they now start the rehabilitation.' (S2L)

Assessment, however, is not a one-time activity:

`We *review our clients on a regular basis and find out the areas where they need help.'* (N3L)

- **Occupational therapist assessment**

The client is engaged in special activities, including games and one-on-one interaction with the occupational therapist to assess client functioning. Occupational therapists also listen to reports from the client's caregivers and make their initial assessment to learn more about the client.

'*When the client comes to the hospital, they might not disclose all that has been happening to him or her to you. It's the caregiver that comes to narrate to us what has happened. … So, we look at all these things, take a report, and do our initial assessment.'* (T2).

Occupational therapists take a detailed history about the client's normal functioning and usual lifestyle, and compare this to the client's level of functioning during the state of illness; this informs them of the interventions to take to rehabilitate the client.

`We *tend to look for the clients' interest, using what we call interest checklist or maybe through observation. We engage the client in the activities to see ourselves what the client enjoys doing. When we get this interest, we now capitalise on that and do a full assessment. Our assessment will determine if the client can undertake a particular vocational training.'* (T2)

However, an occupational therapist's assessment is an ongoing activity.

'Immediately, they come on admission; we start our assessment. So, from time to time we evaluate, we know what the client has acquired, and if there any deficit, we try to correct it.' (T2)

Psychological assessment

Psychologists are mainly involved in the psychological assessment of clients. One psychologist describes this as the core of what they do as psychologists.

'*The core of what we do is assessment. We do behavioral analysis, SWOT analysis, and so on to know their Strength, Weakness, and Threats…. What we are looking at is to look at the functional part of life. Then see how we can help them to live independently in society*.' (P1)

Clients usually receive a referral to the clinical psychologist after being calmed down on the ward, after admission. The psychologist does a psychological assessment to enable them to administer psychotherapy and provides information for the medical doctors to inform their treatment mode.

> '*After admission, when they are settled, they refer them to a psychologist for psychological assessment and psychotherapy … If the person can have a personality assessment, know more about the person, and help a doctor, we do that*.' (P3L)

7.2.1.3 PSYCHOTHERAPY

Clinical psychologists usually administer psychotherapy as a form of treatment during the rehabilitation of individuals with schizophrenia. These are psychological therapeutic modalities aimed at increasing a client's insight into their condition and treatment, improvement of client's behaviour and cognitive functions, as well as client and family relationships. Forms of psychotherapy are client education (psychoeducation), cognitive behaviour therapy, insight orientation therapy, counselling, family therapy, and behaviour modification therapy. Medical doctors, nurses, and medical social workers undertake some of these.

- **Education of client (psychoeducation)**

Nurses and medical doctors usually conduct psycho-education. This is to enlighten the clients on the condition and treatment to promote their cooperation with treatment, especially, medication regimen. Two nurses and a medical doctor shared their experiences:

> '*You know, we also ensure that the psycho-education is being done around them so that the client can understand their treatment, adhere to medication and come to the hospital for review as directed.*' (D1L)
>
> '*The only thing is that we advise them to take their medication … With our wealth of experience since all these years, we have seen that most of them, do comply. Those that don't comply, what we used to do is that we keep on encouraging them*.' (N10Ac)

- **Insight orientation therapy**

Psychologists conduct insight orientation therapy to help clients gain insight into their condition. Working to improve the insight of persons with schizophrenia is necessary because

it is a common problem among them. Psychologists usually do this by targeting their awareness and understanding of their mental illness and acceptance of the diagnosis.

> *'What we mainly do is to work on the area of their insight because one of the main problems of the clients with schizophrenia has to do with their level of insight.'* (P1)

> '*So, we start working on their awareness. Their understanding of what is going on and their acceptance of that. … I have found out that once they don't accept that they have a mental illness, they tend to relapse, it affects the prognosis and also makes it difficult for them to manage.*' (P4L)

- **Counselling**

Counselling of clients was usually the role of nurses, but during the data collection, several HCPs reflected on their role in counselling. This occurs when relatives report a client's problem, especially concerning the client's response to medication problems.

> '*Most of the time, when the clients with schizophrenia are brought to the hospital, their relatives tell us what they do, and if there is any problem, we counsel them. Most of them are the effect of the drug that they are talking about that is making them do what they do. So, we counsel them on what to do.'* (N2L)
> '*Another rehabilitation intervention we have been doing for them is counselling.'* (S3)

One medical social worker used the strength-based approach.

> '*We do structured counselling with them, which will help us explore so many other areas to help th em. We use the strength-based approach in our counselling, which focuses on promoting the strength of the client*.' (S3)

- **Family therapy**

Participants indicated family therapy usually takes place when the clients are admitted, but it also occurs after discharge. The aim is to address issues relating to client and family relationships. A nurse and two clinical psychologists shared their experience with family therapy:

> '*Mostly, we do family therapy once they are still on admission. Even after granting them trial leave, we still do family therapy whereby we call all necessary people from the family and the social workers*.' (N2Aw)

'*Clients with problems with family relations are also invited to the family therapy session to help address the problem.'* (P4L)

- **Behaviour modification therapy**

One clinical psychologist recounted her experience of administering behaviour modification therapy to a female individual with schizophrenia. She did this by allowing the client to focus on the good aspects of her behaviour, which were her strengths, before addressing undesirable behaviour.

'We still allow her to live her life, but what we do is to strengthen the area of strength by helping her to focus on things that she can do well while we work on the undesirable behavioural aspects of her life.' (P1)

7.2.1.4 Occupational therapy

Persons with schizophrenia also receive occupational therapy at rehabilitation facilities. There are several interventions carried out to provide occupational therapy to rehabilitate clients with schizophrenia; these include therapeutic community (therapeutic community meeting), recreational therapy, activities of daily living (training on self-care practices), sheltered workshop, vocational rehabilitation, art therapy, role play, and social skills training (assertiveness skills).

At one tertiary hospital, clients even received a referral to the occupational therapy unit before their discharge. The conducting of assessments is to learn what trade the client may be interested in and which occupation best suits the client based on his or her health status.

‘*Before the client is discharged, we refer the client to the occupational therapy unit where they will do an assessment - occupational assessment -, to see what this client as of now can do. We also look at the interest of the client.*’ (D1L)

‘We have departments like occupational departments where they can go to acquire some of the skills that they need. By doing so you will find out about their area of interest.’ (N3L)

In another facility, referral to the occupational therapy unit occurs as soon as the client gains insight into their condition and can interact with others.

‘*So as soon as they have insight and can interact, we introduce them to occupational therapists.*’ (N2L)

The occupational therapy units usually have many subdivisions where various trades are taught to clients whilst rehabilitating them. One tertiary facility even has an educational college where clients who dropped out of school due to mental illness can enroll to catch up with academic activities.

> '*Those who want to learn about computer we have computers, for those who want to learn how to barbering, they are allowed to do that, for those who want to learn tailoring, we have tailoring unit, cobbler unit, beads making, and tie and dye, 'Adire'* (local textile design).' (D1L)

> '... *We have all these units. They make things like beads, interior decoration, and all that, so clients can learn a trade. … We have a college of education around. So those who drop out of school, we have enrolled them into schools.'* (D2L)

One nurse also mentioned that the occupational therapy unit in her facility has many sub-units.

> '*They have tailoring, shoe-making, and a lot of departments in the occupational therapy unit*.' (N1L)

One occupational therapist from a tertiary facility indicated their facility has instructors for all the subdivisions under the occupational therapy unit.

> '*The government had already employed instructors for us. We have tailors that are training them in tailoring, sewing, fashion designing. We have cane weaving men. We have woodwork men. The cabinet makers. Then we have leather works, the shoemakers. We have them and likewise, we have professionals. The artisans … we have very competent artisans here. … We have a competent barber, hairdresser and all that. Even we have a music trainer, who trains them in music and takes them through computer lessons too*.' (OT2A)

In another hospital, the rehabilitation unit serves as a place away from the ward where clients go to engage themselves in exercises and activities, including recreational activities and some forms of trade to keep them occupied during the day.

> '*There is an occupational therapy unit within the hospital setting where clients leave the ward area to go and exercise themselves, engage in some recreational activities,*

or learn a trade. With this, the client is not in bed for 12 hours, but they will be outside doing other activities.' (N1Aw)

Clients are also sensitised, counselled, and encouraged to maintain their occupation to prevent them from becoming dependent on others.

'*So as part of rehabilitation, any form of occupation that the clients have, we encourage them to carry on because they cannot be dependent on the people for long. … We encourage them, we counsel them so that they will be focused and know that there is a need for them to work, and if they don't work, there is no way they can carry on with life*.' (N10Ac)

During working hours, there is the observation of clients when engaging in occupational therapy activities and reports sent to their doctors to inform their treatment decisions. Usually, their engagement is for a few days during the week.

'*At the occupational therapy unit, the staff observe the clients' mental state to know how the client is doing. … If a client's behaviour is questionable, they quickly link up with the doctor and say that this client in our unit observes this and that, and we want you to review*.' (D1L)
'*Once they are referred, the occupational therapist will engage them for about three days in a week.*' (N2L)

One occupational therapist explained that activities carried out at the occupational therapy department are to impart skills to the clients and improve their levels of functioning.

'*With the help of the medical team, which involves occupational therapists, … we impact skills into our clients and we engage them meaningfully to ensure that they achieve their level of functioning*.' (OT2A)

The client's relatives are also involved in occupational therapy. One nurse mentioned this is done to ensure relatives can help clients with the resources to start working in the community after they have successfully learnt a trade.

'…*When the client gets to the occupational therapy unit, they invite the clients and their relatives. They assess the capacity of the client and their relations and know if the relatives have the financial capacity to set clients up to practice the trade after discharge*.' (N3L)

Relatives are encouraged to provide the necessary resources for clients to practice their trade successfully after discharge to promote independence.

> '*We encourage the relatives to establish them by providing them with what they need to practice their learnt trade. Once they establish themselves, they will be able to achieve their independence.*' (OT2A)

In one facility, clients who had successfully learnt a trade went through a graduation ceremony to celebrate them.

> '*In the past, we did graduation for those who learnt their trade well. As we graduated from that work, we celebrated those people.'* (N4Aw)

- **Therapeutic community**

Occupational therapists conduct therapeutic community meetings during the rehabilitation of clients with schizophrenia. Clients congregate in groups to discuss an issue, which includes general issues or issues relating to self-care; this is to facilitate client interaction with others. Clients can also chair some of these meetings to boost morale and confidence in interacting with people.

> '*Like the activities that we do for individuals with schizophrenia, we have group discussions, group therapy, also we have what we call therapeutic community meetings, whereby they come out and then we have a discussion on a topic or any issue.*' (OT1A)

> *'We do group therapy for them where we discuss activities of daily living. They get to know how to take care of themselves and to also perform it.*' (T5L)

- **Activities of daily living (Training on self-care practices)**

Clients are also oriented on and guided to carry out activities of daily living, such as self-care practices, on their own; these include activities such as bathing, grooming, eating, washing, and taking medication.

> '*At the occupational therapy unit, clients are also taken through activities of daily living such as mouth care, bathing, grooming, and feeding, by the staff who teach and encourage them to care for themselves*.' (D1L)

'*So, we train them on how to eat effectively, how to take their bath effectively without depending on other people. Some will even bathe, they don't bathe properly*.' (T3L)

Sheltered workshop

One tertiary facility operates what the staff calls a sheltered workshop, a system where clients obtain paid employment in the occupational therapy unit for the facility.

'*So, what we do now is like a sheltered workshop. We call it a sheltered workshop. Such that they are paid a salary just like you and I go to work and come back. So they've made the occupational therapy department their working place*.' (T1)

Non-governmental organisations (N.G.O) pay most of them for their work at the sheltered workshop.

'*Here, in the sheltered workshop, it's not the government that is paying them. It is the concerned N.G.O or caregivers that still pay them. Like I just finished paying a client when you walked in. It was the N.G.O that referred, he is not aware, he thought it's just salary, but it's the N.G.O that is paying them so that they will come Monday to Friday*.' (T1)

- **Vocational rehabilitation**

Clients enrol in various trades and activities, including dressmaking, hair care, bed making, the printing of cloth, and other trades all at the occupational therapy unit, under the supervision and guidance of the staff at the unit.

'*They are introduced to different kinds of activities like baking, tailoring shoes, tie and dye, bead making. … They introduce them to all these, but later the client will pick the ones they are more interested in and concentrate on it.*' (N2L)

'We have those we have enrolled in barbing, fashion designing, and cobbling.' (D2L)

'Some of them are trained well and they can bake meat pies.' (S1)

Previous occupation or trade informed the decision of the occupational therapist as to which activity to enrol the client in. Those who were dressmakers were retrained in dressmaking, whilst women who were housewives received training on how to manage a home.

'*We find out, 'you were a seamstress; will you still cope with that?' If she has been a housewife before having this problem, the occupational therapist and social workers will see how they can gradually introduce her back to the market. Follow her to the market, supervise her, make some bargains in the market, buy things and prepare things*.' (D1L)

Those discharged are still welcome at the occupational therapy to continue with rehabilitation at one neuropsychiatric hospital. Clients keep returning to the occupational therapy unit until they have mastered the trade or skill they are learning.

'*Even on an outpatient basis, clients come in to learn from the occupational therapy unit. They learn the basics of the trade and go on ahead to master it at other workplaces if they wish to do so. They learn as part of their rehabilitation.*' (D1L)

'*They still keep coming, … they come for more lessons to finish up what they have been learning. … Some of them keep coming till they have been able to master what they are doing*.' (N2L)

There are activities conducted as a form of treatment for the clients, and not necessarily for them to learn a trade.

'*We do cane weaving, basket weaving, and others. These are activities that we use to treat our clients.'* (T2)

- **Social skills training**

Social skills training comprises socialising activities organised by occupational therapists, where clients are grouped to interact with each other and socialise through dancing and playing games.

'*We have social sections; we call it socials. It's actually like a party. We have the opening prayer. They dance and I dance with my clients. So that is about games*.' (T1)

'*So, we bring them out of their shell to interact with other people. We expose them to other people. So that, to improve their social interaction and all that.*' (T6L)

Clients learn communication skills as they interact with each other. Clients showing negative symptoms of schizophrenia are also motivated to speak out and interact with others. In group therapy sessions, there are discussions on socialisation skills.

'*We have group therapy. Under group therapy, we may say today we want to discuss social skills training. In social skills training, we talk about interpersonal skills., how to communicate with people.*' (T3L)

'*Schizophrenia has what we call negative symptoms, which can prevent a client from doing what he was doing before. For such people, socialisation skills will be poor. So, we put clients like that in such social groups that have social skills involved. We teach them the proper way of speaking in the environment. Taking turns, initiating conversation and ability to end the conversation.'* (T6L)

Some start from one-on-one social activities and then move on to larger group activities to facilitate client interaction with others.

'So, we grade the activities. We start from the simplest one to the bigger one. Some are big activities, so we start from one on one to see how receptive the client is to one-on-one interaction. On the ward, we tell a client to come and play a game with us. Table tennis is available on all wards. We may pair the client with another to play table tennis and we observe and supervise.' (T1)

Part of socialisation is assertiveness skills training, which clients receive as a form of rehabilitation. This occurs as part of group therapy, where clients have to assert themselves and be able to speak out freely without fear of intimidation and not allowing anyone to have their way around them.

'*Then, we do assertiveness skill training. Some of our clients with schizophrenia are not assertive. They don't have the courage to say no when they want to. They don't have the initiative to assert themselves. So, we give them assertiveness skills training.*' (T1)

'*We have group therapy and we discuss all these things. We do self-esteem training and assertiveness training because some devalue themselves. They just devalue themselves. Like you can push them around. We teach them to be confident, speak out, and not to allow others to manipulate them: Stand your ground, these are things you do, and these are the things you don't do. These are some of the training we give to them*.' (T3L)

7.2.1.5 Multidisciplinary mental healthcare

The rehabilitation practices carried out on persons with schizophrenia employ a multidisciplinary approach to mental healthcare. This approach involves the inclusion of many HCPs that make up the team involved in rehabilitating clients with schizophrenia and includes the medical social worker, clinical psychologist, mental health nurse, occupational therapist, and psychiatrist. These HCPs provide psychotherapy, chemotherapy, occupational therapy, counselling, and electro-convulsive therapy for the treatment and rehabilitation of people with schizophrenia.

> '*You know it is not only occupational therapists that are working here. If there is a need for a psychologist, they refer such a client to a psychologist and so on.*' (OT2A)

> '*In this facility, we have been able to use different kinds of therapy to manage them like psychotherapy, chemotherapy, occupational therapy, counselling, we use physical therapy which is electro-convulsive therapy. We use electro-convulsive therapy for a kind of schizophrenia-like Catatonic schizophrenia.*' (N4)

- **Need-based rehabilitation**

The rehabilitation services provided by this multidisciplinary mental healthcare team are need-based. The practice of need-based rehabilitation aims at providing unique and individual rehabilitation services to individual clients based on their presenting problems and unique needs. The participants asserted that the needs of clients differ with some needing rehabilitative intervention in one domain of their life, whilst others might need rehabilitation in many domains.

> '*Now, the needs of every client differ. For some people the area of rehabilitation may be very small, not covering so many domains, but for clients with chronic mental illness, the enormity of rehabilitation work is high*.' (D1L)

> '… *but it depends on what the client actually presents. This will determine the kind of treatment to give*.' (P3L)

Need-based rehabilitation is to address the unique needs of each client whilst respecting the individuality and uniqueness of each.

> '*Rehabilitation has to address the interest of the client, which is unique. If the client doesn't find the activity meaningful, they will not participate. …So, when you have a problem with*

schizophrenia. We don't group. Each of them is scheduled to do an activity based on their unique needs.' (OT1A)

- **In-patient and outpatient rehabilitation services**

Rehabilitation services provided by the multidisciplinary mental healthcare team can be in the ward during admission, or on an outpatient basis. Based on the assessment, those who need in-client care are admitted for treatment and rehabilitation, while those not requiring such care are treated and rehabilitated on an outpatient basis.

'*We see and treat to the best of our ability and if there is need for admission, we refer to Aro, neuropsychiatric Hospital, but if it's something that is not too critical or too bad, we treat on an outpatient basis here.'* (D1)

Concerning treatment on an outpatient basis, doctors review clients and give them prescriptions to buy their medication; the nurses then counsel them and encourage them to take their medications. Conversely, facilities within rehabilitation centres receive clients referred to the unit on an outpatient basis and engage them in rehabilitation activities during the day throughout the week.

'*Outpatients are referred from outpatient clinics and they come to the occupational therapy department. They come Monday to Friday from their home and when they come, we engage them in all our activities including for vocational rehabilitation.*' (T1)

Those admitted go through the usual treatment process. After their psychosis is resolved, they receive a referral to the occupational therapy unit where PSR takes place, and subsequently, are discharged to reintegrate into the community.

'We have an occupational therapy unit here. When they are admitted, we clear them of their psychosis. We take them through the appropriate psychosocial rehabilitation and they are discharged and back home and get integrated into the community.' (D2L)

7.2.1.6 Community care

Apart from in-or-outpatient modes of treatment and rehabilitation, there are some treatment and rehabilitation services conducted within the community. Activities carried out within the community include community sensitisation on mental health and rehabilitation services, home tracing, follow-up services, home visits and client integration into the community. The community mental health team includes doctors, nurses, and medical social workers. This

team is responsible for following up on clients at home, especially those already discharged from the psychiatric hospital after treatment, to help rehabilitate them in the community. Clients from the community undergo assessment at the facility to determine if management in the community is possible, and those determined to be manageable are then referred to the community mental health unit for treatment and rehabilitation.

> '*Before the client can even obtain a card here, we first assess the client to know if that case is one that we can manage in the community…. If they notice that this client can be managed in the community, they will refer the client to the community psychiatric unit here, for us to manage.*' (N12As)

In some instances, clients do not have the means to go to the hospital to see the doctors. Mental health nurses in the community take the clients' history and send the records in a folder to the doctors to review after they return to the community to administer treatment to the clients. This makes access to mental healthcare and rehabilitation services easy for clients.

> *'We are only seeing them within their community … We take their file from that place to the doctor to review, and we go back to the community to give them long-acting medications and some of them are stable.*' (N11Ac)

- **Community sensitisation on rehabilitation services**

One of the activities carried out by the community mental health team is sensitisation of the community to mental health, and the availability of PSR services. Nurses usually undertake this in various places, including schools, churches, health facilities, and workplaces.

> '*We go to the hospitals, to schools, to community meetings and parent-teacher association meetings, to churches, to educate them because people are not knowledgeable about mental health. So, we go into the community, anywhere we find ourselves. Even in the post-natal clinic, in the antenatal clinic, we give health talks.*' (N10Ac)

> '*We do sensitisation all around. In the nooks and corners of the area. In the market places, at the palace, in the hospital premises, even garages, and schools*.' (N8Ac)

- **Follow-up services**

Follow-up services in the follow-up of home visits and checking up on clients occurs in some parts of the country to ensure continuity of care of persons with schizophrenia. Some clients

are traced to their homes and followed up for treatment and rehabilitation, others are visited at home, whilst others are contacted by phone to receive education and counselling services.

> '*When we get some information about one with mental illness in the community, we would collect the full information of the area then we would go and trace the home. We would let the relatives be aware of our treatment and rehabilitation services and how beneficial it is. … Once the treatment is commenced and they are aware, … they will now come for review*.' (N8Ac)

> '*The fact that the client is discharged does not mean we are going to throw the file somewhere. We still pick the file once in a while we call them, like the people that are here right now*.' (T6L)

Medical social workers and nurses are those who mainly conduct follow-ups in the form of home visits however, occupational therapists also follow up on their clients. This is to ensure comprehensive care of the clients and to know how clients are faring at home, especially those who fail to come for review.

> '… *We have social workers. If there is any need to follow up on the clients to their home, they do*.' (N2L)

> '*Yes, …social workers go to visit them at home because that is their area.*' (N3L)

However, others do not offer any follow-up services to their clients after discharging them; one nurse explained this was to instill independence in the client.

> '*But once they are discharged, we don't have any community-based intervention.*' (P2L)

However, one medical social worker explained that clients who receive follow-up services do better than those who do not.

> '*Those of them that we are actually able to follow up are doing very well.*' (S2L)

- **Client integration into the community**

Reintegration of clients into the community is the final part of the treatment and rehabilitation process and is mostly championed by the medical social worker and the nurses. This involves assessment of the home and community situation to ensure the smooth integration of clients

into the community. They try to reach out to clients' employers and family members to ensure the client gets back to work and is welcomed by the family.

> '*Generally, we use social workers to link up with their employers to see how such clients can go back and get their job if they have lost their job. Then link up with the family members to ensure that the client is received into the community again and if it means getting accommodation for them … or ensuring that they don't stigmatise such clients and ostracize them*.' (D1L)

In some instances, family members have an invitation to see the clinical psychologist for family therapy to resolve relationship problems between client and family to guarantee proper integration into the family after discharge. The social worker also addresses issues with work, marriage, and other socio-cultural problems at home and in the community that may hinder clients' smooth integration into the community before discharge.

> '*The social worker will write their report. We will study the report and see. Oh! We need to invite (the) family member for family therapy and a psychologist will handle that. If they are ready to accept the client or the client having a broken marriage or no spouse to take care of this client, we see what we can do. Sometimes, we liaise with the employer too, to see what can be done to help the client*.' (D3L)

7.2.1.7 Collaborations for effective care

To ensure effective treatment and rehabilitation of the clients, there are collaborations with numerous stakeholders to secure financial support and other resources. It also aims to secure cooperation with family and client's employers and includes collaborations with philanthropists, local government, informal caregivers, employers, family members, religious organisations, and individuals.

- **Philanthropist support**

Collaboration with philanthropists provides some financial aid for the treatment and rehabilitation of our clients. They pay the rent and other expenses of some clients after being treated and rehabilitated to ensure their settlement in the community.

> '*We have some that use to give out money for treatment and rehabilitation of our clients. One traditional leader used to donate five thousand Naira each month for this course.*' (N10Ac)

'*Though we have some philanthropists who support the facility financially, they are very few … They even pay for accommodation for the clients after catering for their treatment and rehabilitation.'* (N6L)

Traditional leaders, local government officials, and business executives also come to the aid of the clients.

'*The philanthropists are traditional heads like some Baale. Kabiyesi in some local governments*.' (N10Ac)

'The philanthropist could be managers of organisations or factories. They could be chiefs; they could be 'Obas' (the head of towns). *So, we just reach out to them. We explain to them what is happening, we tell them about the needs of our clients, and some respond.*' (N9Ac)

- **Collaboration with local government**

Concerning collaboration with the local government, nurses make concerted efforts to appeal to authorities at the local government for funding for the treatment and rehabilitation of some clients.

'*What we do in the community is to go from the local government level to the grass-root level to be able to have access to some funding to be able to treat and rehabilitate our clients.'* (N10Ac)

- **Collaboration with informal caregivers**

To ensure smooth care of clients away from the health facility, HCPs collaborate with their informal caregivers. The effort made by informal caregivers in providing care for clients at home is appreciated, while a collaborative effort is maintained to ensure effective treatment and rehabilitation of the client at home; this is undertaken by doctors, occupational therapists, and nurses.

'*We collaborate with the caregivers of the clients, all right*.' (D1L)

'*Informal caregivers can get tired and that's why we liaise with them from time to time. We thank them on behalf of our clients for their care ...*' (T1)

- **Collaboration with employers**

Due to the critical role employers play in ensuring clients are re-employed after treatment and rehabilitation, collaboration with them ensures the smooth transition of this process. This avoids instances where clients remain unemployed after discharge and have to depend on family members and friends for financial assistance.

> '*Sometimes, we liaise with the employer too, to see what can be done to help clients get some work to do and not depend on others for financial support*.' (D2L)

- **Collaboration with family**

Family members are an important aspect of the treatment and rehabilitation process. Effective collaboration with family members ensures smooth treatment, rehabilitation, and reintegration of clients back into the community. This helps to access some money from the family to aid in the treatment and rehabilitation of the client, and to ensure continuous rehabilitation.

> '*The family is asked to leave some tokens for their relatives. At the end of the month, the money is given to the client and the client feels he is earning money for engaging in rehabilitation activities. This is just to serve as an encouragement for them to continue with rehabilitation activities.*' (S2L)

> '*If the client does not come on time for rehabilitation, the occupational therapist can link up with social workers and they can make a phone call to the client or the family members so they can ask why she is not coming*.' (D1L)

Participants also meet with family members to discuss treatment and rehabilitation plans and keep the family updated about their treatment and rehabilitation activities.

> '*We have meetings with the client's family. Some relatives too will bring their opinions about treatment and rehabilitation of their relative. … Some because of their financial Status will say they cannot do all these things. So, we now listen to what they propose and we reach an agreement*.' (T3L)

Collaboration with the family is also to ensure they receive the client back home after discharge from the hospital.

> '*Then link up with the family members to ensure that the client is re-absorbed into the community again and if it means getting accommodation for them……or ensuring that they don't stigmatize such clients and ostracize them*.' (D1L)

At home, the participants also collaborated with clients' families to monitor the client's progress through contact with the family. This took the form of phone calls to the family members to find out about the client, receiving reports from family on the client's behaviour at home during weekend leave, and during parole to inform treatment and rehabilitation activities.

> '… *In some cases, we make a call to the family members of the clients to ask how our client is doing in the community*.' (N12As)
>
> '*After discharge, we will still want to know how they are doing, if they are doing well or not*.' (T6L)

Collaboration with the family is not only for the benefit of the client but also for the family.

> '*The hospital involves the family of the client with schizophrenia to provide support for the family affected.*' (N1Aw)

- **Collaboration with religious organizations and individuals**

Religious leaders and organisations also serve as sources of funding for the treatment and rehabilitation of persons with schizophrenia. Collaboration between participants and religious organisations their clients belong to helped secure funds to treat and rehabilitate some of their clients and reintegrate them back into society.

> '*Sometimes we link up with maybe churches or religious homes that the clients belong to. Sometimes some individuals, highly spirited individuals, make funds available. …They get accommodation for clients, and help them to learn a trade*.' (D1L)

7.2.2 Psychosocial rehabilitation constraints

Challenges faced with PSR of persons with schizophrenia in Nigeria mainly involved challenges associated with the management of facilities providing PSR services. Management problems included but were not limited to inadequate funding, inadequate facilities, and resources needed to provide standard PSR services, in addition to lack of the required human resources to provide PSR for persons with schizophrenia in Nigeria. These constraints with PSR of persons with schizophrenia in Nigeria is not only limited to challenges with management, but extends to challenges faced by the very staff involved in PSR and the clients and their families who are at the receiving end of these PSR services; these include poverty, stigma and discrimination of clients, their families and staff, and frustration on the part of families of clients with schizophrenia. Eight categories emerged from the theme PSR constraints: Lack of facilities, Financial constraints, Stigma, Poor family commitment, 'No

mental health legislation, Lack of material resources, 'Referral challenges, and Inadequate staff.

7.2.2.1 Lack of facilities

Facilities for proper treatment and rehabilitation of persons with schizophrenia are lacking in Nigeria, and described in terms of inadequate rehabilitation centres and inadequate psychiatric wings.

- **Inadequate rehabilitation centres**

The existing facilities are full beyond capacity thus, placing so much stress on available resources in the facilities. There is also a lack of space for the staff to engage in treatment and rehabilitation activities with the clients. Consequently, instead of admission for observation for treatment and rehabilitation, some clients end up returning home.

> '*Because why am I saying this is that, presently, the neuropsychiatric hospital is overstretched with clients beyond its capacity… clients are sent back home just because there is no space, but where will they go?'* (N3Aw)

> '*O.K.…Availability of space for the staff to engage them fully is a problem.'* (N6Aw)

One clinical psychologist lamented not enough was being done for persons with schizophrenia due to space constraints and inadequate structures required for the delivery of effective and convenient treatment and rehabilitation services.

> '*So, for me as far as rehabilitation is concerned, we are not doing enough. We don't have enough resources*…'. (P1)

Existing rehabilitation centres in Nigeria are few in number, and those that do exist are not well established to provide standard treatment and rehabilitation services for persons with schizophrenia.

> '…*and those rehabilitation centres, even though they are not properly set up and not well structured, they are still very few in numbers.*' (D1L)

Some psychiatric hospitals do not even have rehabilitation centres. One hospital used to have one but had to close the centre down due to financial constraints.

'*Also, our hospital doesn't have a rehabilitation centre for now. There was a time we had one that was functioning, but because we had some financial constraints, we had to close down.*' (N1L)

One nurse and one occupational therapist expressed concern about the non-existence of halfway homes that serve as transition centres for clients after discharge from the psychiatric hospital.

'*As a nurse, I know there is a place called halfway home. Where you keep a client for rehabilitation, but we just see it on paper. It has never been implemented here in Nigeria. I have never seen such a structure'*. (N3Aw)

'*We need to have a transition home; we don't have it. Some call it halfway home*.' (T3L)

However, there are no additional structures and wards under construction to accommodate the overflow of clients at the facilities even though some of these facilities have enough land and space available for expansion. This is how one nurse lamented over the situation:

' … *what is stopping Aro from building more wards. We have the land, why are we not building more wards* …' (N3Aw)

- **Inadequate psychiatric wings**

Psychiatric wings attached to general hospitals where persons with mental illnesses, including schizophrenia, stay for treatment and observation are also lacking in Nigeria. Poor administration of the few existing facilities for treatment and rehabilitation of persons with schizophrenia in Nigeria compounds the problem.

'*In the general hospitals in Lagos, one would have expected all these general hospitals to have psychiatric units but they all don't.*' (D2L)

'*Also, the administration of the place is not properly done.*' (N1L)

The challenge is that even with available wings there is poor administration.

7.2.2.2 Financial constraints

Financial constraints are represented by inadequate and poverty. Inadequate funds for the smooth running of treatment and rehabilitation centres for persons with mental illness is a major challenge in the psychosocial rehabilitation of persons with schizophrenia in Nigeria.

Poverty among clients and their families and the existence of private rehabilitation centres that offer treatment and rehabilitation services at a high cost that is difficult for the majority of persons with schizophrenia and their families to afford, compounds this problem.

- **Inadequate funds**

Challenges concerning inadequate funds for the smooth running of psychosocial treatment and rehabilitation centres in Nigeria include inadequate funds for community activities and low budget allocation for mental healthcare. It also includes inadequate funds for infrastructure development, inadequate funds for physical healthcare of clients, inadequate funds for feeding clients, inadequate funds for logistics, inadequate funds for maintenance, delay in supplies, lack of funds to care for clients, and inadequate money for transport.

Some HCPs engaged in community mental healthcare complained about inadequate funds; some end up spending their own money on call credits to be able to reach out to clients and their families in the community.

> '*The hospital only gives us 1,500naira for the call credit card for the two of us. The two supervisors working in that zone will divide it into 750naira each. We will be calling the clients and we are using part of our money because the money is not sufficient for the two of us.*' (N11Ac)

Participants also commented on low budget allocations for mental healthcare in Nigeria.

> '*Nationally, when you look at the budgetary allocation to health, it is so small. That which is allocated for mental health from the health budget is far from okay*.' (D2L)

For some of the participants, the woefully inadequate budgetary allocation to mental health practice is due to a lack of interest in mental healthcare on the part of the government.

> '*One part of the problem is the financial constraint on its own and the second is that the government does not see mental health care service as important. … Government prefers to spend more of the money in the general health care setting than to spend money in the psychiatric setting.*' (N12As)

Although participants were aware of the standards of rehabilitation facilities required for proper rehabilitation of persons with schizophrenia, the lack of funding was the major impediment to the materialisation of these expectations.

'*When you don't have the funds for putting structures in place, that's a big problem too. We have the ideas, … but unfortunately, as much as we desire that, funding is a big issue. Funding is a very big issue, and unfortunately too.*' (D1L)

The government has also reduced subsistence to facilities, thus crippling their ability to expand or to construct new rehabilitation facilities.

'*With regards to finances, we are not getting enough subsistence from the government. The government has cut the subsistence to this hospital marginally. More than 2/3rd of what is supposed to be given to us to work with has been taken away. So, you can't see a new building or the construction of a new rehabilitation centre*.' (N1Aw)

Without any financial support or subsistence from the government, the hospital also has the burden of bearing the cost of physical treatment of abandoned clients. Nurses and medical social workers have to accompany these clients for treatment of physical conditions at the expense of the psychiatric hospital.

'… *some have been here for 20-30years. So, when they develop some other medical complications, or medical problems because of old age, heart diseases, diabetic problems, skin problems; it is the hospital that is saddled with the responsibility of taking them to other general health facilities for treatment. So social workers and nurses will get them to the ambulance and take them there to receive treatment or care*.' (D1L)

Although funding is unavailable or inadequate to acquire the needed logistics to expand existing facilities, there are also inadequate funds for the maintenance of the already existing facilities and resources.

'*You also know the kind of country we are … we are not even getting funds to maintain the department.'* (S2L)
'*The funding is not coming in like every other place in the world. So, we cannot do any proper maintenance of the facility*.' (T2)

Financial constraints also led to delays in supplies needed for treatment and rehabilitation activities by the rehabilitation team in the facilities.

'*We don't have the things we need even for personal hygiene. Though hospital supplies, I mean give us an impression, but it might not be available or come at the due time*.' (N4Aw)

'*The reason it's not made available is because the management will tell you there is no funds to provide that. So, we go back and wonder what we can do without the needed supplies*.' (T1)

Consequently, some participants impress upon each other to make contributions of their own to acquire the needed supplies with which to work.

'*So, we beg one another to contribute or donate to buy the things we need to work with. So, it's money*.' (N4Aw)

Inadequate funding also affected the operational activities of these hospitals and rehabilitation centres in terms of transportation services.

'*Some people in that health centre may be waiting. They may be waiting for us to get there, but there may not be money to fuel the car for us to go. When there is no fuel there is nothing you can do. You cannot dip your hand into your pocket and go and buy fuel.*' (N11Ac)

'*Sometimes the staff will want to go out for follow-up services and they will say there is no fuel in the bus; things like that*.' (N2L)

- **Poverty**

The poor economic status of clients and their families is part of the financial constraints in the treatment and rehabilitation of persons with schizophrenia in Nigeria. Clients and their families have low incomes, thus no money for rehabilitation, food, medicines, or treatment, in addition to inadequate money to cater for the cost of transportation to and from the hospital or rehabilitation centres.

'*One of the challenges is that when you look at the people or the client themselves, you will see that these are people living with poverty*.' (D1)
'*Probably the income of that individual is not enough and the extended family members are not able to offer any financial support*.' (N2Aw)

Due to the poor background of the clients and their families, they are unable to pay for treatment and rehabilitation services provided to them. To most of them, the costs of treatment provided in their public rehabilitation and treatment centres are expensive.

'*So, they cannot afford going to Aro because they feel Aro is expensive*.' (D1)
'*Majority of the people that are assessing this treatment are poor. They are from poor backgrounds; they can't afford to pay for treatment*.' (N1Aw)

- **Expensive private rehabilitation centres**

The existence of expensive private rehabilitation centres does not help with the financial constraints faced by the already impoverished persons with schizophrenia. These privately run rehabilitation centres provide treatment and rehabilitation services at high costs.

'*We have few private rehabilitation centres, but they are unaffordable for an average client and their family. I didn't talk about that because I know many of the clients and their relatives will not be able to afford them. … I can tell you, most of them are largely unaffordable*.' (D1L)

These facilities are not subsidised by the government, and only thrive on payment of services provided by their clients. Secondly, these are also profit-making organisations and this explains why their services are expensive.

'*Of course, they are not being subsidised by the government. They are running it on their own and they are in business, not for humanitarian effort alone, but also as a profit-making organisation.*' (D1L)

'*Most of the rehabilitation centres that we have are privately owned and the government ones are very few. … So, it is very unfortunate that most of the private care homes that we have, are being operated by private individuals who do it for profit-making.*' (S2L)

One social worker lamented about the non-existence of Non-Governmental Organisations (NGOs) that run treatment and rehabilitation centres for clients with mental illness in Nigeria, although these NGOs support people with other chronic illnesses such as HIV/ AIDS.

'*Although we have been seeing some NGO who claim to be supporting people with other illnesses like HIV, but we have not been seeing NGO that are operating within the mental*

health, that will say, I have this facility, come for rehabilitation free of charge and go … we don't have that.' (S3M)

- **Lack of material resources**

Participants spoke about the lack of material resources to aid their practice. Issues raised were lack of bed capacity to admit clients, transportation problems, and lack of consumables to work with.

- **Lack of bed capacity to admit clients**

Participants stated they do not have the capacity or accommodation resources to admit clients. Many projects started years ago have stalled due to lack of funding. One psychologist stated they have the personnel but are constrained by space to admit clients to work to full capacity.

"*Our main constraint is our inability to admit clients. We have a place where we…it was intended by the government to be admission unit, but they started building and half-way they stopped, they said they don't have money to complete it*" (D1)

"*We don't have an admission capacity. There is no admission*". (N11Ac)

"...*some rehabilitative measures wanted to start in this place about five years ago, but we were unable to. ……up till now, they have not started it, because they were unable to raise funds.*" (N1Aw)

- **Transportation problems**

Many participants complained about the lack of transportation means, a necessary resource the mental health workers needed to facilitate their home visits and community care. Some participants stated their facilities used to have between two and four vehicles, but they have no functional ones with which to work.

"*The only constraint presently is the vehicle. Because, before, we were using two Hilux. Presently we have only one Hilux, and the hospital gave us one car. Some health centres that are supposed to be visited during the rainy season, we cannot even get access to them, but we drop, and we now take a bike to that health centre. Come back to come and meet our vehicle where we pack it.*" (N11Ac)

"*One of the major challenges we face has to do with logistics. At times when you want to go out, there might be a vehicle, but they may say there is no fuel". Or if somebody else wants to go for something. For example, if somebody wants to go for investigation*

or go for an assessment, they give priority to such than for you going into the community for community service". (S2L)

- **Lack of equipment and consumables to work with.**

Participants spoke about the lack of materials to work with; key among these was the lack of equipment for rehabilitation.

"*If largatil is finished in this hospital, I am telling you, madam, in the next five hours, five hours is too much, in the next one hour, they will provide largatil, they will provide diazepam in this hospital, but for 5years, 10years down the line, we have been asking for the same material that will not cost the hospital a dine, yet they have not been able to provide it and yet, clients are coming in everyday and you say the occupational therapy is the hallmark of rehabilitation" (T2)*
"So my kitchen rehabilitation, if I take you to the kitchen, I don't have enough utensils, I don't have enough…" (T1)

"*Even this unit is not well established, we are not there yet, because, in this department, we should have an ADL training room, because some of these clients by the time you discharge them, some might even forget how to sit down in the sitting room, how to cook. These things are needed.*" (T3L)

"*Improvise most of the time because by the time we start sourcing for funds, to get the funds we have to wait and wait and wait and we can't continue waiting, so we have to think of what we can do and how we can go about it.*" (T6L)

Limited consumables were one major complaint from an occupational therapist. She mentioned consumables such as paper, materials for soap-making activities of daily living, and baking.

"*What I will say to that is material, we don't have enough material in discharging our duty. When we see these clients we use a lot of materials that cannot be used again. We do a lot of print out that we give to them individually to work on. Whether good or bad we cannot use it for another person.*" (T6L)

"*We have to wait for a long period before we will be able to get another material to continue and this is giving us a sort of step back. For example, we have a soap-making*

section. Soap making is supposed to be weekly, but we can't have it weekly. We have it only when we have a request." (T6L)

"*Like training a client how to bake or how to make small chops or snacks like that, we may not, we can't keep those things, we have to have them and continue……. we can't, we can't, you can't use the material you used for this section for another.*" (T6L)

- **Lack of human resource**

The participants reported a lack of human resources, presented in terms of staff shortages.

- **Staff shortage**

Not having adequate HCPs was a major constraint stated by the participants.

"*You know, in working with that lofty idea of taking psychiatry to the community, we also need to employ people. It cannot be the same people that will work here, morning till after they are the ones you will know post to the community again, not likely like that. We can't be running a clinic here and it's also the same staff that will be attending to people in the community". (D1L)*
"We are very short staffed. We cannot adequately cover all the units, but we are trying our best. Issue of being short-staffed is one of the problems facing us." (OT2A)

"*I won't say we have so many resources at our disposal, but if we are looking at mental health as a team approach, we have the medical doctors, psychologist, and occupational therapist.*" (P1)

Some participants recorded staff turnover, especially social welfare personnel, leaving the institutions and the remaining HCPs with heavy workloads.

"*So also the personnel are not enough. The number of clients outweighs the number of available personnel. The ratio of clients to personnel is very high*." (P2L)

"*Social welfare for the staff is not encouraging. People are living, and once they are leaving, we are losing expertise and leaving us with less experienced staff that are newly employed. These are the challenges that can remember accurately*." (N1Aw)

- **Inadequate rehabilitation** HCPs

The participants stated rehabilitation staff were critically inadequate. They explained the government is not employing due to funding issues.

> "*Over one hundred and eighty thousand clients, with manpower of about 32 social workers to about one hundred.*" (S1)

> "*We all know that the government are not doing any employment and I can even say that we are very short staffed here as regards occupational therapist*." (OT2A)

- **Effect of staff shortage**

Due to the activities involved in the assessment, diagnosis, and treatment planning of a mentally ill person, it takes time to care for them, therefore lack of staff increases the amount of time a practitioner spends on a client.

> "*Most of these activities are time consuming and you need a lot of personnel to be able to attend effectively to these clients*." (P2L)

> "*Clients come here, we have over three hundred clients to see in the clinic and then it takes hours for them and also our staff are tired, fatigued. The staff are tired, fatigued, and seeing clients*." (D1L)

> "*Mental illness is exponentially increasing at a very alarming rate and the health care* practitioner*s that are being turned out do not even have jobs, again it bulges down to the fact that we are not expanding. Already those around, those available are overworked and burn out syndrome is setting in*." (D2L)

7.2.5 Referral challenges

Participants also spoke about the challenges they have with the referral process. These challenges encompass cumbersome admission processes, lack of cooperation from other institutions, lack of HCPs.

Friction between state and federal government institutions.

One major difficulty was the fact that federal and state government hospitals have some friction that affects the referral of clients between the two categories of health facilities, even though their commitment should be to the same to all citizens of Nigeria.

> "…*but when we feel that those clients need that kind of assistance, to get down to those rehabilitations can be very difficult, very difficult, very, very difficult… maybe they*

are also trying to avoid their canters being overcrowded, maybe. Maybe that is why they also put some stringent measures in place that make it practically difficult to get clients from here to those centres." (D2L)

"*So that in our experience here, we…...the relationship between us and those rehabilitation centers is obviously not so cordial again. We have a lot of clients that need rehabilitation. That needs where they can settle or whatever. Those citizens are Nigeria Citizens and some of them are citizens of this state too. So the issue that we are federal institutions and they are state institutions should not be a stumbling block in helping those clients*." (D1L)

7.2.5.1 Lack of HCPs at PHC level

A medical doctor highlighted the fact that it is difficult to refer people living with mental illnesses to the primary healthcare settings for continuity of care because they do not have mental healthcare workers to care for the clients.

"*That is hardly done because virtually almost all of them, to the best of my knowledge, I may be wrong, but to the best of my knowledge, they lack mental health workers. I am not talking about psychiatrists, but I am talking about primary mental health care workers who are supposed to be like mid-level mental health workers that are supposed to be there and ready to assist clients with the follow up of their care. Oftentimes they don't have such*." (D3L)

7.2.6 Stigma

Stigma and discrimination of persons with schizophrenia were not only from the community and their families but from organisations as well. Stigma is not only limited to persons with schizophrenia but also extended to the HCPs involved in the treatment and rehabilitation of persons with schizophrenia. This harms the treatment and rehabilitation of persons with schizophrenia in Nigeria and this underscores the need to reduce stigma and discrimination in mental illness.

7.2.6.1 Stigmatisation from the society and family members

People in the community tend to avoid associating with persons with schizophrenia. Most of them receive derogatory and stigmatising names.

'*People with schizophrenia face a lot of stigmas, they are stigmatised, and people don't want to associate with them. People call them a lot of names. Like you know they call them 'WERE', they call them mad and it tends to bring them down*.' (S3)

'*If you go out with the majority of people and you just ask about Yaba psychiatric hospital, you will hear a lot of comments. Some will call it a camp of mad people, some call it Yaba left. So, they stigmatise people. Once anybody gets here, even if their client has been healed, it's a problem*.' (T3L)

Organisations also stigmatise the mentally ill by isolating themselves from such facilities or institutions involved in the care, treatment and rehabilitation of persons with mental illness.

'*You will hear that this organisation or person donated a Kidney Centre to a general hospital, but I have never heard of any organisation or individual donating a building to the psychiatric hospital and you will ask…why*?' (N3Aw)

'*You have to know that because of the stigma now, most of these multinational groups are not involved or trying to identify with anything psychiatry or anything mental health*.' (S1)

7.2.7 Poor family commitment

Poor family commitment refers to situations where family members are unable to provide the necessary care and support in the treatment and rehabilitation of persons with schizophrenia in Nigeria. These include situations associated with delays in reporting their sick relatives for treatment and rehabilitation and neglect and abandonment of persons with schizophrenia at psychiatric hospitals and rehabilitation centres.

7.2.7.1 Delay in reporting for treatment

Some family members delay taking their sick relatives for treatment and rehabilitation, first sending the client to places for traditional and faith-based healing services.

'*Once they have the illness, before the present here, they might have gone to different places, maybe to religious homes or herbalists*.' (S2L)

'*They go to different kinds of places, seeking for a solution and you should know at that moment, it would have worsened to chronic level and when it gets to chronic level, it is difficult to be cured*.' (N4Aw)

7.2.7.2 Family neglecting client

Some family members end up neglecting their relatives. They pretend to be nice by coming to visit their relatives at the hospital and then they relocate and stop visiting, thus making it difficult to trace them. Others just abandon their relatives in the hospital immediately after bringing them for admission.

> '*Some of their relatives, immediately they know that our client has already been admitted to a rehabilitation home, some may be coming to visit, but sooner or later we just see them changing their environment. There is no way you can trace them.*' (N11Ac)

> '*Some brought their relatives to the hospital and left them at the gate or at the assessment unit and they left a fake address so we are unable to reach out to them*.' (N4Aw)

> '*Because in some cases, the relatives might just bring their clients, dump them and then go away*.' (OT2A)

7.2.7.3 Family or caregiver fatigue

Some family members become tired of supporting their relatives with schizophrenia in their treatment and rehabilitation; this usually occurs when the condition is chronic and treatment and rehabilitation are prolonged for an unusual length of time.

> '*Some of them are actually committed to the care of their relatives initially, but when they see the trend of things that it seems the problem persists, some of them become tired and run away. The burden is actually too much for the family* …' (P2L)

Some family members become tired and frustrated with providing care and spending money for the treatment and rehabilitation of a condition that is recurrent and seems not to resolve.

> '*You know. Schizophrenia ... we are all human beings. It's because we are health care* practitioner*s. We don't get tired of them. But at home, some of them get tired of them. They say ah, we have to tell him to do this……we have to tell her to do that……. she cannot do it on her own ... He cannot do it on his own… Some of them will say they are fed up. They can't continue buying medications and things like that … These are the constraints we usually have.'* (N2Aw)

Others get tired of bringing their relatives to the hospital for admission for treatment and rehabilitation. They get despondent and end up leaving them at home, without treatment, to their own fate.

> '*Even some people, instead of bringing their relatives to the hospital again, they will decide to keep them at home and say they are tired of going to the hospital*.' (S2L)

7.2.8 No mental health legislation

Regarding the availability of policy and legislations guiding the practice of mental health in Nigeria, participants from all categories of health professions unanimously lamented the lack of commitment by successive governments to pass the Mental Health Act. According to the participants, the legislation has been developed and laid before parliament but not passed for several years.

> "*Also, we have (a) challenge with mental health policy that has not been developed in this country. It has not been developed*." (N1Aw)

> "*There was a senator of the federal republic of Nigeria, Senator Yellow Wheel, pushed to that level and what our legislators wanted is for this bill to be sponsored. In the Nigerian context, when they say come and sponsor (the) bill, it means to) come and spend money to push a bill that …. What one has expected is for this bill to have been expedited, passed in no time, but I mean you will be so disappointed to know that we are still working without the bill*." (D2L)

> "*Well…I think the only thing I would like to say is about the issue of policy. There is no policy guiding mental health care. The government should be interested in mental health. You'll find out that everybody is interested in malaria and stuff like that. Meanwhile, there are a lot of families suffering from mental illness*". (P2L)

7.3 Suggestions for Improvement in Psychosocial Rehabilitation

This theme presents the suggestions made by the participants to improve PSR in Nigeria. Seven related categories constituted this theme, provision of resources, Government-sponsored rehabilitation, capacity building, public education on mental health, the enactment of mental health law, collaboration, and community care. The description of these categories follows.

7.3.1 Provision of resources

Participants recommended that the government should provide resources for PSR.

7.3.1.1 Establishment of rehabilitation centers

Participants stated that they could help the clients if the government and other stakeholders or funding agencies provided rehabilitation centres.

> "*They still need more land; I mean they need more buildings for this kind of thing. This place is not enough for them again. They need land and more money, that is resources…to make this place to be more elaborate than this.*" (N5Aw)

Having government-lead and funded rehabilitation centres where the clients can be treated has been strongly recommended. The participants emphasised that with a well-structured rehabilitation or occupational therapy centre, the clients could learn trades such as barbering, which they can rely upon to make a living when discharged.

> '*Well. We need—giant rehabilitation centres. … Government-funded rehabilitation centres. The majority of the rehabilitation centres apart from the refugee camps and co that we have in Nigeria are not…. They are non-governmental.'* (N9Ac)

> "*We need…when we say rehabilitation therapy; it's not just that you come and do a single thing; there should be a diverse range of handy works that people should come and learn from. So those facilities should be put in place, even if it's one big hall and then you partition it, and you have tailoring there … By the time they go like that they will pick an interest in one thing or the other. Let things like tailoring, shoemaking, and all those things be there with their little, little bits with individuals at that post to teach those things and then follow up*". (S3m)

7.3.1.2 Provision of material resources

Participants lamented the lack of, or the state of the available equipment and other resources needed for psychosocial health in Nigeria.

> "*Even equipment… We have no equipment. The ones bought are outdated. If you want to get maximum results in rehabilitation, you have to invest in it because by the time we don't have the equipment; we need to do something we can't wait for."* (T3L)

> "*Is it just proper for us to have a bus or car so that whenever we want to do a visit, we can have access to a car? What will even motivate me is if I don't have to use my*

money for transport, I will go. It is a clarion call I have signed for. I will go. It's my job. I will go and do it, right now if I tell you the number of clients I want to see, but I don't want to use my money to do them because I have children to take care of at home too." (T1)

7.3.2 Government-sponsored rehabilitation

A few participants recommend the government establish rehabilitation centres and provide rehabilitation of clients free of charge.

"*I know of a family where the three children have mental illness and even the mother. The father alone is saddled with the responsibility of caring for them, and the man Is old. The last time I saw him, he was about to retire, and I know that he must have even retired now. If there is support for these kinds of people, they will become a source of distress even to their neighbours and environment. So the government should take that responsibility."* (P2L)

"*There are some other things like ECG; EEG, they need to have access to it free of charge. So when the government makes it free, but money there, buy the equipment*." (S3)

Aside from the suggestions that psychosocial treatment should be free, other participants suggested the government should subsidise the treatment. Specifically, a participant cited the high cost of medication for clients.

"The government is supposed to subsidise their medication when selling a particular drug for others like drug clients using the same thing as a client with schizophrenia. When they are selling for them #20, for a client with schizophrenia, they should be selling it #5. [The] government should subsidise their medication." (N2Aw)

7.3.3 Capacity building

7.3.3.1 Recruitment of more staff

Participants recommended the recruitment of more staff for deployment to the psychiatric units because of psychiatric clients' nature. Others recommend the employment of skilled personnel willing to work with the clients.

"*They will need manpower* (workforce) *too……. like Nurses……...doctors……. I think those will be a special one because it's geriatrics. After all, we have geriatric cases here, even nearly all the cases are geriatrics."* (N5Aw)

"I think in the past they used to employ if I am not mistaken we have like two or three of our staff in the O.T that they said were former clients". (N5L)

7.3.3.2 Staff motivation

Staff motivation is one of the areas where participants suggested an improvement. They stated that the government should recruit and motivate staff, especially when the mental health workers work in the health facilities and go into the community for follow-up care.

"What are those incentives that they want to give to that person to encourage, the person can be on the ward and *still be collecting his or her normal salary, but here you are saying, please come and go out there to be involved in the community. To me, it is an added task, and since it is an added task, such a person should also be given an incentive. So as to encourage the person."* (N6L)

"Government will have to get, employ more health care practitioners*, motivate them, give them their salary, give them their inducement as at when due and make sure that there is peace where they are working. With all these, life will be better for all."* (S3)

7.3.3.3 Continuous Professional Development

Some participants recommended continuous professional education or development programmes for staff who have been on the ward or in the hospital for a long time. Health to a first degree.

"Perhaps do as much as to perhaps upgrade the school from offering a diploma….to…you know, there Is so much we can do entirely before we begin to…ah…. seek assistance." (D2L)

"I think we really need community psychiatry, whereby they will gather some people and train them to go to the community. Give lectures and do it as if it is their health issue. You know the way they do in local government. We need that in psychiatry too. We need that." (N3L)

7.3.4 Public education on mental health

7.3.4.1 Education on causes of mental illness

Although many participants spoke about community outreach or mental health promotion services, only two participants recommended it. They cited two different examples:

> *'We need to educate them that mental illness is not contagious. You cannot contact mental illness by living with someone who has (a) mental illness; you cannot contract the illness by even getting married to them.'* (S3)

> *We need to educate and let people know they can get better. It's not spiritual because many people believe it's spiritual.*' (T1)

7.3.4.2 Education on early reporting

Also recommended was advocating for early detection and prevention.

> "When people *have (a) proper understanding, they will not be keeping those clients at home or taking them to a traditional centre where their illness will become chronic. They will be able to bring them to the hospital on time, and we will be able to assist them, support them and be part of their rehabilitation effort. That will also go a long way in ensuring that clients don't become chronic, with schizophrenia."* (D1L)

> *'Also, there should be enlightenment for families not to keep individuals with mental illness at home, and there should be a law guiding that. Enlightenment can take place at* (the) *mosque and with religious bodies.'* (P2L)

7.3.4.3 Education on rehabilitation services:

> "*We also need to create awareness. So they (the community) don't know that. So it's now left for us to have the resources available for the community that gives awareness. In fact, most people don't even know O.T. We need awareness."* (T1)

7.3.5 Enactment of mental health law

Law on funding of mental health services.

Participants believe that most of the difficulties experienced by the mental health and psychosocial healthcare intuitions and HCPs could be partly resolved by the passing of the Mental Health Act or Bill by the parliament of Nigeria.

> "*If it means certain percentages of the budget or whatever for the resources will be for that. If it's going to be an aspect of this hospital's budget, that certain percentage should*

be for this area, maybe half-way home. Maybe it will be in law that we must have this and since it's a must. The *government will now have to ensure that they devote funds for that."* (D1L)

"Second, there needs to be a mental health act, and that will come from the government. If there is a mental health act, they will be able to assess mental health facilities free of charge."
(S3)

7.3.5.1 Law to guide mental health practice

The passing of the bill will ensure all stakeholders' roles are clear and their functions well defined.

"*If we have a mental health law, that will also take care formally, the aspect of psychosocial rehabilitation. Nobody will just come up as a private person and start running a rehabilitation centre. What should a rehabilitation centre look like, what should they address, who are supposed to run such centres."* (D1L)

“The mental health bill, the mental health law, should be able to spread that out so that the rights of clients are taken care of. So that the practice could be regulated. The role of the government or any other agencies should be spelt out, you know.” (D1)

7.3.6 Collaboration

Participants recommended collaborating with organisations that are already providing mental healthcare in the country, collaborating and sourcing support from the private sector, and utilising renovated, or providing new materials for psychosocial care.

‘*Part of our efforts and advocacy here is also to partner with the media houses to ensure that we disseminate information.’* (D3L)

"Our plan has been, we should be able to ……adopt some local governments that we can start from, this aspect of rehabilitation. To ensure that we have a better working relationship with those centres and hopefully, eventually, our clients who come from those, what I call, catchment areas covered by those local governments, nearest clients living around those local governments should be able to attend their clinic." (D1L)

7.3.7 Community care

One participant stated that the plan of psychosocial care was to reduce the number of hospital beds and increase the care of the clients at home or in the community, as being done worldwide.

> "*So this is our plan, to see how we can take psychiatric practice to the community because that is the trend worldwide. It's not by increasing the bed space for clients, but also by having satellite centres, where we don't admit clients, but we see clients on (an) outpatient basis."* (D1L)
>
> *"As we are here in the hospital now, they can pick some nurses, go to the community, organise some women, men, teach them, and educate them on this."* (N3L)

7.3 DISCUSSION PER THEME

7.3.1 Theme 1: Psychosocial Rehabilitation Practices

The study revealed that HCPs' practice of rehabilitation of individuals with mental illness is both hospital and community-based. It also revealed there are referral systems within the hospital and the community that serves as avenues for continuity of rehabilitation. The HCPs' description of their practice of rehabilitation revealed an individualised rehabilitation approach, which is categorised as a client's general assessment and need-based rehabilitation. The participants described their first line of action as the assessment of the client's willingness for rehabilitation, the most suitable programmes that would meet a client's need, or the clients' expectations in rehabilitation. This is consistent with the findings of Gal (2021), that assessment for readiness for rehabilitation is vital before instituting rehabilitation programmes, as this helps to assess clients' willingness and hasten required adjustments if need be. This is also in agreement with global recommendations (World Health Organization, 2019), and Morin & Franck's (2017) assertion that rehabilitation should be based on clients' preferences.

Another approach that HCPs adopted under therapy-based care were behavioural analysis and modification. There is an assessment of the client's attitude towards events or attitude towards disappointment under behavioural analysis. This is supported by the study of Forber-Pratt et al. (2019), who emphasised the need for HCPs to assess role identity, understand and avoid different situations during rehabilitation. However, concerning behavioural modification, it is the re-teaching of clients about grooming, emotion management, and etiquette. HCPs in the study believe that mental illness can rob people of their decorum and manners. This contradicts the globally accepted belief about mental illness, as the study of Taylor & Workman (2019) revealed that delinquent behaviour emanates from faulty upbringing, and is not necessarily limited to mental illness. Supportively, Venkatesan & Suresh (2021) report there

can never be a general rationale for the description of psychiatric mannerism, as individuals have their own peculiar stories.

7.3.2 Theme 2: Psychosocial Rehabilitation Constraints

The second theme is constraint during which the HCPs lamented about limited human resources, limited infrastructural facilities, and little funds allocation. van Weeghel et al. (2020) supported this assertion with the fact that lack of funds affects rehabilitation programmes, especially when they entail occupational rehabilitation. This gives vivid clarity that the issue of lack of funds is not only limited to Africa, and specifically Nigeria, but also extends to other regions of the world, as in the report of van Weeghel from the Netherlands.

Another issue of constraint expressed in this study is limited infrastructure. The participants desire more psychiatry facilities and expansion of psychiatric hospitals to accommodate more clients for admission and rehabilitation. This request is consistent with a review report from low-income countries and results from the lack of information about the non-necessity of formalised structure for rehabilitation (Gelkopf et al., 2021).

7.3.3 Theme 3: Suggestions for Improvement in Psychosocial Rehabilitation

The professional suggestion for the mental health law is important for the correct channelling of rehabilitation in Nigeria. This is consistent with the report of the WHO (2013) in the mental health action plan, where mental health law is important for facilitating mental healthcare in low- and middle-income countries.

Another suggestion from HCPs is the provision of a practice guide. The WHO (2013) agrees that a context-specific practice guide is necessary for uniformity of practice in PSR. The WHO (2013) declared the same platform upon which to base their practice of PSR, which would help in removing unnecessary divergence of focus, had the potential to help HCPs.

7.4 SUMMARY

This chapter summarises the HCPs' view of rehabilitation and facing challenges of human resources, structure, and financial constraints.

7.5 CONCLUSION

The HCPs expressed their willingness to engage in PSR if they have the necessary financial support from the government, structural facilities conducive for both clients and HCPs for conduction of rehabilitation, and a procedure manual to guide their practice.

PHASE THREE

CHAPTER EIGHT: PRACTICE GUIDE DEVELOPMENT

8.1 INTRODUCTION

The previous chapter presented the findings of HCPs' interviews, during which there were interviews with HCPs who are differently involved in the care of individuals with mental illness; this involved nurses, doctors, psychologists, social workers, and occupational therapists. Chapter Eight is the practice guide development, which includes the data triangulation that involved combining the scoping review (Chapter 4), interviews with clients (Chapter 5), interviews of families (Chapter 6), and interviews of the HCPs (Chapter 7). Here the researcher presents the practice guide and the process of developing it for the rehabilitation of individuals with mental illness.

8.2 DATA TRIANGULATION

This stage is where the researcher takes outcomes from different data collection methods and merges them to answer the study's research question (Curry & Creswell 2013; Subedi, 2017). To triangulate, Table 8.1 is a succinct display of information gathered through interviews in Chapters 4, 5, 6, and 7 and comparing them with information from global standards (WHO, 2018). This was to respond to the study's research question, "*How are clients living with schizophrenia in two tertiary health institutions in Southwest Nigeria rehabilitated and how can they be better rehabilitated?*

TABLE 8.1: DATA TRIANGULATION TABLE AND INFERENCE

Description of rehabilitation service	**Information source**					
Subject	**Data collected Interviews)**	**Scoping Review (Sub-Saharan Africa)**	**Global standards (WHO 2010-2018 recommendations)**	**Remarks on context findings (interviews) in comparison with scoping review**	**Remarks on context findings (interviews) in comparison with global standards**	**Inference from data and reference for practice**
Client	Keeping people occupied(busy) with skills/vocations	Engagement with occupations and effective re-integration to the community	Client expression of needs Assisting the client to make an informed decision	Both have a similar focus, which is focused on occupational engagement	The description of a client solely focused on occupation, which is at variance with global standards that are focused on holistic life	Clients need to be aware that rehabilitation is holistic and not just the acquisition of occupational skills
Clients Family	Complete independence of people with mental illness without the intervention of	Individuals who have what keeps them occupied and busy	Families are defined by clients and the description of the role in rehabilitation is as expressed by clients apart from the	Both ideologies believe that clients should be productive and independent	Both ideologies point towards clients' autonomy and independent	Ideal ideology flows in the interview, scoping review and match the global

	family or no reliance on family for going out and finances		already existing role and relationship that defines such individuals as families		description of the family system	standards The ideology needs to be upheld
HCPs	The ability of clients to recuperate from psychiatric symptoms and engage in occupational skills	Clients empowerment and community engagement	These are facilitators of the rehabilitation programme and are meant to guide the client on areas where clients expressed the desire for guidance	The professional's description of rehabilitation shows a lack of understanding of the concept, as the presence of psychiatric symptoms is not a hindrance to rehabilitation Contrariwise, the review reveals the understanding of clients' needs from HCPs' perspectives	HCPs' description is at variance with global standards that are ideal for rehabilitation	HCPs need training on what rehabilitation is
Benefits of rehabilitation service	**Information source**					
Subject	**Data collected (Interviews)**	**Scoping Review(Sub-Sahara Africa)**	**Global standards (WHO 2010, 2011, 2012, 2014,2016,2018 recommendations)**	**Remark on context findings (interviews) in comparison with scoping review**	**Remark on context findings (interviews) in comparison with global standards**	**Inference from data and reference for practice**
Client	It restores meaningful living, It improves the human relationship, it helps in behaviour modification, it gives a sense of hope of better future	It helps with support and improves relationships	It should be that which adds life to years (meaning living)	Both views align well and are potential benefits of rehabilitation	Both views of clients align with global standards of rehabilitation	A Concerted effort towards sustaining the outcomes of rehabilitation in a way that the benefits will be achieved in SW Nigeria settings should be encouraged
Clients Family	It gives family relief from care burden	It changes the orientation of family and the community about mental illness from believing that it incapacitates the ability to function independently	The benefit of rehabilitation is seen in the individual functioning in areas of strength alongside the limitation of the illness	The benefits from family perspectives in interviews aligns with benefits in scoping review	Family perspectives of benefits of rehabilitation align with global standards	A Concerted effort towards sustaining the expressed benefits from a family perspective should be encouraged. Also, efforts should be made towards achieving the benefits that are entrenched in rehabilitation but not yet achieved in those settings
Concerns about rehabilitation service	**Information source**					
Subject	**Data collected (Interviews)**	**Scoping Review (Sub-Saharan Africa)**	**Global standards Global standards (WHO 2010, 2011, 2012,**	**Remark on context findings (interviews) in comparison**	**Remark on context findings (interviews) in comparison**	**Inference from data and reference for practice**

			2014,2016,2018 recommendations)	**with scoping review**	**with global standards**	
Clients	There are no varieties of occupations(vocations) to choose from within the institution	Individuals undergoing rehabilitation complain of family monitoring, which is undesired	Lack of mental health legislation in 64% LMICs	Clients' concerns pointed out the approach of engagement by institutions, which would not have come up if clients were exposed to other facilities where their preferences could be attained The findings in the review also pointed out gaps in practice, as it shows that families are not properly educated on what rehabilitation is	Global concerns which reveal lack of legislation could answer for reasons why gaps in practice occurred, as seen in the expression of confinement of clients to institutional facilities	In the absence of legislation, available evidence can serve as a guide for practice
Clients Family	There are no varieties of occupations in these institutions The cost of enrolment for rehabilitation is not affordable There are no experts for different training, which makes it difficult for learners to compete with the outside world	Individuals undergoing rehabilitation have little support to start businesses of their own	Families are to support the achievement of goals but not serve as decision-makers.	Finance are challenges from family perspectives in both interviews and scoping review However, the aspect of financial challenge differs Interviews reveal the challenge of affordability of service while reviews reveal limited support through finance	The desire for expert service reveals a lack of understanding of rehabilitation rather than support as recommended by global standards	Family education on rehabilitation is necessary
HCPs	There are limited resources for the execution of rehabilitation, which is defined in terms of human resources, materials, and finance	There are limited volunteers and the distance they cover before getting to the clients is much and tiring	Rehabilitation is best performed in clients' natural environment or as preferred by the client, not necessarily in a structured environment. Voluntariness is also encouraged.	Limited human resources are expressed by both HCPs and In review but it's worse if rehabilitation efforts depend on the health professional alone	The HCPs' challenge of human resources will reduce if voluntariness is embraced, as suggested by the WHO	Encouraging voluntariness in areas close to the locations and central to where there are several clients will reduce the challenge of distance
Suggestions for improvement of rehabilitation service	**Information source**					
Subject	**Data collected (Interviews)**	**Scoping Review(Sub-Sahara Africa)**	**Global standards (WHO 2010, 2011, 2012, 2014,2016,2018 recommendations)**	**Remark on context findings(interviews) in comparison with scoping review**	**Remark on context findings(interviews) in comparison with global standards**	**Inference from data and reference for practice**
Clients	Making the rehabilitation setting comfortable	Training of volunteers on correct	The Institutionalisation of individuals with	Rehabilitation should be done in the client's natural setting,	If institutional rehabilitation is discouraged and rehabilitation is	Interested family members can also be trained

		approaches to rehabilitation	mental illness should be discouraged	so the request for equipping rehabilitation setting is not needed, while proper training of volunteers is necessary	made available in a natural setting, there will be no need to request equipment	the act of rehabilitation
Clients Family	Provision of more facilities for hospitalisation	Rehabilitation is done at community-based facilities or residences of clients	Rehabilitation should be voluntary work and not a paid cost.	Rehabilitation is best suited in the community and not in the hospital environment	Where it is entrenched in-hospital services, it should be on an outpatient basis and not a basis for continuous hospitalisation	Community-based rehabilitation should be encouraged while prolonged hospitalisation is discouraged
HCPs	Building of more mental health facilities, employment of more HCPs, and increment in salary	The available facilities are used for rehabilitation	A natural setting is best suited for rehabilitation	Available facilities are best suited for rehabilitation, as suggested in the scoping review, rather than clamouring for additional structures	Natural setting, as suggested in global standards and scoping review, is best suited for rehabilitation	The natural setting is best suited in rehabilitation and should be encouraged in each context

Table 8.1 shows the themes captured from data sources as collected in this study and global standards. Only four themes yielded a description of rehabilitation service, benefits of rehabilitation service, concerns about rehabilitation service, and suggestions for improvement of rehabilitation service.

8.3 INTERPRETATION OF DATA (PARTICIPANTS INTERVIEWS) IN LINE WITH THE THEORY OF COMPENSATION (APPLICATION OF THE THEORY)

Adopted into the interpretations of each section of the interviews was the theory of compensation, which was the theory that underpinned this study. This theory is considered the most suitable theory for unpacking the expectations of the WHO about rehabilitation, as indicated in Chapter One under theoretical framework (WHO, 2010, 2011, 2012, 2014, 2016, 2018). This study takes the stance that for effective rehabilitation, there must be compensation achieved for every function, skill, or time lost to illness. Table 8.2 shows the data from the study, the description of compensation, and an example of how compensation is achievable in rehabilitation.

TABLE 8.2 DATA INTERPRETATION INLINE WITH THE THEORY OF COMPENSATION

Description of rehabilitation service			
Subject	**Data collected from the study**	**Interpretation from compensation**	**Compensation opportunities**
Client	Keeping people occupied with skills	This is the diversion of attention of an individual into skill acquisition (compensation compliant)	It does not necessarily have to be skills. It can be hobby preoccupation, sports, socials, schooling, etc.
Client's Family	Complete independence of people with mental illness without the intervention of family or no reliance on family for going out and finances	This is prevention of monitoring and appraisal of freedom and independent living (Compensation complaint)	Alternate to monitoring is establishing friendships or encouraging friendship establishment with individuals' preferred clients Friendships will help to overcome dictatorship from monitoring and give the opportunity to compensate for time lost to restrictions
HCPs	The ability of clients to recuperate from psychiatric symptoms and engage in occupational skills	The client does not necessarily have to achieve full remission of symptoms to engage in occupational skills Compensation requires functioning in other areas irrespective of a defective part of life (non-compensation compliant.	Accept rehabilitation as not necessarily means remission of symptoms Eliciting client's desire and readiness for change to areas of possible functioning
Benefits of rehabilitation service			
Subject	**Data collected (Interviews)**	**Interpretation from compensation**	**Compensation opportunities**
Client	It restores meaningful living, it improves the human relationship, it helps in behaviour modification, it gives a sense of hope of better future	Rehabilitation that is well planned and executed gives the opportunity for compensation	Activities that clients find fulfilling and have the capacity for should be encouraged In a situation where the capacity for such activity is lacking, capacity building should be done
Clients Family	It gives family relief from care burden	Rehabilitation that is properly conducted should reduce or remove the burden of care This can be achieved through compensation	Activities that could increase client's independence should be encouraged Enquiries should be made on resources available at the client's disposal Efforts should be made to instigate clients support in areas of need
Concerns about rehabilitation service			
Subject	**Data collected (Interviews)**	**Interpretation from compensation**	**Compensation opportunities**
Clients	There are no varieties of occupations to choose from within the institution	Compensation requires having multiple alternatives that the individual requiring rehabilitation can shift to	Collaboration with other facilities can help with rehabilitation and effective compensation Referral to other facilities not collaborated with can also help rehabilitation through compensation
Clients Family	There are no varieties of occupations in these institutions. The cost of enrolment for rehabilitation Is not affordable There are no experts for different training, which	Rehabilitation consultation should be such that it is affordable and subsidised, as without which clients may not have the opportunity of being engaged in opportunities of compensation	Collaboration with non-governmental organisations and philanthropists may serve as an alternate way of getting individuals engaged in rehabilitation that is geared towards compensating for the dysfunctional aspect of life

	makes it difficult for learners to compete with the outside world	Collaborations with other settings with other services not available at a facility will help the client	
HCPs	There are limited resources for the execution of rehabilitation which is defined in terms of human resources, materials and finance	The same response under clients and family concerns about rehabilitation services is applicable in this concern	The same response under clients and family concerns about rehabilitation services is applicable in this concern
Suggestions for improvement of rehabilitation service			
Subject	**Data collected (Interviews)**	**Interpretation from compensation**	**Compensation opportunities**
Clients	Making the rehabilitation setting comfortable	Compensation through rehabilitation requires services delivery in the natural setting of clients where possible. Where institutional structures are used, services should be provided in a non-strict routine manner	Services can be provided at recreational centres, club-houses, religious centres, or homes of clients . This will help the clients see other activities that can serve as a compensatory avenue during the rehabilitation process
Clients Family	Provision of more facilities for hospitalisation	This is non-rehabilitation and non-compensatory compliant, as the WHO has disannulled continuous hospitalisation.	
HCPs	Building of more mental health facilities, employment of more HCPs, increment in salary	Available facilities or collaboration with other existing facilities is appropriate for rehabilitation and compensatory activities, not necessarily building additional structures	

Based on the compensation theory in this study, rehabilitation service tends towards dictatorship, as highlighted from excerpts in the interview.
One participant said:

> "*I am into tailoring. I have learnt measurement, I have learnt to spread, but it remains to sew. I am here because they (the therapists) felt it's best for me."* (C1L).

Another one said:

> "*I wanted computer (science) but was directed to tailoring by the HOD. There, I couldn't pass thread into the needle. I just wasted the three years. Later, the HOD agreed for me to learn computer … in this computer age, I would like to be a computer analyst.* (C5L)

The preference of service should be voluntary and decided by clients. The benefits of rehabilitation service should rightly give autonomy.

> "*When I was diagnosed with this illness, I had to stop school and had to stay at home doing nothing … not being active is worse than the illness. I felt like dying then … but with this rehabilitation that I am undergoing, I am now in order, doing well, now at OT. I am into knitting, so as I progress further … I no longer feel idle, and I know I will be well settled after completing the training*.'' (C2L)

> "*I have been gaining a lot because I am an introvert. So, I don't relate because I don't talk that much, but since I came in now, I have been able to come out of that attitude of being an introvert … I talk to people and relate well. No longer shy. I know I will go back fully to my work when I am very okay and can relate very well.''* (C8L)

Concerns about and suggestions for improvement for rehabilitation service means it is entrenched in the entirety of this practice guide. It is also one of the rationales for this practice guide.

8.4 PRACTICE GUIDE DEVELOPMENT PROCESS

This guide followed an **inclusion** and **referred** approach, as recommended by the WHO, in the development of a rehabilitation practice guide (WHO, 2010, 2011, 2012, 2014, 2016, 2018). For the **inclusion approach,** this study approached inclusion from two angles. Firstly, by identifying the key concepts identified as important in the development of this rehabilitation practice guide, and ensuring and describing its meaning and application to the current study or practice guide. Secondly, the key concepts, as indicated in section 8.6, emerged by triangulating and including the findings from the interviews on preferences of clients, families, and HCPs and comparing them with global standards, as indicated in Table 8.1. The **referred approach** describes the subsections available in other developed practice guides and adapted to suit the description of the setting in this study; an example in this study was engagement recommendation (as indicated in Table 8.6).

8.5 THE OUTLINE OF THE PRACTICE GUIDE

- Definition of Concepts
- The objective of The Practice Guide
- HCPs Eligible for Facilitation of Rehabilitation
- Paradigm Shift
- HCPs and Rehabilitation Roles
- Similarities and Differences Between Rehabilitation and Psychosocial Rehabilitation
- Rehabilitation Process to Be Followed by Facilitators
- Sample of Engagement Plan
- Engagement Sample
- Engagement Recommendations

8.6 DEFINITION OF CONCEPTS

- **Who is a client:** In the context of this manual, a client is an individual with chronic mental illnesses/or schizophrenia. For the purpose of this practice guide, a client will mean a service user
- **Who is a family:** A family in this context is anyone documented and described by the service user as a person closely related to them; someone involved in the day-to-day care of the client
- **Facility:** These are mental health institutions or places within a formal setting designated for rehabilitation related consultations
- **Home:** The service user's place of residence
- **Manual:** A practice guide for rehabilitation
- **Professional:** An individual offering rehabilitation services; in the context of this guide, is regarded as facilitators
- **Felt needs:** These are needs that individuals service users described as pressing for them, and for which they desired rehabilitation
- **Unfelt need:** These are needs that individual feels they require but are not regarded as pressing
- **Stable**: The clients must have insight into her state and diagnosis before engagement in rehabilitation; they need to understand what rehabilitation is and must be willing to commit themselves to the process
- **Facilitator**: An individual who engages with a service user in achieving the goal of rehabilitation
- **Rehabilitation:** in literary terms, from two words which are "re" and "habilitate." **Re** means to repeat something or redo an event, while **habilitation** is from house and habitation, which means a place of abode. Combining the meaning of the two words give us a clearer understanding of rehabilitation as re-establishing an individual in a previous place of abode or community life and functioning (Oyelade & Mafutha, 2021a)
- **Psychosocial rehabilitation**: from two words, psyche meaning mind, social meaning relationship. A description of psychosocial relationships could be re-establishing an individual into social life and productivity on what the person has the capacity and ability to do, with little intervention void of interference (Oyelade & Mafutha, 2021a)

8.7 OBJECTIVE OF THE PRACTICE GUIDE

The objectives of the practice guide were to provide a succinct document that could serve as a procedure manual for HCPs directly involved in the rehabilitation of individuals with chronic mental illnesses, such as schizophrenia in Southwest Nigeria.

8.8 HCPs ELIGIBLE FOR FACILITATION OF REHABILITATION

The facilitators in this guide are those directly involved in the care of individuals with chronic mental illnesses, that is, those HCPs who have direct contact with them. In the context of Nigeria, it involves psychiatric/mental health nurses, occupational therapists, social workers, psychologists, and psychiatrists.

Health Care Practitioners: These should be professionals interested in and who have undergone updated training in rehabilitation.

Service providers: These are individuals working voluntarily under HCPs as direct engagers of clients. The recruitment should be on a voluntary basis, meaning those who are interested and made themselves available for training and recruitment to serve in rehabilitation facilities. However, in the context of Nigeria, there are limited resources available for the training and recruiting of laypeople to serve in rehabilitation services. Where possible, men and women who volunteer should undergo training to work as service providers.

8.9 HCPs AND REHABILITATION ROLES

- **Occupational therapists:** These are HCPs involved with the allocation of clients for skill learning. Training includes good grooming, eating habits, behavioural modification, etc.
- The rehabilitative roles of these individuals will entail eliciting what the expressed area of need of the client is in relation to their job scope and guiding the client on making a choice by intimating them about the available alternatives.
- **Social workers:** These HCPs assist indigent clients to meet their financial needs. They also work by tracing clients who default from hospital visits or whose relatives have abandoned them in the hospital. The aid of the tracing is to help them return to their community.
- The rehabilitation goal of these individuals will entail eliciting the specific social or capacity-building needs of the client, working as liaison officers between clients in need and non-governmental organisations who could provide help with the required need or link the client with the non-governmental organisation of this manual developer.

- **Psychologists:** These are HCPs who work towards the analysis of the psychological state of clients, and provision of assistance on psychology-related issues of mental illness.
- The rehabilitative task will include the provision of emotional support for individuals who are victims of abuse and need close assistance with abuse-driven emotion-related issues.
- **Mental Health Nurses:** These are HCPs who provide in-house institutional care, such as admission and observations; their task also extended to meeting the activities of daily living and psychosocial related care to clients on admission. For rehabilitation, however, these groups of individuals are better equipped for out-of-facility care, the incorporation of which can be into the Public Health Aspect of Mental Health Nursing.
- **Psychiatrists/Doctors:** They focus on diagnosis, and institution of medical and pharmaco-therapy. The psychiatrists serve as hospital heads, and thus have a great role in incorporating rehabilitation into post-discharge care of clients who expressed their desire for such at no cost. This can be practicable by communicating rehabilitation and its potential benefit to government and funding agencies.

Table 8.3 indicates the similarities and differences between rehabilitation and psychosocial rehabilitation as applied in this practice guide.

TABLE 8.3: SIMILARITIES AND DIFFERENCES BETWEEN REHABILITATION AND PSYCHOSOCIAL REHABILITATION

S/N	Concepts	Rehabilitation	Psychosocial rehabilitation
1	Inclusiveness	Every individual requiring physical therapy	Individuals who realise their need for psychological or social therapy
2	Responsiveness	Individualised and measured by skill mastering speed	Individualised and dependent on the level of client satisfaction
3	Collaborations	This is conducted in collaboration with health institutions and occupational skill centres	This is conducted in collaboration with community members, community stake-holders, and families
4	Professionalism	Being a skilled and seasoned professional in the area of occupational and physical therapy or a skill trainer is key	No structured professionalism is required. What is key is need assessment, felt and expressed needs
5	Continuity	There is the permanent termination of training after skill mastery	There is an opportunity for continuous assessment as the need arises
6	Equipment	They are diverse depending on the types of training the facility offers	There is no specialised equipment; interventions are based on individuals' felt needs for independent living
7	Structure	There is a hierarchical structure among HCPs and trainees; also formalised structural facility	Both HCPs and clients work as partners in progress, without hierarchy
8	Update report and certification	There are written updates and issuing of certificates of completion	Writing of progress reports is at the discretion of the parties involved; no certification

(Table 8.3 developed through study data)

8.10. PARADIGM SHIFT IN REHABILITATION

The emphasis of paradigm shift is suitable for HCPs recruited into the rehabilitation service of individuals with mental illness. This research finding shows that the existing paradigm of mental healthcare in Nigeria is a patriarchal system, where HCPs use a dictatorship style with individuals with mental illness, some of which include forced medication, forced admission, forced grooming, and self-health care routine.

For example, some participants in this study indicated that HCPs decide for them:

"*I am into tailoring. I have learnt measurement, I have learnt to spread, but it remains to sew. I am here because they (the therapists) felt it's best for me*." (C1L)

"*I wanted computer (science) but was directed to tailoring by the HOD (Head of Department). There, I couldn't pass thread into the needle. I just wasted the three years. Later, the HOD (Head of Department) agreed for me to learn computers … in this computer age, I would like to be a computer analyst.*" (C5L)

"*What I want is for them to help me to achieve going back to my school and graduating. I feel I will do well going back to school rather than learning a trade and wish to complete my study and work as a professional in the discipline I studied*." (C6L)

However, the new paradigm of rehabilitation is such that respects the opinion of the individuals with mental illness and gives them the sole power to make an informed decision (WHO, 2010). This in essence means the task of the health professional is to make them aware of opportunities available for their preferences, and not to make a decision for them or discourage the trial of their choices.

8.11 REHABILITATION PROCESS TO BE FOLLOWED BY FACILITATORS

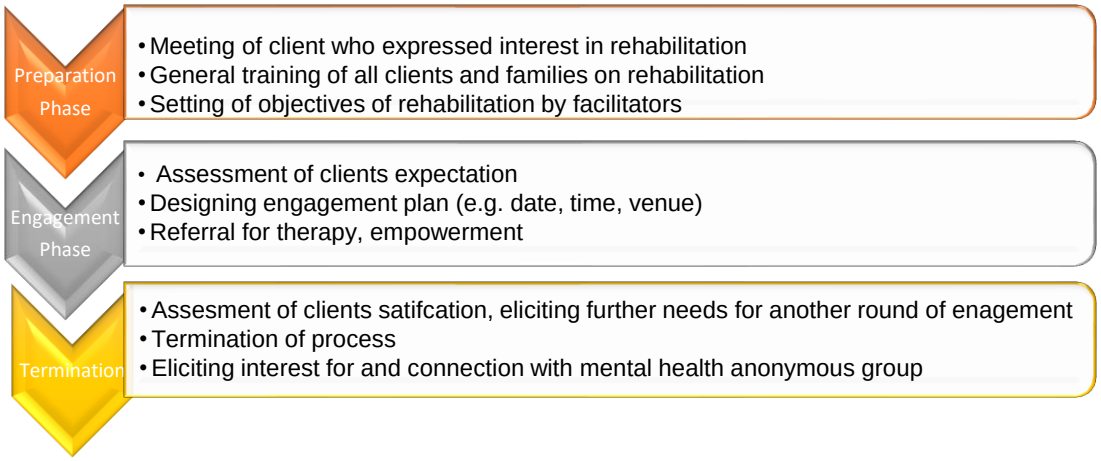

Figure 8.1: Process for rehabilitation outlines

The practitioner will need to set objectives for the rehabilitation as below, and set an engagement plan as described in Tables 8.4, 8.5, and 8.6.

Preparation phase

This is the first phase in psychosocial rehabilitation. This involves meeting with intended service users, training on rehabilitation, and setting objectives. The training will require eliciting the pre-conceived idea of participants about psychosocial rehabilitation, after which there will be information dissemination on the definition of concepts (point 8.6), HCPs, and rehabilitation roles (point 8.9). Table 8.3 presents the similarities and differences between rehabilitation and psychosocial rehabilitation. The facilitator will need to take into consideration their objectives for facilitation, as described below.

Facilitator's objectives

The objectives of the facilitators are to:

- Find out what the clients needs are
- Guide the client towards prioritising the needs
- Engage with the client on working out strategies of meeting the needs
- Explore the available avenue of meeting clients' needs with the client
- Develop a workable engagement plan with the client

Engagement phase

This is the second phase in psychosocial rehabilitation. It starts with the assessment of service users' expectations of rehabilitation. It is paramount to assess what the client expects of rehabilitation and to document it, so that at the end of the process the success there will be a

comparison of the set objectives and the client's expectations. The designing of the engagement plan will follow this, as displayed in Table 8.4, followed by the referral decision as displayed in Table 8.5, then the engagement itself, as displayed in Table 8.6. In some instances, the clients might require empowerment in the area of felt need, but require external support. The empowerment requirement may differ from one client to another; some may need financial empowerment, while others may require being empowered with emotional stability skills in face of stigmatisation, or any other form of empowerment. Engagement recommendations are also included at this stage, which serves as the guiding rules on rehabilitation policies that are bendable, and the ones the facilitators should adhere to strictly.

Table 8.4: Sample of the engagement plan

Date	Venue	Readiness	Focus
Agreed date between facilitator and service user	The preferred venue for facilitator and service user	The readiness of the service user must be explored by asking questions on felt and unfelt needs	The focus of the meeting depends solely on the service user and this is based on expressed needs
Agreed upon based on the availability of the service user and facilitator	For example, the personal office of the facilitator	For example, intention for rehabilitation should be expressed by the service user	For example, a service user can decide they want to be rehabilitated on their ……
Note the agreed date of the next meeting			

Table 8.5 indicates how facilitators select a specific therapy based on the indicated needs of the service user.

Table 8.5: Table of criteria for referral for therapy

Need	Example	Therapist
Occupational related needs	Job, challenges at workplace, desire for a skill acquisition	Occupational therapist
Medical-related needs	Request for referral, medication modification or change request, symptoms of concern, medication reaction, request for a medical report	Psychiatrist
Environment and relationship-related needs	Housing, conflict with neighbours or families Challenges at workplace	Social worker
Recruitment and capacity building related needs	Communities' awareness creation about rehabilitation, referral to NGOs for capacity building support Productivity and engagement follow up at community level.	Public Health Mental Health Nurses
Emotions and psychology-related issues	The feeling of suicide, homicide, loneliness, neglect, and complaints related to emotional issues	Psychologist

Table 8.6 presents an engagement sample, which is a prototype of how HCPs are to relate with or attend to the service user during the consultation

Table 8.6: Engagement sample

DAY 1		EXAMPLE	
Familiarization	The facilitator needs to engage in familiarisation with the service user, even if the person is previously known at any level This is because there is a change in paradigm meaning the platform of their relationship has changed from whatever it was to a non-hierarchical pal-to-pal discussion	Facilitator	Service user
		Good day, I am (the facilitator mentions his/her name without adding any professional title, e.g., don't use Dr., Prof., Bar., Pharm., but you can use Mr., Ms., Mrs., Miss.) You can address me as (whatever the facilitator prefers between the first name and the surname, but no title)	
		You may know me as (Doctor or nurse ……) OR Have we ever met before? Where, and how?	Respond
		You are meeting me now in a new form as your equal and (the facilitator states the aim of the meeting, e.g., my aim is for us to discuss your most pertinent need and together look into possible ways of meeting them Please note, we can only discuss possible ways, you have the sole authority to decide)	
Identity preference	The facilitator(s) needs to enquire how the service user prefers to be addressed	How do you prefer to be addressed, e.g., first name, surname, or nickname? (Plus preferred title) Please address the client with their professional title or as preferred; the aim is to boost their morale and move them back into positive thinking about self, which in some cases might have been lost to stigma The professional need not use their professional title in either case	
Session's confirmation and appraisal	The facilitator needs not enquire about the previous session the service user has undergone; s/he needs to enquire about the number of sessions per week available for their meeting and the suitability or availability of the service user	I am available these days……., which of these is suitable for you and at what time, OR the reverse Which days are you available or do you prefer, and what time?	
Contact termination agenda	The facilitator and the service user need to agree on when to terminate the contract and the termination modality	As agreed, this class will terminate after……weeks and the modality it will take is that none of us will feature for the class again	
Strategies of post-termination re-engagement	The facilitator has to intimate the service user about the strategy of re-connection after the termination of the contract	If you feel you need other sessions with me or any other person after the dissolution of this class, kindly contact the NGO director in charge of allocation, specifying your needs for further sessions with the previous facilitator or another	

The facilitator can use the engagement sample to facilitate the process of rehabilitation, as well as engagement recommendations (Section format: adopted with modifications from

Lecomte et al., 2017). Engagement recommendations (as seen in Table 8.7) are provided to guide the facilitators on some engagement aspects that should be strictly followed as unmalleable (strong recommendation) and aspects that can be adjusted based on facilitators discretion or situation at hand (weak recommendation).

Table 8.7: Engagement recommendations

SN	Recommendation	Strength
1	Facilitators should ensure the conducting of rehabilitation engagement for service users discharged from admission, and the engagement should be at a neutral place.	**Weak recommendation**
2	Facilitators should carry the next of kin of service users along with engagement schedules or engagement resolutions. Families do not necessarily have to be present except for cases of children.	**Strong recommendations**
3	Facilitators should avoid advising the service user, but rather furnish them with opportunities available around their needs, and allow them make informed decisions. It is also worthy to note that service users should be treated as colleagues and there should not be a hierarchy of any form.	**Strong recommendations**
4	Facilitators should also make the family members aware of the opportunity of access they have to engage with referring NGOs on any mental or psychological-related issues.	**Strong recommendations**
5	Facilitators need to undergo rehabilitation training, which is available onsite or online. Also, undergoing periodic and continued knowledge upgrades is necessary for continuity as a facilitator.	**Strong recommendations**
6	Facilitators and service users should maintain therapeutic relationships and mutual respect.	**Strong recommendations**
7	Facilitators should discuss confidentiality with service users, and exceptions to confidentiality expressed in rationale, clear terms.	**Strong recommendations**
8	Facilitators should endeavour to come down to the level of the service users. Language preference of the service users should be considered as language of discussion. Facilitators should also avoid the use of medical jargon, but rather speak in a way and the language that best suits the service user.	**Strong recommendations**
9	Facilitators need knowledge of the culture of the geographical location of practice and ensure respect for such culture.	**Strong recommendations**
10	The client must be self-driven and not coerced into undergoing rehabilitation.	**Strong recommendations**
11	The HCPs conducting rehabilitation must volunteer by themselves and not be forced or posted.	**Strong recommendation**

TERMINATION PHASE

This is the last stage of the rehabilitation process, also regarded as the stage of disengagement. This stage involves assessment of the processes for the exhaustion of the set goals, followed by assessment of client's satisfaction, and then eliciting further needs, which may necessitate another round of engagement. However, if the clients express further need, it is advisable that another facilitator takes over the next need to avoid over-familiarity, while the current facilitator initiates process termination and referral to another facilitator. In a situation where there is no further need expressed, the client is encouraged to connect with a mental health anonymous group of a non-governmental organisation (Oyelade & Nkosi-

Mafutha 2021) developed in the process of conducting this study. This is will help with connectivity with other clients who have been rehabilitated and coping well post-rehabilitation.

8.12 SUMMARY

This chapter is the description of the practice guide developed from this study's findings as a guide for HCPs' practice of rehabilitation. It showed the introduction to the development process and the step-by-step approach of engaging in rehabilitation. It showed the rehabilitation process in three stages, preparation, engagement, and termination. The preparation stage is the level at which the facilitator prepares the service user towards rehabilitation by eliciting their understanding of it, and readiness for it. The engagement stage is the period of assessment of clients' expectations and instituting referrals, while the Termination stage is the level at which there is a top put on rehabilitation, and this occurs after achieving the objectives.

8.13 CONCLUSION

In conclusion, the practice guide in this chapter is an evidenced-based approach to the rehabilitation of individuals with mental illness. The shreds of evidence came from the scoping review and interviews with clients, families, and HCPs. This practice guide is for use in Southwest Nigeria, but with a detailed description so that other settings with similar characteristics as Southwest can decide if it is suitable for replication in their setting.

NGO Affiliations:

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CHAPTER NINE: SUMMARY OF FINDINGS, LIMITATIONS OF THE STUDY, RECOMMENDATIONS, AND CONCLUSION

9.1 INTRODUCTION

The previous chapter presented the development of the practice guide in this study. Chapter Nine, the final chapter, reveals the summary of the findings in this study, the recommendation, and the conclusion.

9.3 SUMMARY OF FINDINGS

Findings from the review of the study show that the evidence from two available articles on rehabilitation of individuals with schizophrenia, out of the thirty-nine countries that make up Sub-Saharan Africa, come from a district in Ethiopia and South Africa. Of note, was that the publishing of these two articles was in 2014 and 2018 respectively, which shows that before 2018, there was possibly no evidence of rehabilitation for individuals with schizophrenia anywhere in Sub-Saharan Africa. During interviews with individuals living with schizophrenia, the findings reveal that participants perceived themselves as worthless when inactive, and this inactivity aggravates feelings of ill health in such individuals. Another finding of self-perception in this study is the feeling of uselessness through rejection or abandonment in the hospital. Of note in this study, is the defective insight of some of the participants about their diagnosis or their lack of knowledge of the diagnosis.

Interviews conducted on families of individuals living with schizophrenia also reveal social undesirability, which was due to the crime some participants had previously committed. This study (interviews) also shows that some participants felt compelled to do some activity that had no positive result; however, those who had a sense of productivity through self-initiated activity were excited and expressed feelings of productivity. This study (interviews) further revealed that the cases of murder in this report were traceable to a sense of abuse. Those who reported cases of abuse at the traditional home, such as chaining to a tree in the bush and beating, also reported they became more aggressive after their release.

Moreover, family members wished their relatives to be independent and self-accountable, but also to achieve a level of monitoring. The family definition of monitoring in this study is the assessment of clients for any stressor, while the participants in this study desired continuous monitoring from the fear that their relatives could go missing, which they validated with their previous experiences. There was satisfaction derived from the fact that clients were learning a trade and got engaged or productive through that process. Dissatisfaction in this study arose

from the fact that the training such individuals received was not thorough, physical exercise was not part of the training, the environment was not conducive, and the cost of receiving rehabilitation care constituted a burden for those unable to afford it. Families in this study regard ideal rehabilitation as that which will earn them relief from the burden of care.

From the interviews conducted among the HCPs, the study revealed that HCPs' practice of rehabilitation of individuals with mental illness is both hospital- and community-based. It also revealed there were referral systems within the hospital and the community, which serve as avenues for continuity of rehabilitation. The HCPs' description of their practice of rehabilitation shows an individualised approach to rehabilitation, categorised as a client's general assessment and need-based rehabilitation. The participants described their first line of action as an assessment of clients' willingness for rehabilitation and the most suitable programmes that would meet a client's needs or expectations in rehabilitation. Another approach that HCPs adopted was under therapy-based care, behavioral analysis, and modification. There was an assessment of the client's attitudes towards events or attitudes towards disappointment under behavioural analysis. HCPs in the study believed mental illness robs people of their decorum and manners. HCPs lamented about limited human resources in the study, limited infrastructural facilities, and little fund allocation. They indicated a desire for more psychiatry facilities and expansion of psychiatric hospitals to accommodate more clients for admission and rehabilitation. The HCPs suggested the mental health law was important for the correct channeling of rehabilitation in Nigeria. The psychosocial rehabilitation practice guide was developed in this study, as described in Chapter Eight, and featured in terms of description of the concept, interpretation of data, data triangulation, practice guide development process, the practice guide as an engagement sample, description of HCPs' role, and paradigm shift

9.2 JUSTIFICATIONS

The purpose of the study was to improve the care of people living with schizophrenia in Southwest Nigeria through the development of a context-specific practice guide for psychosocial rehabilitation. This study successfully achieved the development of the practice guide, as presented in Chapter Eight.

Achieved were the objectives described below:

- Review the literature to determine the work conducted on psychosocial rehabilitation in Sub-Sahara Africa. (Phase 1- Chapter 4)
- Describe the experiences of clients living with schizophrenia as well as their expectations of psychosocial rehabilitation. (Phase 2- Chapter 5)

- Describe the experiences of families of clients living with schizophrenia as well as their expectations of psychosocial rehabilitation. (Phase 2 - Chapter 6)
- Describe the current practices of HCPs on psychosocial rehabilitation and describe their constraints and suggestions for effective psychosocial rehabilitation in their context. (Phase 2 - Chapter 7)
- Develop and confirm a context-specific practice guide for psychosocial rehabilitation that HCPs could use for rehabilitation of clients with schizophrenia in Southwest Nigeria. (Phase 3 - Chapter 8)

9.4 LIMITATIONS OF THE STUDY

The study's limit was time and financial constraints. The researcher proposed validating the practice guide, but it was postponed to the post-doctoral stage because of the time and financial demands of training the researchers on the use of the practice guide and its validation. There is a limit to the practice guide's scope; this is because the scoping review and the interviews that constitute the local pieces of evidence are limited to Sub-Saharan Africa and Southwest Nigeria respectively. The available global evidence that served as the basis for recommendation came from WHO resources (WHO, 2010, 2011, 2012, 2014, 2016, 2018). The researcher contacted the WHO officials for updated documents, but they mentioned they were in progress; it is, therefore, possible there may be additional recommendations, which may necessitate the updating of the practice guide from time to time.

9.5 RECOMMENDATIONS

The recommendations based on the findings of the study follow.

Nursing Practice and research

The researcher recommends further research by mental health nurses on impact of confinement of individuals with mental illness and strategies to improve acceptability of rehabilitation. Also consider mental nursing practice such as in-service training for mental health nurses on psychoeducational and rehabilitative principles as very important and an urgent need. Nurses to provide family mental health education, involve families in patient care and explore rehabilitative interventions such as interpersonal skills training.

The researcher also recommends implementation and further refinement (validation) of the practice development guide

Nursing Education and Training

This study recommends the inclusion of rehabilitation training into the nursing curriculum. Also, training on the utilisation of the available resources for the implementation of rehabilitation in Nigeria. This will help to prepare HCPs for rehabilitation practice.

Nigeria and African countries

Based on the scoping review conducted in this study, only two articles came from Sub-Saharan Africa, which is an indication of increased research output. Therefore, the recommendation is for further studies (in line with clinical practice and practice guides) to be undertaken in African countries (Low-middle income countries). The WHO recommends that each country have its practice guide, and align with the WHO's 2018 recommendation. The practice of rehabilitation in Nigeria has the potential for effectiveness if handled by HCPs in the country.

Policymakers

The recommendation is that the policymakers encourage adoption and replication of the practice guide in other settings with similar characteristics to Southwest Nigeria and adoption with modifications in other settings that are not similar to Southwest.

9.6 SUMMARY

The purpose of the study was to improve the care of people living with schizophrenia in Southwest Nigeria by the development of a context-specific practice guide for psychosocial rehabilitation of individuals with schizophrenia. Firstly, there was a scoping review conducted in this study, which revealed that rehabilitation is at its insidious stage in Sub-Saharan Africa, Nigeria inclusive. In this study, the researcher managed to achieve this by finding out their experiences as the acquisition of vocational skills, employment in a hospital facility, entrepreneurial activities, and family dependence. The researcher identified the need to rehabilitate individuals with self-initiated and collaborative goals and cultivate their capability to be independent as individuals living with schizophrenia. The study discovered that those who are not dependent on HCPs can live independently, regardless of the illness. Additionally, the study explored the family's perspective of rehabilitation, which revealed the desire for clients' independence. Exploration of HCPs' experiences and expectations on rehabilitation revealed desires to have additional income for rehabilitation and recruitment of more HCPs.

9.7 CONCLUSIONS

Chapter Nine is the final chapter of this study, it concludes the research study and revealed the significance of conducting the study. The researcher in this study also showed revealed the need to guide health professionals for optimum rehabilitation of individuals living with schizophrenia. Moreover, the clients and family member emphased the need for independence while health professionals revealed the need for resources. Therefore, a practice guide was developed to ensure that health professionals have some resource that guides them towards holistic care of the patients as the findinings guided.

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ANNEXURES

Annexure A: Demographic profile of clients

Study number					
File Number					
Age range	15-25	26-36	37-47	48-58	59-69
Gender					
Diagnosis					
Occupation					
Marital status					
Educational status					
Religion					
Other illnesses(specify)					
Date of diagnosis					
Date and length of the first admission					
Frequency and dates of relapse in the last two years					
Types of treatment received					
Result of treatments					
Age of next of kin					
Relationship with client					

Annexure B: Study Information Sheet for clients

Study Title: The rehabilitation of individuals with schizophrenia: Experiences and practices of the clients, families and healthcare practitioners.

Greeting: Dear Sir/Madam, good day to you.

Introduction: I, Oyeyemi Oyelade, a doctoral student of Mental Health Nursing from the University of the Witwatersrand, South Africa, am working on the rehabilitation of individuals with schizophrenia: Experiences and practices of the clients, families and healthcare practitioners,

under the supervision of Dr. Nokuthula Mafutha.

Research is a process used in seeking new **knowledge;** thus, in this study, we have identified there is no study inquiring practice from clients, families, and health care practitioners. Also, we identify there is no context-specific psychosocial rehabilitation guide available for the management of schizophrenia in Nigerian hospitals and communities, hence, to facilitate the guided approach of rehabilitation of clients after discharge, we would like to enquire and possibly develop a practice guide.

Invitation to participate: I am inviting you to participate in this study: The study will start in 2018 and end in Dec 2020.This study, which involves using a qualitative multi-method to develop and confirm a contextual psychosocial rehabilitation practice guideline, requires the interview of clients, families, and health care practitioners. Your involvement would help facilitate the development of the practice guide. Specifically, we are seeking clients' input on their experiences with rehabilitation and their expectations. There will be an information session held to explain the study and answer your questions about the study. If you agree to take part after the information session, I will ask you to sign a consent form to confirm your agreement to participate.

What is involved in this study? You will participate in semi-structured individual interviews, in which you will describe your experience with the rehabilitation and expectations. With your permission, these interviews will be audio tape-recorded and will last for approximately 45 – 60 minutes per section with about four to five sections. The sections may be on consecutive or separate days, depending on the availability of the participants. You will also select the date, time, and venue for the interviews, subject to your availability. You will confirm the correctness of the information gathered from you on the last day of the data collection.

Risks and benefit involved in participation in the study: There are no risks of being involved in participating in this study. As with most studies, there is no direct benefit to you; however, the contextual practice guide to be developed, may facilitate recovery and productivity for individuals living with schizophrenia.

Participation is voluntary: You have time to think about participating, and please feel free to ask questions of me, my supervisor, or the Wits Ethics committee; contact numbers are below. There is no foreseen physical risk. To prevent social risk, there will be an individual interview, for which you, as the participants will determine the venue and time. This study poses no harm, although recounting the experience can bring about emotional reactions. In the event of this happening, you will receive a referral to the psychology unit of the hospital and the treatment for the emotional distress, due to the inquiry, will be at the researchers' cost and the interview.

Reimbursements: There is no cost to you other than your time, should you decide to participate. In a situation where you take transport to the interview venue, there will be a reasonable reimbursement of costs by the researcher.

Confidentiality and anonymity: There will be maintaining of confidentiality and anonymity throughout: Your name will not appear on any documentation or in any publication that may arise from the research study. You will receive a code for self-reference during the interview. With your agreement, there will tape recording of the sessions, but all recordings and transcriptions will remain with the researcher and stored in the confidential custody of the research supervisor's office for the duration of the study. After scanning, written copies of the transcripts will be burned. According to Wits policy, the will be erasure of the tapes after two years, if there has been a publication, and six years if there is no publication.

Outputs: The results of the study will be written into a research report, which will be examined by external experts who will not know the identity of any of the participants, and may be published in a scientific journal. You can have access to the study results, should you wish to see them, by contacting me at any time.

Contact details

Oyeyemi Oyelade (Principal investigator)
Phone number: +27656155496 (South Africa)
+2348076580198 (Nigeria)
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Dr. Nokuthula Mafutha (Supervisor)

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Phone number: +27(0)114583094

The Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee") granted approval for this study. A principal function of this committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concern over the way the study is being conducted, please contact the Chairperson of this committee, Professor Clement Penny, who may be contacted on telephone number +27 11 717 2301, or by e-mail on Clement.Penny@wits.ac.za. The telephone numbers for the committee secretariat are +27 11 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Thank you for reading this Study Information Sheet.

Date: November 2018

Annexure C: Study information sheet the clients' family member

Study Title: The rehabilitation of individuals with schizophrenia: Experiences and practices of the clients, families and healthcare practitioners.

Greeting: Dear Sir/Madam, good day to you.

Introduction: I, Oyeyemi Oyelade, a doctoral student of Mental Health Nursing from the University of the Witwatersrand, South Africa, am working on the rehabilitation of individuals with schizophrenia: Experiences and practices of the clients, families and healthcare practitioners,

under the supervision of Dr. Nokuthula Mafutha. Research is a process used in seeking new knowledge; thus, in this study, we have identified there is no study inquiring practice from clients, families and health care practitioners. In addition, we identified there was no context-specific psychosocial rehabilitation guide available for management of schizophrenia in Nigerian hospitals and communities; hence to facilitate the guided approach of rehabilitation of clients after discharge, we would like to enquire and possibly develop a practice guide.

Invitation to participate: I am inviting you to participate in this study: The study will start in 2018 and end in Dec 2020. This study, which involves using a qualitative multi-method to develop and confirms a contextual psychosocial rehabilitation practice guideline, requires interviews with clients, family, and health care practitioners. Your involvement would help facilitate the development of the practice guide. Specifically, we are seeking input from family members of clients on their experiences with rehabilitation and their expectations about rehabilitation of their relative with schizophrenia. There will be an information session held to explain the study and answer your questions about the study. If you agree to take part after the information session, I will ask you to sign a consent form to confirm your agreement to participate.

What is involved in this study? You will participate in semi-structured individual interviews, in which you will describe your experience with the rehabilitation of your family member and expectations. With your permission, these interviews will be audio tape-recorded and will last for approximately 45 – 60 minutes per section, with about four to five sections. The sections may be on consecutive or separate days depending on the availability of the participants. You will also select the date, time, and venue for the interviews, subject to your availability. You will confirm the correctness of the information gathered on the last day of the data collection. You may receive an invitation to a confirmation meeting of the practice guide after the completion of data collection and development of the practice guide.

Risks and benefit involved in participation in the study: There are no risks involved in participating in this study. As with most studies, there is no direct benefit to you; however, the

contextual practice guide, which this study aims to develop, may facilitate recovery and productivity for individuals living with schizophrenia.

Participation is voluntary: You have time to think about participating, and please feel free to ask questions of me, my supervisor, or the Wits Ethics committee any questions; contact numbers are below. There are no foreseen physical or emotional risks involved in families participating in this study. To prevent social risks, there will be individual interviews and you, the participants, will determine the venue and time.

Reimbursements: There is no cost to you, other than your time, should you decide to participate. In a situation where you take transport to the venue of the interview, the researcher will reimburse reasonable costs.

Confidentiality and anonymity: There will be maintaining of your confidentiality and anonymity throughout: Your name will not appear on any documentation, or in any publication that may arise from the research study. You will receive a code for self-reference during the interview. With your agreement, there will be tape recording of the sessions, but all recordings and transcriptions will remain with the researcher and stored in the confidential custody of the research supervisor's office for the duration of the study. After scanning, written copies of transcripts will be burned, and according to Wits policy, the tapes will be erased after two years if there has been a publication, and six years if no publication.

Outputs: The results of the study will be written into a research report, which will be examined by external experts who will not know the identity of any of the participants, and may be published in a scientific journal. You can access to the study results should you wish by contacting me, at any time.

Contact details
Oyeyemi Oyelade (Principal investigator)
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Dr. Nokuthula Mafutha (Supervisor)
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Phone number: +27(0)114583094

The University of the Witwatersrand, Johannesburg ("Committee") granted approval for this study. The principal function of this committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project, and the integrity of the research.
If you have any concerns about the way in which this study is conducted, please contact the Chairperson of this committee, Professor Clement Penny, on telephone number +27 11 717 2301, or by e-mail on Clement.Penny@wits.ac.za. The telephone number for the Committee secretariat is +27 11 717 2700/1234, and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Thank you for reading this Study Information Sheet.

Date: November 2018

Annexure D: Study information sheet for health care practitioners

Study Title: The rehabilitaion of individuals with schizophrenia: Experiences and practices of the clients, families and healthcare practitioners.

Greeting: Dear Sir/Madam, good day to you.

Introduction: I, Oyeyemi Oyelade, a doctoral student of Mental Health Nursing from the University of the Witwatersrand, South Africa, am working on The rehabilitation of individuals with schizophrenia: experiences and practices of the clients, families and healthcare practitioners, under the supervision of Dr Nokuthula Mafutha.

Research is a process used in seeking new knowledge; thus, in this study, we have identified there is no study inquiring practice from clients, families and health care practitioners. We also identify there is no context-specific psychosocial rehabilitation guide available for management of schizophrenia in Nigerian hospitals and communities; hence, to facilitate the guided approach of rehabilitation of clients after discharge, we would like to enquire and possibly develop a practice guide.

Invitation to participate: I am inviting you to participate in this study, which will start in 2018 and end in December 2020.This study involves using a qualitative multi-method to develop, and confirms a contextual psychosocial rehabilitation practice guideline requires the interview of clients, family and healthcare practitioners. Your involvement would help facilitate the development of the practice guide. Specifically, health care practitioners' input on their current experiences in the practice of Psychosocial Rehabilitation and expectations for future practice are sought. There will be an information session held to explain the study and answer your questions about the study. If you agree to take part after the information session, I will ask you to sign a consent form to confirm your agreement to participate.

What is involved in this study? You will participate in semi-structured individual interviews, in which you will describe your method of Psychosocial Rehabilitation practice, constraints and expectations. With your permission, these interviews will be audio tape-recorded and will last for approximately 45 – 60 minutes per session, with about four to five sections. The sessions may be on consecutive or separate days depending on the availability of the participants. Scheduling of the interviews will be at a time, date and venue suitable for the professional. You will confirm the correctness of the information gathered on the last day of the data collection. You may also receive an invitation to a confirmation meeting after completion of data collection and development of the practice guide.

Risks and benefit involved in participation in the study: There are no risks of being involved in participating in this study. As with most studies, there is no direct benefit to you,

however, the developed contextual practice guide may facilitate recovery and productivity for individuals living with schizophrenia.

Participation is voluntary: You have time to think about participating, and you can ask questions of my supervisor, the Wits Ethics committee, or me; the contact numbers are below. There are no foreseen physical or emotional risks involved in families participating in this study.

Reimbursements: There is neither cost nor payment for taking part in the study.

Confidentiality and anonymity: There will be confidentiality and anonymity maintained throughout. Your name will not appear on any documentation, or in any publication that may arise from the research study. You will receive a code for self-reference during the interview. With your agreement, the sessions will be tape-recorded, but all recordings and transcriptions will remain with the researcher and stored in the confidential custody of the research supervisor's office for the duration of the study. After scanning, written copies of transcripts will be destroyed by fire, and according to Wits policy, the tapes will be erased after two years, if there has been a publication, and six years if no publication.

Outputs: The results of the study will be written in a research report and undergo examination by external experts who will not know the identity of any of the participants; the results may also be published in a scientific journal. You may have access to the study results, should you wish, by contacting me at any time.

Contact details
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Phone number: +27656155496 (South Africa)
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Dr. Nokuthula Mafutha (Supervisor)
Email address: nokuthula.mafutha@wits.ac.za
Phone number: +27(0)114583094

The Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee") approved this study. A principal function of this committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concern about the way the study is conducted, please contact the Chairperson of this committee, Professor Clement Penny, on telephone number +27 11 717 2301, or by e-mail on Clement.Penny@wits.ac.za. The telephone number for the committee secretariat is +27 11 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Thank you for reading this Study Information Sheet.

Date: November 2018

Annexure E: Participant consent sheet

The rehabilitaion of individuals with schizophrenia: Experiences and practices of the clients, families and healthcare practitioners.

I have received a Participant Information Sheet, which explains the nature and processes involved in this study. I was given time to read it, or had it read to me, in the language I best understand.

I had time to ask any questions I wanted to, and found answers given to me to be reasonable and satisfactory.

I believe I fully understand the reasons for conducting this study, and the intended outcomes.

I understand there will be no immediate benefit to me, should I agree to participate, nor will I receive any payment; conversely, participation will not cost me anything but my time.

I understand that, even if I initially consent to take part in the study, I may subsequently withdraw at any time and would not need to give any reasons; if that happened, any data collected about me for the purposes of the study will immediately be destroyed, unless I give consent for it to be retained.

I have received contact details, as listed below. If I require further information or become concerned about any aspect of this study, I am free to speak to any of these contacts.

Contact details:

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Phone number: +27656155496 (South Africa)
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Email address: 1815816@students.wits.ac.za

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Email address: nokuthula.mafutha@wits.ac.za
Phone number: +27(0)114583094

Date: _____

Place: _____

Signature or mark of participant: _____

Witnessed by:

Name of Witness: _____

Signature: _____

Date: _____

Annexure F: Consent form for an audio recording of study participation

The rehabilitaion of individuals with schizophrenia: Experiences and practices of the clients, families and healthcare practitioners.

I hereby consent to the audio recording of the interview.

I understand that:

The storing of the recording will be in a secure location (a locked cupboard or password-protected computer), with access restricted to the researcher and the research supervisor.

There will be transcription of the recordings, and any information that could identify me removed.

The recordings will be erased within (a) three (3) years of the publication of the research findings, or (b) six (6) years if no publications arise from this research.

Anyone wishing to access this information in the future will first have to obtain the approval of the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg.

There may be citing of direct quotes from my interview, without information that could identify me, in the research report or other write-ups of research.

Date: _____

Place: _____

Signature or mark of participant: _____

Witnessed by:

Name of Witness: _____

Signature: _____

Date: _____

Annexure G: Referral letter to psychologist

The rehabilitaion of individuals with schizophrenia: Experiences and practices of the clients, families and healthcare practitioners.

Oyeyemi O Oyelade (Investigator)

Phone number: +27656155496 (South Africa)

+2348076580198 (Nigeria)

Email address: 1815816@students.wits.ac.za

The Psychologist

_____

_____

_____

_____

RE: RESEARCH PARTICIPANT

Kindly see the research participant at our cost

Please provide a report after consultation

Please do not take the name of the participant; signature only is required

Thank you

Investigator's signature: _____

Date and Time: _____

Annexure H: Interview Guide for clients

The question for clients:

Can you please describe any programme that you undergo towards assisting you to go back to your previous way or a new level of functioning?

What are the ways by which you consider the programme beneficial?

What are your issues of concern about the programme and your suggestions for improvement?

Annexure I: Interview Guide for client's family

The question for the families:

Can you please describe any programme that your relative undergoes towards assisting him or her to go back to their previous way or a new level of functioning?

What are the ways by which you consider the programme beneficial?

What are your issues of concern about the programme and your suggestions for improvement?

Annexure J: Interview Guide for health care practitioners

The question for health care practitioners:

Can you please tell me about Psychosocial rehabilitation?

How have you been providing it to clients, especially those with schizophrenia?

With regard to psychosocial rehabilitation, what have been your barriers and what could make it better?

Annexure K: Request for permission to conduct a study

Plot 5 Block 8
P.D.C.O.S Estate,
Ibadan,
Nigeria
21st August 2018.

The Chief Medical Director,
Neuropsychiatric hospital,
Aro,
Abeokuta,
Nigeria.

Dear Sir/Madam,

PERMISSION TO CONDUCT RESEARCH

TITLE OF THE STUDY The rehabilitation of individuals with schizophrenia: Experiences and practices of the clients, families and health care practitioners.

I, Oyeyemi Oyelade, am a Nigerian who is currently pursuing a doctoral degree in Nursing at the University of the Witwatersrand, South Africa. As part of my studies, I have to complete a research project. My proposed project title is The rehabilitaion of individuals with schizophrenia: Experiences and practices of the clients, families and health care practitioners. As part of this research, I would like to interview health care practitioners, clients, and their families. *T*o achieve this, I will need access to clients' case files, specifically clients with schizophrenia, to sort those eligible before contacting those clients and their family members. Also, approximately twenty (20) health care practitioners (psychiatric nurses, psychiatrists, psychologists, social workers) currently working within the hospital and involved in community service, who would be prepared and able to participate in individual interviews for four days, at a date and time considered most suitable by the professional.

Contacting the potential participants among clients and their families will be by phone, and proper consent was taken when the client visits the hospital for a follow-up appointment, if they agree to participate. After consent, the data collection from clients and family will take place at a preferred venue by each participant. Considering the vulnerability of clients, the researcher will exclude clients prone to emotional breakdown by removing those with emotional co-morbidity. However, it is not impossible for some clients to break down emotionally; in the event thereof, the data collection will be discontinued with such clients and the will be referral a referral to the psychologist at the researchers' cost.

Your participation, in essence, would mean you would:

Give me access to clients' files

Allow me access to health care practitioners employed within your hospital

Give permission to select 20professional for the individual interview

Provide me with a suitable room within the hospital premises to conduct the interviews

Your participation and those of the participants would be anonymous. The name of the institution and the participants would not appear in the final dissertation, nor the publication in a peer-reviewed journal that would follow.

I would be grateful for your permission and support to undertake this study, and look forward to hearing from you shortly.

Thank you.

Yours faithfully,



Oyeyemi Oyelade

Tel: +234(0)8076580198

Email: yemilad13@gmail.com

Annexure L: Request for permission to conduct a study

Plot 5 Block 8
P.D.C.O.S Estate,
Ibadan,
Nigeria
21st August 2018.

The Director,
Primary Health Centre,
Aro,
Abeokuta,
Nigeria.
Dear Sir/Madam,

PERMISSION TO CONDUCT RESEARCH

TITLE OF THE STUDY The rehabilitation of individuals with schizophrenia: Experiences and practices of the clients, families and healthcare practitioners.

I, Oyeyemi Oyelade, am a Nigerian who is currently pursuing a doctoral degree in Nursing at the University of the Witwatersrand, South Africa. As part of my studies, I am required to complete a research project. My proposed project title is The rehabilitation of individuals with schizophrenia: Experiences and practices of the clients, families and healthcare practitioners. As part of this research, I would like to interview health care practitioners, clients, and their families. *T*o achieve this, I will need access to client's case files, specifically clients with schizophrenia, to sort out those eligible before contacting clients and their family members. Also, approximately twenty (10) health care practitioners (psychiatric nurses, psychiatrists, psychologists, social workers, occupational therapists) who are currently working within the hospital and are involved in community service, who would be prepared and able to participate in individual interviews for four days during their half-hour break period.

Contacting the potential participants among clients and their families will be by phone, and proper consent taken when the client visits the hospital for a follow-up appointment if they agree to participate. After consent, the data collection from clients and family will occur at a preferred venue by each participant. Considering the vulnerability of clients, the researcher will exclude clients who are prone to emotional breakdown by removing those with emotional co-morbidity. However, there is the possibility some clients may break down emotionally, and in the event thereof, the data collection will cease with such clients and there will be referral to the psychologist at the researchers' cost.

Your participation, in essence, would mean you would:

Give me access to clients' files
Allow me access to health care practitioners employed within your hospital
Give permission for a selected 10professional for the individual interview
Provide me with a suitable room within the hospital premises to conduct the interviews

Your participation and those of the participants would be anonymous. The name of the institution and the participants will not appear in the final dissertation, nor the publication in a peer-reviewed journal that would follow.

I would be grateful for your permission and support to undertake this study.
I look forward to hearing from you shortly.

Thank you.
Yours faithfully,



Oyeyemi Oyelade
Tel: +234(0)8076580198
Email: yemilad13@gmail.com

Annexure M: Request for permission to conduct a study

Plot 5 Block 8
P.D.C.O.S Estate,
Ibadan,
Nigeria
21st August 2018.

The Chief Medical Director,
Neuropsychiatric Hospital,
Yaba,
Lagos,
Nigeria.

Dear Sir/Madam,

PERMISSION TO CONDUCT RESEARCH

TITLE OF THE STUDY: The rehabilitation of individuals with schizophrenia: Experiences and practices of the clients, families and healthcare practitioners.

I, Oyeyemi Oyelade, am a Nigerian who is currently pursuing a doctoral degree in Nursing at the University of the Witwatersrand, South Africa. As part of my studies, I am required to complete a research project. My proposed project title is The rehabilitation of individuals with schizophrenia: Experiences and practices of the clients, families and healthcare practitioners. As part of this research, I would like to interview health care practitioners, clients, and their families. *T*o achieve this, I will need access to clients' case files, specifically clients with schizophrenia, to sort out those eligible before contacting those clients and their family members. Also, approximately twenty (20) healthcare practitioners (psychiatric nurses, psychiatrists, psychologists, social workers, occupational therapists) currently working within the hospital and involved in community service, would be prepared and able to participate in individual interviews for four days during the half-hour break period.

Contacting of the potential participants among clients and their families will be by phone, and proper consent was taken when the client visits the hospital for a follow-up appointment if they agree to participate. After consent, the data collection from clients and families will occur at a preferred venue by each participant. Considering the vulnerability of clients, the researcher will exclude clients prone to emotional breakdown by removing those with emotional co-morbidity. However, there is the possibility some clients may break down emotionally; in the event thereof, the data collection will cease with such clients, and a referral made to the psychologist at the researchers' cost.

Your participation, in essence, would mean you would:
Give me access to clients' files
Allow me access to health care practitioners employed within your hospital
Permit selection of 20 health care practitioners for the individual interviews
Provide me with a suitable room within the hospital premises to conduct the interviews

Your participation and those of the participants would be anonymous. The name of the institution and the participants would not appear in the final dissertation, nor the publication in a peer-reviewed journal that would follow.

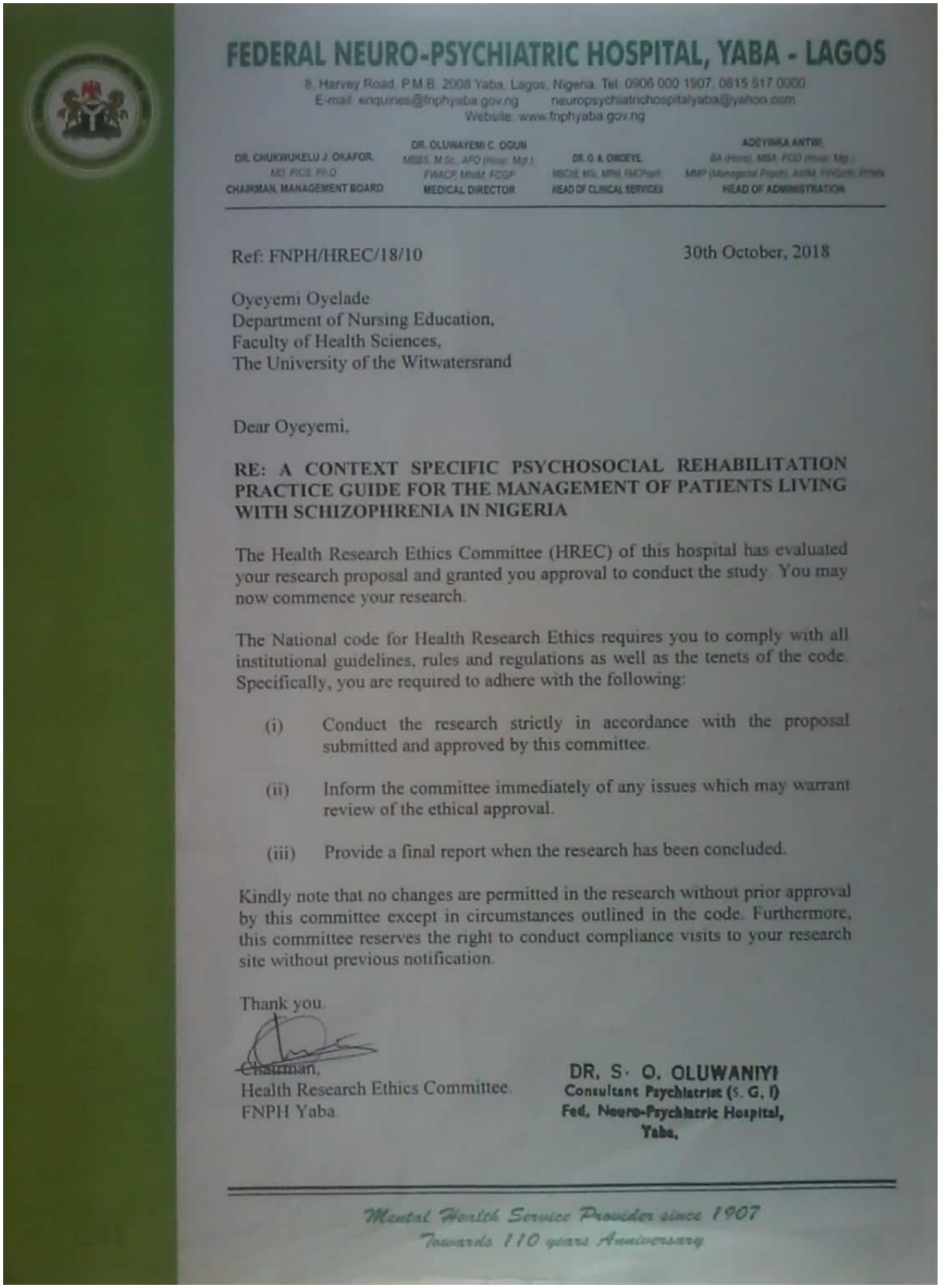
I would be grateful for your support and permission to undertake this study.
I look forward to hearing from you shortly.

Thank you.
Yours faithfully,



Oyeyemi Oyelade
Tel: +234(0)8076580198
Email: yemilad13@gmail.com

Annexure N: Ethical approvals



FEDERAL NEURO-PSYCHIATRIC HOSPITAL, YABA - LAGOS

8, Harvey Road, P.M.B. 2008 Yaba, Lagos, Nigeria. Tel: 0906 000 1907, 0815 517 0000
E-mail: enquiries@fnphyaba.gov.ng neuropsychiatrichospitalyaba@yahoo.com
Website: www.fnphyaba.gov.ng

DR. CHUKWUKELU J. OKAFOR, MD, FICS, Ph.D, CHAIRMAN, MANAGEMENT BOARD
DR. OLUWAYEMI C. OGUN, MBBS, M.Sc, AFD (Hosp. Mgt.), FWACP, MNIM, FCGP, MEDICAL DIRECTOR
DR. O. A. ONIDEYE, MBChB, MSc, MRM, FMCPsych, HEAD OF CLINICAL SERVICES
ADEYINKA ANTWI, BA (Hons), MBA, PGD (Hosp. Mgt.), MMP (Managerial Psych), ANIM, FHSAN, FPMN, HEAD OF ADMINISTRATION

Ref: FNPH/HREC/18/10

30th October, 2018

Oyeyemi Oyelade
Department of Nursing Education,
Faculty of Health Sciences,
The University of the Witwatersrand

Dear Oyeyemi,

RE: A CONTEXT SPECIFIC PSYCHOSOCIAL REHABILITATION PRACTICE GUIDE FOR THE MANAGEMENT OF PATIENTS LIVING WITH SCHIZOPHRENIA IN NIGERIA

The Health Research Ethics Committee (HREC) of this hospital has evaluated your research proposal and granted you approval to conduct the study. You may now commence your research.

The National code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations as well as the tenets of the code. Specifically, you are required to adhere with the following:

(i) Conduct the research strictly in accordance with the proposal submitted and approved by this committee.

(ii) Inform the committee immediately of any issues which may warrant review of the ethical approval.

(iii) Provide a final report when the research has been concluded.

Kindly note that no changes are permitted in the research without prior approval by this committee except in circumstances outlined in the code. Furthermore, this committee reserves the right to conduct compliance visits to your research site without previous notification.

Thank you.

Chairman,
Health Research Ethics Committee.
FNPH Yaba.

DR. S. O. OLUWANIYI
Consultant Psychiatrist (S. G. I)
Fed. Neuro-Psychiatric Hospital,
Yaba.

Mental Health Service Provider since 1907
Towards 110 years Anniversary

NEUROPSYCHIATRIC HOSPITAL, ARO.
RESEARCH ETHICS COMMITTEE
P.M.B. 2002, ABEOKUTA, OGUN STATE, NIGERIA.

Ref No. NPHA/276/VOL.IV/1232 **Date:** 2nd January, 2019

NPHAHREC Registration Number: NHREC/24/07/2013

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

RE: A context specific psychosocial rehabilitation practice guide for the management of patients living with schizophrenia in Nigeria.

NPHA Ethics Committee assigned number:	**PR012/18**
Name of Principal Investigator:	**Oyelade Olajumoke Oyeyemi**
Address of Principal Investigator:	**University of the Witwatersrand, Johannesburg, South Africa.**
Date of receipt of valid application:	**19th October, 2018**

Date of meeting when final determination on ethical approval was made **2nd January, 2019.**

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and given full approval by the NPHA Ethics Committee.

This approval dates from **2nd January, 2019** to **1st January, 2020**. If there is delay in starting the research, please inform the NPHA Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the NPHA HREC assigned number and duration of NPHA HREC approval of the study*. It is expected that you submit your annual report as well as an annual request for the project renewal to the NPHA HREC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code of Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the NPHA REC. No changes are permitted in the research without prior approval by the NPHA HREC except in circumstances outlined in the Code. The NPHA HREC reserves the right to conduct compliance visit to your research site without previous notification.

You are to submit a copy of your report to the committee for vetting before any peer review or examination defense upon completion of your research.

3/1/19

Dr. Peter O. Onifade
Chairman, NPHA Ethics Committee

E-mail: hrec@neuroaro.com **Phone No: +234 - 8133970504**

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

R14/49 Ms Oyeyemi Oyelade

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M180944

NAME: (Principal Investigator)	Ms Oyeyemi Oyelade
DEPARTMENT:	Nursing Education Neuro-Psyciatric Hospital, Nigeria Neuropsychiatric Hospital, Aro
PROJECT TITLE:	A context specific psychosocial rehabilitation practice guide for the management of patients living with schizophrenia in Nigeria
DATE CONSIDERED:	28/09/2018
DECISION:	Approved Unconditionally
CONDITIONS:	
SUPERVISOR:	Dr Nokuthula Mafutha
APPROVED BY:	CB Penny Doctor CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	21/01/2019

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the Third Floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in **September** and will therefore be due in the month of **September** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Annexure O: Approval of Change of Title

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

Reference: Mrs Sandra Benn
E-mail: sandra.benn@wits.ac.za

06 January 2021
Person No: 1815816
TAA

Ms OO Oyelade
Plot 5, Block 8, P.d.c.o.s Estate, Ibadan, Nigeria
G.p.o. Box 10367, Dugbe, Ibadan
A234
Nigeria

Dear Ms Oyeyemi Oyelade

Doctor of Philosophy: Change of title of research

I am pleased to inform you that the following change in the title of your Thesis for the degree of **Doctor of Philosophy** has been approved:

From:	**A context-specific psychosocial rehabilitation practice guide for the management of patients living with schizophrenia in South West Nigeria**
To:	**The Rehabilitation of individuals with schizophrenia in South West Nigeria; Experiences and practices of the patients, families and Health care practitioners.**

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

Annexure P: Publication of clients' interview

Received: 28 December 2019 | Revised: 8 September 2020 | Accepted: 9 September 2020

DOI: 10.1111/hex.13139

ORIGINAL RESEARCH PAPER

WILEY

Living beyond the limitation: Rehabilitation, life and productivity of individuals with schizophrenia in South-West Nigeria

Oyeyemi Olajumoke Oyelade RN, RPN, MN(Mental Health)[1,2] |
Nokuthula Gloria Nkosi-Mafutha PhD(Nursing)[1]

[1]Department of Nursing Education, School of Therapeutic Sciences, University of the Witwatersrand, Parktown, Johannesburg, South Africa

[2]Department of Nursing Science, Faculty of Basic Medical Sciences, Obafemi Awolowo University, Ile-Ife, Osun-state, Nigeria

Correspondence
Oyeyemi Olajumoke Oyelade, Department of Nursing Education, School of Therapeutic Sciences, University of the Witwatersrand, Johannesburg, South Africa.
Email: yemilad13@gmail.com

Funding information
This study is supported by: 1. The Consortium for Advanced Research Training in Africa (CARTA). CARTA is jointly led by the African Population and Health Research Centre and the University

Abstract

Introduction: Schizophrenia, the most chronic and stigmatized form of mental illness, can be described as a brain disorder that affects an individual's cognition. Individuals with schizophrenia exhibit socially unacceptable symptoms that affect their psycho-social lives. They suffer from reduced productivity due to the debilitating effect of the illness, and the negative symptoms impede their employability; such symptoms and effects aggravate the stigma around mental illness. However, when rehabilitation is successfully achieved, so is productivity, and this decreases the associated stigma. Thus, this study describes the rehabilitation experiences and productivity of individuals with schizophrenia in South-West Nigeria.

Methods and analysis: A descriptive qualitative approach with semi-structured interviews was used to gather information from mental health service users. The discharged users in this study received in-hospital or outpatient rehabilitation care at four outpatient units within two specialist mental health-care facilities in South-

Annexure Q: Publication of families' interview

Received: 1 October 2020 | Revised: 10 October 2021 | Accepted: 12 October 2021

DOI: 10.1111/hsc.13617

Health and Social Care in the community WILEY

ORIGINAL ARTICLE

Expectations and experiences of family members regarding the rehabilitation of relatives with schizophrenia in South West Nigeria

Oyeyemi Olajumoke Oyelade RN, RPN, BNSc, MN (Mental Health)[1,2] |
Nokuthula Gloria Nkosi-Mafutha PhD Nursing[1]

[1]Department of Nursing Education, School of Therapeutic Sciences, University of the Witwatersrand, Johannesburg, South Africa

[2]Department of Nursing Science, Faculty of Basic Medical Sciences, Obafemi Awolowo University, Ile-Ife, Osun-State, Nigeria

Correspondence
Oyeyemi Olajumoke Oyelade, Department of Nursing Education, School of Therapeutic Sciences, University of the Witwatersrand, 07 York Road Park Town, Johannesburg, South Africa.
Email: yemilad13@gmail.com

Funding information
This study is supported by: The Consortium for Advanced Research Training in Africa (CARTA). CARTA is jointly led by the African Population

Abstract

Schizophrenia is a major mental illness attributed to demonic influences in sub-Saharan Africa. In Nigeria specifically, schizophrenia is seen as an illness caused by the god of the sun, and it is believed that the condition of individuals suffering this illness worsens during the summer. This and many other beliefs result in people thinking that those with schizophrenia are dangerous and that it is contagious, resulting in avoidance and leaving their care to the family alone. Most times, families seek medical help after chronicity has set in. In many instances, the family unit is the only source of support for people with schizophrenia. The responsibility of care and stigma attributed to schizophrenia can be so enormous that family members feel overburdened; however, in situations where support services are available to help individuals return to their premorbid state or that of independence, there may be a reduction in the care burden faced by families. One such strategy that helps individuals with mental

Annexure R: Publication of scoping review protocol

Oyelade and Nkosi-Mafutha
Systematic Reviews (2022) 11:32
https://doi.org/10.1186/s13643-022-01901-y

Systematic Reviews

PROTOCOL Open Access

Psychosocial rehabilitation of individuals with schizophrenia: a scoping review protocol

Oyeyemi Olajumoke Oyelade[1,2*] and Nokuthula Gloria Nkosi-Mafutha[1]

Abstract

Background: The psychosocial rehabilitation of an individual with mental illness is an evidence-based approach to reducing the burden of the illness and the associated stigma globally. Specifically, in Africa, it has promising scope for African life and the African economy. Psychosocial rehabilitation is described as a set of approaches that aim to assist an individual in achieving restoration from a state of dependency caused by schizophrenia to a state of being an independent decision-maker. However, there seems to be a dearth of literature and implementation of psychosocial rehabilitation in Africa. Therefore, it is necessary to map studies on how psychosocial rehabilitation is conducted for people living in Africa with the most chronic form of mental illness, schizophrenia.

Methods: This study will adopt the Arksey and O'Malley scoping review framework to search and compile relevant studies. This process will involve three steps: title screening, to be performed solely by the principal investigator, followed by abstract and full-text screening, to be performed independently by two reviewers (the principal investigator and co-investigator). Rayyan QCRI, a systematic reviews web app, will be used for tracking the screening records, and data charting form will be used to extract basic data of included studies. The risk of bias in the articles identified for screening will be assessed by the Mixed Method Appraisal Tool (MMAT). Finally, the content analysis of the screened studies will be performed with NVivo.

Expected outcome: This study has the likelihood of revealing a research gap in psychosocial rehabilitation approaches and methods. The review results will constitute part of the available evidence that the researchers aim to adopt in the broader part of the project, which aims to develop implementation strategies for the psychosocial

Annexure S: Proofreading and language editing

Gill Smithies

Proofreading & Language Editing Services
59, Lewis Drive, Amanzimtoti, 4126, Kwazulu Natal
Cell: 071 352 5410 E-mail: moramist@vodamail.co.za

Work Certificate

To	Dr. N. Nkosi-Mafutha
Address	Dept. of Nursing Education, University of Witwatersrand, Johannesburg
Date	21//03/2022
Subject	Thesis: REHABILITATION OF INDIVIDUALS WITH SCHIZOPHRENIA IN SOUTH WEST NIGERIA: EXPERIENCES AND PRACTICES OF PATIENTS, FAMILIES AND HEALTHCARE PRACTITIONERS
Ref	NNM/GS/05

I, Gill Smithies, certify that I have proofed the following for grammar, language and style,

Thesis: Rehabilitation of individuals with schizophrenia in South West Nigeria: Experiences and practices of patients, families and healthcare practitioners, by O. O. Oyelade,

to the standard as required by the University of Witwatersrand.

Gill Smithies