FACULTY OF EDUCATION

DEPARTMENT OF ADULT EDUCATION

IMPLEMENTATION OF HEALTH EDUCATION TO PSYCHIATRIC PATIENTS TOWARDS PROMOTION OF QUALITY OF LIFE: A CASE OF ST JOSEPH CENTRAL HOSPITAL.

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A DISSERTATION PRESENTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS OF THE

MASTER OF ADULT EDUCATION DEGREE.

GWERU, ZIMBABWE

DECEMBER 2018

SUPERVISOR'S STATEMENT

This dissertation report, Implementation of health education to psychiatric patients towards promotion of quality of life: A CASE OF ST JOSEPH CENTRAL HOSPITAL BULAWAYO METROPOLITAN PROVINCE, by Maxwell Mathuthu is thereby submitted for examination.

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This dissertation, IMPLEMENTATION OF HEALTH EDUCATION TO PSYCHIATRIC PATIENTS TOWARDS PROMOTION OF QUALITY OF LIFE: A CASE OF ST JOSEPH CENTRAL HOSPITAL. BULAWAYO METROPOLITAN PROVINCE was prepared under the direction of the candidate's supervisor. It is accepted by the department in partial fulfilment of the requirements for the degree of Master of Adult Education in the Faculty of Education, Midlands State University.

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ABSTRACT

This study sought to explore the implementation of health education to psychiatric patients in St Joseph Central Hospital in Bulawayo Metropolitan Province. A purposive sample of thirty participants from St Joseph Central Hospital out of a total of two hundred and fifty seven health care professionals who deliver health education to psychiatric patients was used. The qualitative research approach was employed in conducting the study. Thirty health care professionals were interviewed and two focus group discussions were conducted. Doctors, psychiatric nurses, occupational therapists, medical social workers and psychologists were interviewed. Checklists were also used by the researcher to analyse content. Data gathered were analysed using the constant comparison analysis method and the emerging themes which were derived from the research questions were developed. The major findings were that, health education is critical to both the psychiatric patients and their caregivers as it empowers them with knowledge and skills of self-managing themselves upon discharge, health education, and health care professionals at St Joseph followed well laid down procedures when delivering health education and they used different teaching methods. The study also revealed that, there were a number of challenges faced by the health professionals when delivering health education, chief among them were the shortages of both human and material resources, knowledge gaps and skills deficit among the health care professionals and the infrastructure that was not ideal for health education delivery.

Key Words: Implementation, health education, psychiatric patients, promotion and quality of life

ACKNOWLEDGEMENTS

This dissertation would not have been possible without the contributions, assistance and participation of several people whose joint efforts I would like to acknowledge.

First to my mentor and supervisor Dr Wonderful Dzimiri, whose wise counsel and direction guided me through the various stages of the research, I am profoundly grateful.

I also wish to thank the Chief Executive Officer, the hospital board, management and the hospital ethics committee of St Joseph Central Hospital who gave me the permission to carry out this study in their institution.

My most profound thanks go to the health care professionals of St Joseph Central Hospital, for assisting me to collect the invaluable information that made the research a success.

I am very grateful to all those whom I have not mentioned by name but made valuable contributions to the success of this dissertation.

To my wife Evelyn, my two daughters Cynthia and Candice and sons Sydney and Calton your support and encouragement are humbly acknowledged.

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Chapter 1

Background of the study

1.1 Introduction

The dissertation sought to analyse, implementation of health education to psychiatric patients towards promotion of quality of life at St Joseph Central Hospital. Chapter one focused on the; background of the study, statement of the problem, aims of the study, research questions, significance of the study, assumption of the study, delimitations of the study, limitations of the study and definition of terms.

1.2 Background of the study

Psychiatric problems affect the way how people function and work in numerous ways and they are one of the leading causes of disability together with heart and muscular-skeletal diseases (World Health Organisation [WHO], 2000). According to WHO (2000) people with mental illness face a number of barriers such as environmental, legal, institutional and attitudinal which leads to their social exclusion. Rahnani et al (2015) report that in a survey carried out on patients referred to mental health services in India, patients with mental disorders reported the most discrimination from their friends, family and co-workers. Health education is therefore seen as one essential way to promote the quality of life of patients living with psychiatric conditions and also helps to minimise the burden of psychiatric conditions, (Jane-Llopis and Anderson, 2006). WHO (2000) observes that people with various disabilities including mental illness are excluded from taking an active life in their communities which costs both the patients and the community as a whole.

In psychiatry, health education for psychiatric patients can be referred to as psycho-education, patient education, patient teaching or patient instructions, (Pekkala and Merinder, 2002). The American Psychiatric Association [APA] (2004) note that health education is one way used to help patients living with psychiatric conditions to manage themselves upon discharge from hospital. The systematic reviews conducted by Morris et al (2007) on the importance of health education revealed that, health educational programmes are useful in supporting patients living with mental illness to cope with their day to day lives. WHO (2012) state that, the main

purpose of health education is to promote health, prevent disease, disability and premature death through education driven voluntary behaviour change activities. Health education plays a critical role in helping patients with mental illness to change their behaviour and that of the community at large.

Shneider (2006) views health education in psychiatric care, as helping to assist patients quickly without stigmatising them and further states that patients are entitled to information concerning their condition. Therefore patient education is a critical treatment modality for psychiatric patients which should be planned from national level (Albada et al 2007). In Finland, patient's right to receive information is provided for by the Act on the Status and Rights of Patients (785/1992), which states that a patient has a right to receive information on his or her illness and treatment. The Cochrane reviews done by Pekkala and Merinder (2002) revealed that health education to psychiatric patients has several benefits compared to standard care. These studies concluded that health education has positive effects on patients' well-being, the findings were based on three studies measuring patients' global psychosocial functioning (Jones and Marder, 2008).

Statistics gathered at St Joseph Central Hospital's main admission ward for male psychiatric patients indicated that for the period of January to October 2017, 703 patients were admitted of which 415 were re-admission. The high number of readmissions can be attributed to lack of adequate information on both the psychiatric patients and their relatives on how to self-manage upon discharge leading to high numbers of readmitted patients. In Zimbabwe the right of patients to receive full information pertaining to their conditions and treatment is enshrined in the Clients' Charter of the Ministry of Health and Child Care of 1999, which states that the patient is entitled to full information pertaining to his or her condition and treatment. However the information on how health education is implemented to psychiatric patients in Africa and particularly in Zimbabwe is very scanty, which is most probably because there are few researches that have been done in this area. This study sought to identify how health education, which is so crucial to patient recovery, is implemented at St Joseph Central Hospital.

1.3 Statement of the problem

Defaults of treatment, patient relapses, continued use of drugs like marijuana, bronchlear and cocaine, family misunderstandings and job losses are the most presenting complaints by patients who came for readmissions. This could be attributed to patients' lack of information concerning their mental illness leading to their poor self-management. Health education plays a pivotal role in empowering patients with the requisite knowledge and understanding of their conditions and skills to properly manage their mental health problems, (Hatonen, 2010). Psychiatric patients who have been empowered with the necessary information through health education pertaining to their conditions are less likely to experience frequent relapses and readmissions (Sakellari, 2014). Accordingly, hospitals should make health education to be part and parcel of the treatment package for all psychiatric patients. It was against this information that this study sought to analyse the implementation of health education to psychiatric patients in an attempt to promote their quality of life.

1.4 Purpose of the study

This study explored the implementation of health education to psychiatric patients as implemented to promote their quality of life.

1.5 Main Research question

How is health education for psychiatric patients at St Joseph Central Hospital implemented?

Sub questions

1 How do participants conceptualise health education for the mentally ill patients?

2 What is the focus of health education for psychiatric patients?

3 What are the procedures and methods employed in delivering health education for psychiatric patients?

4 What are the challenges faced in delivering health education to psychiatric patients?

5 What are the perceived impacts of health education to psychiatric patients?

1.7 Significance of the study

This research is significant to the following groups of people;

1.7.1 Policy makers

This study is going to add more knowledge and highlight the current and more effective methods that are used to deliver health education to the mentally challenged patients so as to promote the quality of their lives. Some of the information and knowledge can be adopted by the policy makers to improve the way health education is delivered to psychiatric patients and other patients in general.

1.7.2 Psychiatric nurses at St Joseph Hospital and Zimbabwe in general

The study is going to assist the nurses with the knowledge and skills and best methods of conducting effective health education sessions to the mentally ill patients. It is also going to assists them with knowledge and skills of solving the challenges that they encounter on the ground when delivering health education to the mentally challenged.

1.7.3 Other researchers

This study is going to add literature to the existing body of knowledge which other researchers can benefit from when doing their researches especially the local researchers since it appears that there is scanty information on this area that has been researched on. At a global level, this study adds literature that is Zimbabwe-specific.

1.8 Assumptions of the study

The researcher assumed that the psychiatric nurses, doctors, medical social workers, psychologists and the occupational therapists were well versed with the subject of health education and its implementation.

The researcher also assumed that the data generation and analysis tools that were used were suitable enough to collect the data that they were intended to and analyse what they were supposed to analyse.

1.9 Delimitations of the study

This study was confined to St Joseph Central Hospital and it focused on the implementation of health education for psychiatric patients only and was conducted within six month.

1.10 Limitations of the study

1.10.1 Time

The researcher was a student on block release and was also on full time employment. This meant that he had limited time for conducting the study. As such, the researcher had to use nights off, day offs and vacation leave days to conduct the study.

1.10.2 Cost

This research project was self-sponsored, as such the researcher incurred the costs of travelling, stationery, printing and binding which were very costly to the researcher since he was supposed to pay the tuition fees as well. The researcher used his own resources to fund the project.

1.11 Definition of terms

1.11.1 Health education

WHO (2012) define health education as deliberate opportunities availed to individuals and communities for learning which involve some communication designed to improve their knowledge on health issues and develop life skills to prevent diseases. On the other hand, Pekkala and Merinder (2002) refer to health education in psychiatry as patient education, psycho-education, patient instruction and patient teaching. According to Pekkala and Merinder (2002), the main objective of health education is to increase knowledge about personal health behaviours and to develop skills that demonstrate the political feasibility and organisational possibilities of various forms of action to address social, economic and environmental determinants of health. Therefore, in this study health education refers to all opportunities for learning deliberately availed to the psychiatric patients by the health care team at St Joseph Central Hospital which are meant to promote

mental health, prevent relapses and re-admissions of patients living with psychiatric conditions.

1.11.2 Quality of life

Quality of life is defined as an individualised concept dependent on one's perceptions regarding their life situation in relation to their cultural background and value system and to what they intend to achieve and the general standard of life in their community (WHO, 2000) while Nutbeam (2000) states that the definition of quality of life is very subjective in that, it reflects one's views in that their needs are being satisfied and that they are not being denied opportunities to achieve happiness and fulfilment regardless of physical health status or social and economic conditions. The quality of life of people may be objectively measured using the social indicators such as unemployment, poor housing quality. Accordingly, quality of life refers to the attainment of the physical, social and mental well-being and functioning of psychiatric patients.

1.11.3 Psychiatric patients

The above term is derived from two words psychiatry and patients. The word psychiatry refers to a branch of medicine which involves the study, diagnosis and treatment of mental health disorders (American Psychiatric Association, 2004). A patient is a person receiving or registered to receive medical treatment (Oxford English Dictionary 2018). Accordingly a psychiatric patient is a person who is receiving treatment for a mental health disorder.

1.11.4 Implementation

Putting a plan or decision into action (Oxford Dictionary, 2018), while the Cambridge Dictionary (20180, have the same definition which is the act of putting a plan into action. Accordingly in this study implementation refers to the act of delivering health education to psychiatric patients.

1.12 Summary

This chapter focused on the background of the study, statement of the problem, significance of the study, research questions, and objectives of the study, delimitations, limitations and definition of terms. The next chapter is going to focus on the review of the related literature.

Chapter 2

Literature review

2.1 Introduction

This chapter focussed on identifying the information that is related to the implementation of health education in an attempt to promote the quality of life of psychiatric patients under the following subheadings:

a) Conceptualisation of health education by health professionals.

b) The focal areas of health education for psychiatric patients.

c) The procedures and methods used in delivering health education to psychiatric patients

d) The challenges faced in delivering health education to psychiatric patients.

e) The perceived impacts of health education to psychiatric patients.

1.6 Theoretical framework

This study adopted the Activated Health Education Model designed by (Demison and Galaszewski, 2000). The Activated Health Education model has three phases namely;

The Experiential Phase which is the first phase. In the experiential phase individuals are actively involved in assessing their health. This phase make use of field studies, laboratory testing/screening and survey of the targeted behaviour, this makes individuals to become aware of their actual health behaviours. This phase assists in coming up with base line measures and overt behaviours which help in setting up of future goals (Dennison and Golaszewski, 2002). Accordingly, in this phase psychiatric patients are given an opportunity to do a self introspection so that they are able to identify behaviours that they engage in such as smoking marijuana defaulting treatment and taking other illicit drugs which causes them to relapse and be readmitted. On the other hand, the health care personnel establish the behaviours from the patients that they have to work on. The next phase is the Awareness Phase; in this phase, the information and reasons for certain behaviours

obtained from the first phase which is meant to create an awareness of the behaviour that needs to be changed is presented to the individual. This phase focuses on increasing feelings of susceptibility and creating tension between actual and ideal behaviour. In this phase psychiatric patients are given information through health education which is intended to help them compare their current behaviours that cause them to become mentally ill and those desired behaviours that will improve their lives.

The third and last phase is the Responsibility Phase, which actively involves participants in coming up with plans of changing the targeted behaviours, good health practices which will lead to change in their undesired health behaviours. In this phase health care workers assist individuals to come up with strategies of managing themselves and are required to develop their own plans of action for example self-monitoring settings, come up with measurable goals, stimulus control, use of social support systems and visual imagery in goal achievement (Kaplin and Sallis, 1993). The model as illustrated in figure 01 assumes that phase one precedes the other phases and that phase two will decrease in emphasis as phase three increase in emphasis.

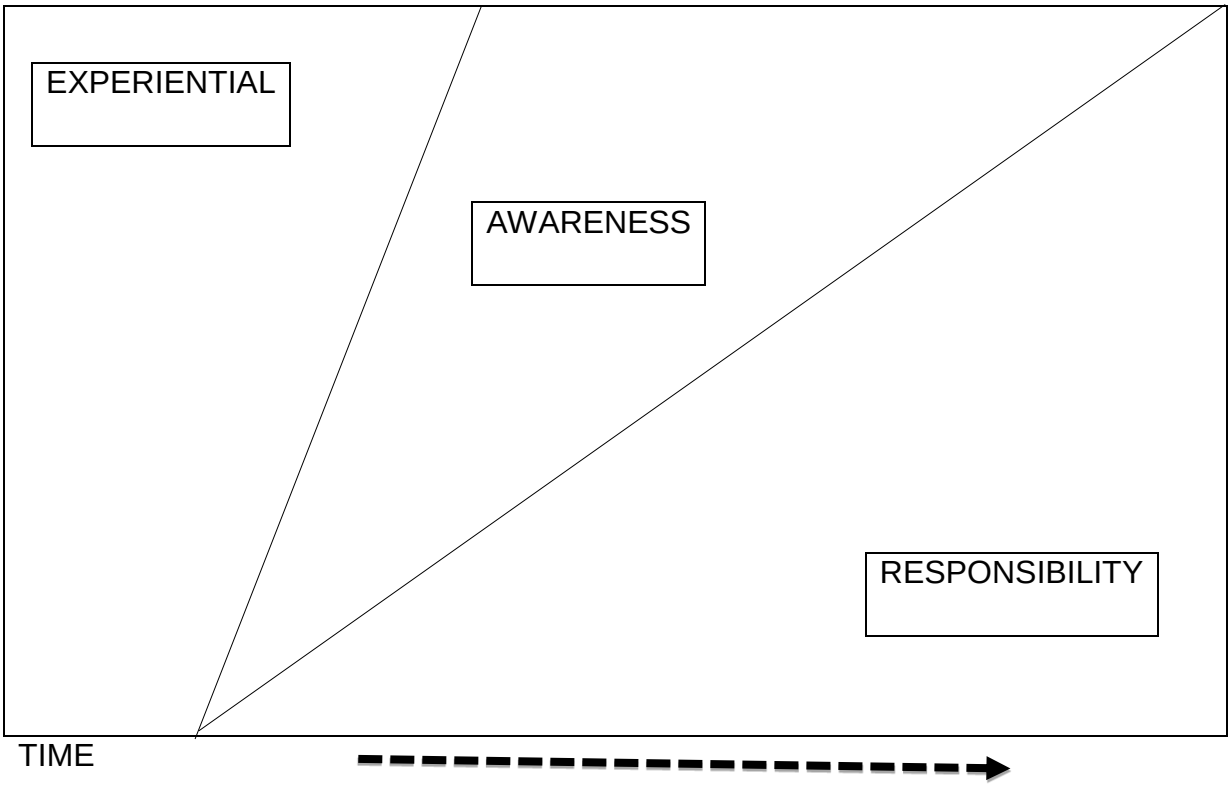

FIGURE 01: The Activated Health Education Model (Demison and Golaszewski, 2000)

2.2 Conceptualisation of health education by health professionals

Health education plays an important role in the management and treatment of chronic illnesses such as heart diseases, diabetes and chronic respiratory diseases as well as psychiatric illness (King et al, 2000). On the other hand, Lincoln et al (2007) observe that health education should be directed to both the patients and their caregivers and that it should address the social, biological and the pharmacological perspectives of the illness. Balum (2014) state that health education for psychiatric patients should be systematic in nature, it should address the causes and the signs and symptoms of mental illness, its management and must provide realistic information about the treatment, the expected outcomes and should stress on the importance of medicine adherence. Studies done in Aminu Kano Teaching Hospital in Nigeria and Spain revealed that health education to patients has a positive influence on the clinical results of patients suffering from mental illness, it improves patient care and compliance to treatment (Balum, 2014).

Balum et al (2006) observes that in countries like Denmark, United States of America and other European Countries health education has been made to be the standard of care for people suffering from severe mental disorders such as schizophrenia and bipolar disorders. Evidence gathered by Balum (2014) in a survey of mental health hospitals in Denmark showed that health education seems to reduce patient relapses, readmissions and it also encourages patients to take their medication religiously. Gellatly et al (2007) suggest that health professionals should encourage family members of psychiatric patients to be closely involved in the management of the psychiatric patients and that they should be given advice and guidance on the treatment process. This helps them to know what they can do for the patient and the behaviours and attitudes that they should avoid. However Gilbody et al (2003) observed that there is need for health professionals to be trained on the new guides that are used to deliver health education like the ones used in Denmark, United States of America and other European countries.

2.3 Focal areas of health education for psychiatric patients

The goals of health education are to empower people living with mental illness and their caregivers with knowledge concerning mental illness and its management as well as coping with the illness (Rummel et al, 2006). As such health education should be a planned activity that is aimed at changing the behaviour and attitudes of individuals and provide knowledge and skills of self-managing themselves upon discharge (Bellamy, 2004). The content of health education for psychiatric patients should include the following; the diagnosis, disease process which include the causes which may be biological, psychological and social factors, signs and symptoms which the patient may experience when having mental illness, the treatment modalities which include the following, chemotherapy, psychotherapy, supportive counselling and rehabilitation also to be highlighted are the myths and truths about mental health and mental illness (Sakellari, 2014). In the African context, it is critical that the area of myth and truth about mental illness is addressed properly because most Africans believe that mental illness is due to witchcraft or may come as a result of angering the ancestors and failure to appease them. Whitehead (2008) note that, health beliefs, health practices and trust on the care providers are all affected by the social and cultural factors of a given community. As a result of these cultural beliefs by their relatives most psychiatric patients are denied treatment from hospitals which worsen their conditions and quality of life.

Studies done in Muhimbili National hospital on factors influencing relapses among Schizophrenics (a type of mental illness) revealed that non adherence to antipsychotic medication was the leading factor to relapses (Sariah, 2012). This is an indication that mentally ill patients sometimes lack adequate knowledge on the importance of adherence to their medication. Following the above study, it was recommended that strengthening of health education on the importance of adherence to treatment was the key to the prevention of relapses (Sariah, 2012). To prevent patients from relapsing, health education should be given to psychiatric patients and their caregivers to create an awareness and understanding of mental illness which help in their self-management and this should be augmented with proper crisis planning, holistic approaches and equitable access to mental health services (Rickwood, 2002). Jones and Marder (2008) posit that for these to happen there should be a deliberate effort in coming up with mental health policies and

service designs which address issues of providing comprehensive mental health care to patients. The other useful treatment strategies which can help to prevent relapses include patient education, family education, motivational interviewing and self-management (Barker, Bucci, Lewin et al, 2006). Nagel (2008) states that the trials on implementing health education on psychiatric patients in Australia (Northern Territory), showed some good potential for relapse prevention. Graf et al (2004) alludes to the importance of highlighting the signs and symptoms of mental illness to both the patient and their relatives so that they are able to seek treatment early and prevent relapses.

People who suffer from mental illness may isolate themselves from the rest of the people and have little chances of being employed while some have symptoms such as poor attention span, memory impairments and judgement, poor self-care deficit and physical problems (Mackin etal, 2007). It is very critical that psychiatric patients and their family members are given health information on the early identification of other physical illnesses so that they are given treatment early rather than ignoring them. Acquier et al (2006) posits that patients with schizophrenia are prone to high mortality rates that are two to three times higher than that of the rest of the population. This therefore necessitate the need for health education sessions and programmes to be properly planned to address the pertinent issues concerning the problems of psychiatric patients so that they are able to self-manage themselves and hence be able to lead the quality of life they deserve (Acquier et al, 2006).

Health education has the potential to empower patients with skills of coping up with their mental illness by giving them adequate and correct information which helps them to distinguish facts about their illness from misconceptions and this makes them to fully utilise the health care services and to adhere to their treatment (Nutbeam, 2000). Health education mainly focuses on assisting patients to improve and maintain their health and cope with their psychiatric condition.

2.4 Procedures and methods used in delivering health education to psychiatric patients

Gilberth et al. (2011) posits that the teaching methods that can be used in the delivery of health education of psychiatric patients include the lecture and discussion methods and these should be used with visual aids. The lecture method has the

advantage of giving the health educator an opportunity to provide factual information in a logical sequence. Friedman et al. (2009) observe that, the use of multiple teaching strategies enhance understanding to patients. Friedman et al furthers state that it is however important for the health educator to choose a teaching method that is suitable for a given situation from the following methods; demonstration, role plays, health talks, lectures, drama and these methods should be used in combination with the appropriate audio-visual aids.

Information delivery to patients' especially psychiatric patients should be structured and not given in an ad hoc random manner (WHO, 2012). This is supported by Cooper et al. (2001) who posit that health education should be a planned learning experience. Health care personnel should be in a position to be able to select information that is specific to individual patients from the general information. Health information that is specific to individual patients' should be given to the respective patients rather than provided as general information (Friedman et al, 2009). Health care personnel should be culture sensitive when delivering health information for minority groups and the educator should always try to use different methods to enhance understanding. Cornet. (2006) posits that health education session for patients should be systematic with an introduction, body and conclusion. In the introduction the person giving health education identifies self to the patients, states his or her purpose and involves patients in establishing the goals of the session. The health educator finally discusses with the patients the expected outcomes of the session. This is followed by the body which mainly consists of information giving with the involvement of the patients. The last part is the conclusion which should start by asking the patients to do what was stated in the expected outcomes. It is important to offer precise and positive reinforcements for even small achievements. Cornet (2006) notes that health educators should use small time blocks for delivering health education of about 5-10 minutes per session. Gucciardi et al. (2007) state that, this time frame help to reduce patients' fatigue and loss of interest or attention. However despite the recommended time of 5-10 minutes, studies done by Gucciardi et al. (2007) in two hospitals in Toronto, Canada revealed that patients preferred to spend between 20-30 minutes for each health education session. On documentation of health education sessions, the Australian institute of Primary care (AIPC) (2003) state that it is critical for health educators to keep records of health education

sessions on an on-going basis since these documents can be used for quality assessments and as reference documents of health education delivery. Documentation should include topics covered, the teaching materials used such as handouts or audio-visual aids and how the patients were responding during the health education session (AIPC, 2003).

2.4.1 Lecture method

This is a simple and quick way of giving information verbally on a topic to the participants (Freidman et al. 2011). It allows for giving of factual material in a direct and sequential way. The disadvantage associated with this method is that it is seen as the least effective by many authors who feel that the patients assumes a passive role while the educator is the one who is given the opportunity to speak. Ranmal, Prictor and Scott. (2008), state that verbal instructions should be used with other teaching methods since it is the least effective teaching strategy. This therefore implies that the lecture method can be combined with other teaching methods like discussions or demonstrations to enhance understanding of information.

2.4.2 Health talks

Tamirat. (2015) note that people talk as a way of sharing information which may include health related information. Group size is very important when delivering health education through health talks. Manageable number of patients is often ideal for the talk to be effective. Tamirat. (2015) states that a health talk should have between 5-10 patients because the larger the number of patients the less chances that each patient will be able to participate in the health education talk. In these groups talks there is free flow of information between the facilitator and the group members.

2.4.3 Lecture and discussion method

Jeste, Dunn, Folsom and Zisook. (2008) posit that, this is a combination of both the lecture and the discussion methods. After the lecture the audience is involved in asking the questions, seeking clarification and challenging and reflecting on the subject being discussed. This makes the patients to take an active role in the teaching and learning situation.

2.4.4 Demonstrations

A demonstration is “any planned performance by a presenter of an occupational skill, scientific principle or experiment” (Fatherston. 2008). An effective demonstration follows three steps of the learning cycle namely the stimulus step (introducing the problem) followed by the assimilative step (which is development of the understanding by the learners and finally the application step where the learners or participants are applying what was demonstrated. The demonstration method can be an effective teaching method in an appropriate situation (Friedman et al. 2011).

2.4.5 Role plays

This is when the participants perform the roles of other people (Santo, Laizner and Shohet. 2005). Role plays in most cases are unplanned acting out of real life situation, other members or participants learn through observing how people behave when faced with certain situations, this is followed by discussions of what they observed. This method allows participants to learn through actively experiencing the rehearsed situations (Friedman et al. 2011). Friedman et al observe that, the aim of role plays is to make people understand their problems and behaviours associated with the problem.

2.4.6 Drama

It is a useful teaching method for discussing subjects where personal and social relationships are involved (Friedman et al. 2009). Drama allows the health educator to disseminate health information to people of various backgrounds for example people of different ages, different educational backgrounds and different beliefs and cultural backgrounds (Santo, Laizner and Shohet. 2005). This method is suitable for people who cannot read because they often experience things visually (Santo et al, 2005). Some psychiatric patients are not able to read and write because they managed only to do a few grades of primary education owing to their mental illnesses, hence this method can be of great benefit in delivering health education to them.

2.4.7 Teaching materials for health education

To enhance understanding of the health education to psychiatric patients, the health care personnel should make use of teaching materials (Jeste et al. 2008). The teaching materials are also referred to as teaching aids and they include the audio-visual materials such as videos and audio tapes, print materials such as charts which show what is being discussed. Santo, Laizner and Shohet. (2005) posit that if these educational materials are correctly used they can enhance patients' understanding of medical jargon and complexities, reduce their anxiety and increase adherence to treatment. Ranmal, Prictor and Scott. (2008) observe that patient educational materials and gadgets are very powerful if used properly to turn health education sessions into actions that can improve health. The use of audio-visual aids such as, print materials and videos have the ability to capture the attention of patients and make the message easier to understand. Friedman et al. (2011) note that the clinic or the hospital should have a clear and comprehensive policy of health education and should provide the audio-visual aids for use by staff when delivering health education to patients.

2.5 Challenges faced in delivering health education to psychiatric patients

Thornicroft. (2008) note that the challenges associated with giving health education to patients with mental illness are usually related to health professionals who are not immune to the effects of stigma regardless of their professional knowledge in mental illness. Patients who suffer from mental illnesses are often labelled as being "difficult" by health care workers and this makes them to be handled with much care or be left out all together (Zolmerek. 2009). People living with mental illness are considered to take much of the health professional's time. Horsfall et al. (2010) further notes that health care professional who trained in handling psychiatric patients, such as psychiatric nurses, psychiatrists and psychologists also stigmatises patients suffering from mental illness. This attitude displayed by the health care personnel has the potential of compromising the quality of health education given to psychiatric patients. Romen et al. (2008) further suggest that unlike people who suffer physical conditions, mentally ill people are usually discriminated and prejudiced leading to negative attitudes about mental illness. Again the issue of stigma prevents a collaborated action from all health care providers in giving health education to

psychiatric patients leaving this task to mental health professionals who in some cases are very few. Rickwood. (2004) says that the stigma that exists in the health care personnel towards psychiatric patients continues to affect the collaboration between the mental health clients and carers.

Stigma put on psychiatric patients by health professionals results in negative attitudes towards patients living with mental illness. The studies done by Giandinoto and Edwards.(2014) revealed that another challenge faced by health care professionals in caring for the mentally ill patients is related to the stigma and label associated with caring for these patients. Patients who suffer from mental illness are also seen as difficult to nurse and to communicate with (Bjorkman et al. 2008). This leads to avoidance of psychiatric patients by health care staff which results in them being given a shoddy service so as to quickly get rid of them (Zolnierek and Clingerman. 2012)

The time needed for the effects of the results of health education to be seen on psychiatric patients is very long compared to other diseases (Arnold et al. 2005). The impact of health education on psychiatric patients may take months or even years with some patients relapsing even after being given health education, the time lag sometimes makes it difficult for both patients and relatives to have faith in health education (WHO. 2012). Hence some patients and relatives may become frustrated and abandon the health education sessions and this has a detrimental effect on the recovery of the patient and provision of effective knowledge and skills to the relatives on how to care for their mentally ill relative. Rahmani et al. (2014) posit that family members play a critical role in the patient's treatment process.

The other stumbling block to effective health education is that some health care delivery institutions especially in Africa are so short staffed such that there is limited time for health care providers to deliver comprehensive health education to psychiatric patients (Adewaya and Oguntande. 2007). Adewaya and Oguntande. (2007) further stress that, lack of sufficient funding is another challenge that prevent effective delivery of health education and development of long term strategies for example buying the audio-visual gadgets and printing enough print materials to conduct health education effectively. This prevents health care professionals from

delivering effective health education to psychiatric patients and sometimes even de-motivates the staff.

Some studies also revealed that fear prevents health care staff from effectively delivering their services to the psychiatric patients (Arnold and Mitchell. 2008). The fear is related to the unpredictability and dangerousness of patients with mental illness causing health care staff to be extra careful about their safety when caring for people with mental illness (Adewaya and Oguntande. 2007). Hence this also affects the provision of health education to psychiatric patients.

Poor mental health literacy has been sighted as another challenge of providing health education to psychiatric patients. In some health care settings frustration of hospital staff to delivering health education to psychiatric patients is related to inadequate knowledge and skills to effectively have a meaningful interaction with psychiatric patients which makes the health care staff to feel inadequate professionally (Arnold and Mitchell. 2008). In Zimbabwe for example general nurses in some health care institutions are responsible for treating and giving health education to psychiatric patients owing to the shortage of health professionals trained in managing patients with psychiatric conditions particularly in the rural areas. These nurses do not have the knowledge and skills of dealing with psychiatric patients. The knowledge and skills gap creates some frustration amongst them when confronted with psychiatric patients. Fernandos et al. (2010) note that many general nurses do not have sufficient knowledge and skills to handle and engage in therapeutic communication with psychiatric patients. Bailey. (1998), state that caring of the mentally ill patients need certain skills gained through experience and training in psychiatric field. Agar. (2012) note that in the qualitative studies which explored the nurses experiences in caring for patients with delirium they discovered that some nurses lacked knowledge and skills of assessing and managing psychiatric patients. This implies that health care professionals dealing with psychiatric patients should always update themselves with current information pertaining to psychiatry.

The other barrier to rendering effective health education to psychiatric patients is that some health care providers, irrespective of the knowledge they have on psychiatry, still believe in the misconceptions and myths as causes of mental illness for example the spiritual causes (Adewaya and Oguntande. 2007). Some health

professionals up today still blame people suffering from mental health problems as such this creates barriers in the provision of proper services to those suffering from mental illness (Adewaya and Oguntande. 2007).

2.6 Perceived impact of health education to psychiatric patients

Bhattaejee et al. (2011) note that health education is one of the treatment modalities in psychiatry which can be effectively used to improve knowledge of people about mental illness, leading to both the patient and the caregivers taking an active role in the treatment and making psychiatric treatment acceptable to people. Hogarty et al. (1991) observe that health education to family members and patients is very important in the general management and rehabilitation of the patient because health education assist to clear any problems which relates to medicine adherence and rehabilitation hence improving the success of the treatment.

Health education to family members of patients suffering from mental illness equips them with the requisite knowledge and skills of looking after those with mental illness. Rahmani, et al. (2015) posits that family members are important in the care of people living with mental illness. The involvement of the caregivers in the treatment of the patient is very important in determining the patient's treatment outcome. Rahmani et al. (2015) conducted a study of 74 families with mentally ill patients in India. The initial results before the families were given health education on how they can look after these patients revealed that 88,9% of the family members had negative attitudes towards people with mental illness but after they were offered health education the study indicated an improvement in family attitudes toward mental illness.

Health education has some benefits to people living with psychiatric conditions since it helps to improve the general condition of the patient in a number of ways (Nagel. 2008). Studies which were conducted by Atkinson et al. (1996) where a comparison was done on patients' quality of life after health education and those on the waiting list. The study revealed that those patients who had received health education showed a significant greater improvement in the quality of life as compared to those who were on the waiting list. Another study in Australia on nutrition which was conducted by Evans. (2005), reported significantly greater improvement in the intervention group when he tested the effects of a 3 months individual nutrition

education and standard care among patients who were taking olanzapine an anti-psychotic medicine. This is an indication that health education can be used as a powerful tool for influencing change of behaviour of individuals, their perceptions of their illnesses and adherence to treatment modalities.

WHO. (2012) identified the following as the benefits of health education to patients;

1) health education make patients to be able to take responsibility for their own health care, helping them to manage their illness. This is critical for psychiatric patients as it empowers them to be knowledgeable about the importance of adherence to their medication which helps in preventing relapses and readmissions.
2) Health education also offers patients adequate information which enables them to make a choice of healthier lifestyles and practice preventive medicine. Mental illness is sometimes caused by indulging in drugs such as cocaine and madrax which are one of the major causes of mental illness. These drugs also interfere with the medicines used in the treatment of psychiatric conditions rendering them ineffective leading to relapses. Therefore health education helps psychiatric patients to refrain from using these substances of abuse hence preventing relapses and readmissions
3) Health education also makes patients to have faith in their health care providers thereby making patients to have trust in the quality of care they receive from the health care providers. This creates high chances of patients coming for their review dates as well as increasing adherence to medication and treatment regimens leading to a more cost-effective health care delivery system.
4) Lastly, health education ensures continuity of care and reduces the complications related to illness and incidence of the disorder. This maximises the individual's independence with home management.

Bhattacharjee et al. (2011) also note that the basic objective of health education is to; provide knowledge about various facets of the illness helping people to have knowledge about the do's and don'ts while rendering care to ill people or how to interact or behave and communicate with ill people, treatment options, side effects of medication and some treatment help people to track early signs of relapses. This

increases the chances of the mentally ill patients' re-entry into their homes and communities with particular regard to the social and occupational functioning.

In contemporary health delivery, health education has the potential to counter the rise of in health care costs by reducing expenses to the hospital and patients thereby helping patients manage pricy chronic conditions (Evans et al. 2005). Evans et al. (2005) further assert that, adoption of health education programmes can help health care providers and organisations produce better outcomes and enhance quality of care. Health education has the potential of preventing relapses of patients and readmissions. It can help in reducing the health care costs of looking after hospitalised patients especially in Zimbabwe where the government has the sole responsibility of funding the hospitals that care for the mentally ill patients. This is enshrined in the Mental Health of 1996 which stipulates that mental health services in Zimbabwe are free of charge. This means that the government has to buy medicines, hospital clothes, food and all other necessities for the up-keep of these patients when hospitalised which is costly.

2.7 Summary

This chapter looked at literature review using the following headings; conceptualisation of health education by the health care professionals, the focal areas of health education for psychiatric patients, the procedures and teaching methods used in delivering health education, the challenges met in delivering health education to psychiatric patients and finally the perceived impacts of health education to psychiatric patients, hospital and family members of psychiatric patients. The next chapter looked at the methodology that was used in this study.

Chapter 3

Methodology

3.1 Introduction

Chapter three covered, the research paradigm, research design, population, sample, sampling techniques, the research instruments, trustworthiness, data generation procedures, ethical considerations, data management and data presentation and analysis.

3.2 Research paradigm

Research paradigms are sets of beliefs and agreements which are shared by scientists about how a research problem should be mastered and addressed or a way of carrying out a research that has been approved by the research bodies, (Dash. 2005). McArthur. (1992) postulates that, once the researcher chooses a research paradigm it act as a guide which helps the researcher to view the fieldwork within a particular set of established assumptions, hence allowing the researcher in conducting rigorous research.

The paradigms are built on some epistemological and ontological assumptions, (Asif. 2013). Ontological assumptions are beliefs that are made about the nature of social reality, claims about what exists, what it looks like and what units makes it up and how these units interact with each other, (Blaike. 2000). Ontological assumptions are concerned with beliefs which constitute social reality. These assumptions lead to epistemological assumptions, (Blaike. 2000). The two main research paradigms are positivism and Interpretivism, (Grix. 2004). Interpretivism is also referred to as constructionist. However some authors add a third paradigm which make use of both positivism and interpretivism, which is called critical realism. May. (2001) posits that critical realism make use of both positivist and interpretivist approaches.

3.2.1 Positivism

Positivism takes natural science as a model for the human science, thereby attempting to come up with a methodology of social and natural sciences (Bernards. 2000). Grix. (2004) postulates that positivism uses scientific methods to human affairs thought as belonging to a natural order open to objective enquiry. Positivists

believe on scientific models in generating knowledge, (Grix. 2004). Therefore, from the above discussion it can be concluded that positivist believe in objectivity than in subjectivity in producing knowledge. Positivist research findings are usually represented in numbers (Mutch. 2005).

3.2.2 Interpretivism

This research paradigm came as a reaction to positivism and did not approve of the views espoused by the positivist of applying natural sciences on human beings, and does not believe that reality can exist without the people (Asif. 2013; Tuli. 2010). Instead they see reality as constructed by human beings. The interpretive research paradigm assumes that people make their own understanding of social realities and that reality is subjective (Krauss. 2005; Mutch. 2005). Interpretivists believe that reality should be examined through observations of subjects in their own environment so that comprehension and deduction of how people create and maintain their social worlds is made, (Blaike. 2000). According to the interpretivists, people are supposed to be put at the centre stage of reality formation since they are the creators of their own world. Cohen et al. (2000) postulate that the interpretivist view research participants not as objects, items or specimens like what the positivist researchers do.

3.2.3 Critical realism

Critical realism combines the views of both the positivist and interpretivist research paradigms (May. 2001). Sayer. (2000) observes that social sciences can use both the positivist and interpretivist approaches. They can use positivism when looking for causal explanations and then migrate away from positivism through taking up an interpretive understanding. Critical realism is important because it attempts to provide a reason for a critical social science but criticizes the social practices that it studies (Robson. 2002). May (2001) believes that critical realism may assist people to build a better world for themselves.

In this study the researcher adopted the interpretivist research paradigm, because it was found well suited for the qualitative study which the researcher was embarking on. The study assumed that since the health care professionals were the ones that delivered health education to the psychiatric patients they were better placed to give

an analysis of its delivery and how it helped to improve the quality of life of psychiatric patients. Again, this study was conducted in the natural setting where the health care professionals conducted their health education. The improvement in quality of life of the psychiatric patients can also be interpreted as a product of the health education delivered to them.

3.3 Research Approach (qualitative research approach)

Shank. (2002:5) defines a qualitative research as a scientific investigation into a phenomenon while Green and Thorogood. (2004) state that qualitative research is characterised by its aims which relate to understanding some aspects of social life and its methods which in general generate words rather than numbers as data for analysis. Qualitative research aims to understand the experiences and attitudes of the respondents which attempt to answer questions about how many or how much?, (Patton and Cochran. 2002). In carrying out their studies qualitative researchers use the following, observations, interviews and focus group discussions as some of the data gathering tools (Patton and Cochran. 2002). The advantages of qualitative research include ability of allowing new ideas during research and examining the systems adequately. The approach takes into account where the participants are located.

3.4 Research Design

A research design is a blue print for conducting a study which guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal(s) or a conceptual structure within which a research would be conducted (Burns and Groves. 2009; Kumar and Ranjit. 2005). A research design assists the researcher to collect relevant information for the study with minimum effort and money (MacMillan and Schmacher. 2001). It can then be concluded from the above definitions that a research design is a plan that guides the researcher in conducting the research study. In this study the researcher used the case study research design.

3.4.1 Case Study

A case study is an intensive investigation of a particular phenomenon under consideration in its context or a systematic investigation that studies a phenomenon

(the case) in detail within its context (Kothari. 2004, Yin. 2014). Fin and Jacobson. (2008) state that, case studies depict experiences of people in program input, processes and results. When using a case study as a research design, the researcher can investigate one or more cases. When one case is being examined, it is called a singular case study and when many cases are being examined they are referred to as multiple or plural case studies (Simons. 2009). Simons. (2009) states that when a researcher is investigating multiple cases, each case is investigated as if it is a singular study and the results are compared to other cases. In this study the researcher did a singular case study.

The researcher chose the case study because it allowed for collection and examination of data on (health education delivery) within the context of its use, that is in its natural setting (St Joseph Hospital) in which the delivery of health education took place (Yin. 2014). Therefore this design was found ideal for this research, since the research was conducted in a natural setting where health professionals at St Joseph Hospital implement and delivered their health education sessions. Zianal. (2007) observes that case studies allow the researchers to do in-depth examination of data within a specific context and allows for the collection of in-depth information which helps to explore and describe the data in real-life situations.

Despite the above mentioned advantages, case studies pose the following disadvantages; ‘‘they lack rigour because in most cases, the researchers in case studies may allow for equivocal evidence and biased views which may have an effect on the direction of the findings and conclusions’’ (Yin. 2014: 21). Secondly, owing to the small number of participants used in case studies which may be one subject in some cases, it makes it difficult to justify the generalisation of their findings (George and Bennet. 2005). The researcher made sure that he remained guided by the format of the questions in the interview schedule to counter the problem of bias and to ensure that rigour was maintained, which may have had an influence on the results if not observed. To come up with results that allowed for the generalisation of findings thirty respondents were interviewed and two group discussions were conducted which the researcher believed sufficed to make the study trustworthy.

3.5 Population

Brink. (2009) states that the population for the study include, the whole group of people who meet the criteria that the researcher is interested in studying. Polit and Hungler. (1999:37) define population as ‘‘all the objects, subjects or members that meet the set criteria’’. Therefore all health care professionals at St Joseph Central Hospital who were involved in delivering health education to psychiatric patients qualified to be the population to be studied. They included two hundred and thirty nine psychiatric nurses, seven doctors, three psychologists, three medical social workers and five occupational therapists. This made a total of 257 health care professionals involved in the delivery of health education at St Joseph Hospital. Participants were purposefully chosen from the senior health professionals who were assumed to have a lot of experience working with psychiatric patients in this institution with a few less experienced health professionals to compare if their views were similar to those of the more experienced ones.

3.6 Sample

De Vos et al. (2007) define it as a portion of the whole population which the researcher is interested in studying. This definition is similar to the one proposed by MacLeod. (2014) who refers to a sample as a segment of the population one intends to study. In this study the sample was drawn from the following health care professionals, doctors, psychiatric nurses, medical social workers, occupational therapists and psychologists. The largest number of participants was drawn from psychiatric nurses because they constituted the majority of the work force at St Joseph hospital which were responsible for delivering health education to psychiatric patients. There were more females than males because the majority of nurses are females and this affected the overall gender composition of the participants. In psychiatric institutions like in St Joseph Hospital, doctors are responsible for diagnosing and prescribing medication to the psychiatric patients, they also give health education and counselling to psychiatric patients. Psychiatric nurses are responsible for administering prescribed medication, delivering health education to the psychiatric patients and their caregivers and counselling as well as doing other nursing duties. The occupational therapists are also responsible for giving health education and rehabilitation of psychiatric patients. The psychologists and medical

social workers are responsible mainly for giving psychotherapy which involves counselling, family therapy and individual therapy. The researcher chose a total of thirty respondents for individual unstructured interviews and two focus group interviews which comprised of seven and ten participants respectively consisting of doctors, psychiatric nurses, psychologists, medical social workers and occupational therapists. The researcher believed that this sample was enough to gather information which allowed for an in-depth understanding of the implementation of health education to psychiatric patients at St Joseph Central hospital.

3.7 Sampling technique

Burns and Grove. (2009) define sampling as a process of coming up with those subjects, events, behaviours or elements to take part in a study. Sampling techniques are divided into probability and non-probability sampling (Patton. 2015). In non-probability sampling, selection of the sample is made based on the subjective judgement of the investigator hence respondents do not have an equal chance of taking part in the investigation (Gentles et al. 2015). In this study the researcher used purposive sampling technique. Purposive sampling falls under the non-probability sampling techniques. Ellsberg and Heise. (2005) observe that purposive sampling assist the researcher to collect data from the participants who are likely to give him/her the necessary data that will answer his or her research questions. This was also noted by Medicine San Frontieres. (2007) that, in purposive sampling technique, respondents are chosen because they are likely to generate useful data to the study. Patton. (2015) postulates that, the power and logic of using purposeful sampling is that the researcher selects those respondents who will generate rich information for the study and from whom the researcher will learn a lot from pertaining to the study. Palys. (2008) observes that purposive sampling is associated with qualitative researchers who are more interested in case study analysis.

The advantage of purposive sampling is that it has a number of types from which the researcher can choose from which are; stakeholder sampling, extreme or deviant case sampling, typical case sampling, paradigmatic case sampling, criterion sampling and disconfirming or negative case sampling just to name a few (Patton. 2015). Selection of the type depends on the objective(s) of the investigation. This study used the stakeholder purposive sampling. This sampling technique is useful in

the context of evaluation of research and policy analysis, it involves identifying the major stakeholders who are involved in designing, giving, receiving and administering the programme or service being evaluated and who might otherwise be affected by it, (Palsy and Atchison. 2008). In this study the researcher targeted the more experienced psychiatric nurses, doctors, psychologists, medical social workers and occupational therapists who were involved in the delivery of health education to psychiatric patients because they had the hands on information and experience in health education, hence were able to make informed evaluations of the health education delivered to psychiatric patients in relation to improvement of their quality of life.

The weakness that the researcher faced with purposive sampling was that it was prone to researcher bias when compared with other probability sampling techniques irrespective of the type of purposive sampling technique used (Palsy and Atchison. 2008). To counter this bias the researcher only interviewed those health care professionals who delivered health education to psychiatric patients, and who were in the service because they were the ones with the relevant information and this acted as a guideline that controlled the bias.

3.8 Research Instruments

The researcher used semi-structured interviews and focused group discussions in conducting this research. Macmillian and Schumacher. (2014) state that research instruments allow a researcher to systematically collect data. Therefore research instruments can also be referred to as the tools used to generate data when conducting a research study.

3.8.1 Interviews

This study used interviews to generate data. Kvale. (1996; p.174) defines an interview as “a conversation whose purpose is to gather description of the [life–world] of the interviewee”. In the same vein, Schostak. (2006 p. 54) notes that an ‘‘interview is an extendable conversation between partners that aim at having an in-depth information about a certain topic or subject, and through which a phenomenon would be interpreted in terms of the meanings interviewees’ bring to it’’. Interviews can either be done to individuals or groups (focus group interviews or discussion).

Clarke. (1999) observes that in group interviews, a number of participants are interviewed at once. Usually the group comprise of five-ten participants who have a facilitated discussion on a given topic with the interviewer acting as the moderator, (Patton. 2001).

A researcher can use face to face, a telephone, internet or email when carrying out individual or group interviews (Bell. 2009). Face to face interviews are carried out on a one to one basis between an interviewee and interviewer (Nelson. 2009). In this study the researcher adopted the face to face interviews. According to Nelson. (2009) interviews can be structured, semi-structured and unstructured. Bolderston. (2009), note that semi-structured and unstructured interviews are usually used in qualitative studies and they allow a researcher to probe and seek clarification of issues that are raised by the participants. In semi-structured interviews the format to be followed is set, however the interviewer is free to follow the respondent's train of thought and to explore unclear areas that may arise (Bell. 2009). Unstructured interviews are ''flexible as they allow for depth to be achieved by providing the opportunity on the part of the interviewer to probe and expand the interviewee's responses'', (Rubin and Rubin. 2005 p. 88). Interviews can also be conducted through the use of a telephone which is especially useful when collecting data from a geographically remote area where it is difficult to reach for the interviewees and is usually used in opinion and social policy research (Smith. 2005). The email, internet and online interviews make use of computers (Bolderston. 2009). In support of Bolderston, Meho. (2006) says that, computers help a researcher to conduct semi-structured on-line interviews and virtual focus groups using e-mail, instant messaging, video conferencing, chat rooms, discussion groups and many other forums that use internet.

The structured interviews are mostly organised around a set of predetermined direct questions that require immediate, mostly "Yes" or "No" types of responses making it difficult for the interviewee and interviewer to manipulate questions, (Berg. 2007). The third type is the unstructured interview (open ended) which is the most flexible one which allows more freedom on both sides that is the interviewee and the interviewer, in terms of planning, implementing and organising the interview content and question (Gubrium and Holstein. 2002 p 35). Dornyei. (2007:136) asserts that in

‘‘unstructured interviews the interviewer is free to probe further on interesting issues of the interview thereby allowing the interviewee to elaborate on various issues’’.

In this study the researcher used the face to face semi-structured interview. The researcher chose to use the semi-structured interview method because it allowed the interviewees to express their viewpoints without a framework imposed by the researcher. Bolderston. (2009) note that semi-structured interview allow the researcher to adapt his or her line of questioning to explore emerging topics from the respondents (Bolderston. 2009). The other reason that made the researcher to choose the interview method was that they have a high return rate compared to questionnaires, and they also allow the researcher to check on the completeness and accuracy of data collected. This was supported by Alshenqueeti. (2014), who states that interviews have a high return rate, fewer incomplete answers, controlled answering order, and that interviews sometimes involve reality. Face to face interviews also allowed the researcher to read and explore non-verbal communication from the respondents.

The challenge that the researcher encountered was that some respondents specifically doctors, refused to have interviews done on them owing to the time taken for conducting the interviews versus their busy schedules. Berg. (2007) notes that, interviews take time to conduct. To deal with this problem the researcher had to make some appointments in advance about two to three days before the interview and informed the respondents about the approximate time that the interview would take so that the respondents allocated themselves time for the interview. The other challenge that was faced by the researcher was that some participants were reluctant to participate since the interviews were face to face, hence did not guarantee the interviewees one hundred percent anonymity. To counter this problem, the researcher informed the respondents and reassured them that no use of their names was going to be done in any part of this research and that their anonymity was going to be guaranteed by the researcher. Bolderston. (2009) adds that interviews need a certain level of interpersonal skill to develop rapport with the participants so as to encourage conversation. Therefore the process needs and require careful planning as such its time consuming. Before the interview the researcher created rapport with the respondents and reassured the respondents that at any time during the interview when they did not feel like continuing with the

interview they were to alert the researcher, this was done so that respondents did not feel threatened or which placed them at ease to have a meaningful interaction with the researcher in a non threatening environment

3.8.2 Semi-structured interviews

The researcher conducted thirty individual interviews using the semi structured interview guide (see appendix) with respondents who included doctors, psychiatric nurses, psychologists, social workers, and occupational therapists at St Joseph Hospital. Teijlingen. (2004) notes that in semi-structured interviews the questions are pre-determined but the interviewer can change their order when he or she sees it appropriate. Semi-structured interviews also allowed for change of wording and giving of explanations hence every respondent got the same questions though there was flexibility in how they were asked. The advantages associated with the semi-structured interviews as alluded to by Finn and Jacobson. (2008) which made the researcher to adopt this method of data collection was that they have; high response rate; they allowed the researcher to explore the respondent's views and their understanding about certain behaviours than just making generalisations; and they also helped the researcher to read the non-verbal indicators hence assisting in evaluating the truth. An interview guide was designed which assisted the researcher to remain focused on the issues central to the study.

3.8.3 Focus group discussion

The researcher generated data from two focus group discussions which were composed of a mixture of all the health care personnel who included, the doctors, psychiatric nurses, occupational therapist, medical social workers and the psychologists. Kumar and Ranjit. (2005), postulate that focus group discussions are becoming one of the most popular research tools used to understand people's thoughts and feelings. Wilkinson. (2004 p 177), posits that a focus group make use of a small number of people to collect data on a certain topic or issues. The advantages of focus group discussions are that they are less threatening to the research respondents and are helpful for discussing people's perceptions, opinions, ideas and thoughts (Krueger and Casey. 2000). The other reason was that focus group discussions are less costly, efficient and a fast means of collecting data from many respondents (Krueger and Casey. 2000). However, the disadvantage of group

discussions is that some group members may dominate the discussion which may make other group members fail to participate, and some group members may feel shy to make contributions in front of all group members even if they have important points (Kumar and Ranjit. 2005). To counter the above disadvantage the researcher encouraged the group members to come up with group norms such as respecting one's contribution and doing constructive critiquing, and also explained that everyone in the group was equal, which made the group members to feel free to say their points of views.

3.9 Trustworthiness

Trustworthiness in qualitative research is the equivalent of reliability and validity in quantitative research. These concepts are important in any research because they ''enhance the accuracy of the assessment and evaluation of a research study'' (Tavakol and Dennick. 2011 p53). Ghauri and Gronheug. (2005) state that there is need to establish credibility, dependability, transferability (repeatability) and confirmability if the research project is to be trustworthy. Merriam (1998) state that credibility is an equivalent of internal validity in quantitative research, and that it deals with question of ''how congruent are the findings with the reality?''. This is supported by Ghauri and Gronbeug. (2005) who say that credibility is parallel to internal validity and focuses on establishing a match between the constructed realities of the respondents and those realities represented by the researcher. In this study the researcher used both the individual interviews and focus group discussion to collect data from the participants. The use of different data collection methods ensured that these methods compensated for their individual limitations and exploited their respective benefits. The researcher also adopted the research procedures for gathering and analysing data that were used by other researchers who did a study in line with the one the researcher conducted. This ensured that the results of the study become credible since the procedures and methods of data gathering and analysis are recognised by the research community.

The other important concept to be observed to ensure trustworthiness of the research results is dependability. Cransford et al. (2000) say that, dependability is a criterion which is equivalent to reliability in quantitative research. It is concerned with the stability of the results over time. Merriam. (1998) note that dependability ensures

that if the same techniques used by the researcher are employed in the same context using the same methods with the same participants, similar results would be obtained. To ensure dependability of this study the researcher attempted to report the processes and procedures employed in this study in detail. This was assumed to help the readers and other researchers to clearly follow the processes and procedures used in carrying out the study and arriving at the results.

The other concept to ensure trustworthiness in research is confirmability. Ghauri. (2004) states that confirmability, is concerned with the objectivity of the qualitative research. The researcher must ensure that the research findings are a result of the experiences and ideas of the participants not the characteristics and preferences of the researcher (Ghauri. 2004). The researcher in this study ensured that responses from the participants were recorded as objectively as possible following the interview guide. Again in this study the researcher used two methods of data collection, the interview and focus group discussion which helped to reduce the researcher's bias.

The last concept to ensure trustworthiness of a qualitative research is transferability. Cransford et al. (2000) posit that transferability is equivalent of external validity or generalisability in quantitative research. It is concerned with the extent to which the findings of one study can be applied to other situations (Ghauri. 2004). Therefore inferring from the above definitions of transferability it can be concluded that it refers to the ability of a research method(s) to come up with the same results over repeated testing periods in identical situations but different circumstances. To ensure that the results can be generalised, the researcher used a sample which was adequate to make such generalisations and the use of triangulation in data collection ensured that there was minimal researcher bias which also made the results to be a true reflection of the experiences of the participants.

3.10 Data generation procedure

This is the evidence that the researcher gather from the study (Polit and Hungler. 1999:267). The researcher first introduced himself to the respondents and explained to the participants the reasons for conducting the study. This helped to allay anxiety on the participants which assisted in the creation of a rapport between the researcher and the participants. This was followed by an explanation of why it was important for the participants to take part in the study and giving of the consent forms

to the participants to read and sign. After signing of the consent forms to take part in the study, the researcher requested for private rooms where he conducted the interviews. This was done to observe the principles of privacy and confidentiality. The researcher asked the participants questions from the interview schedule and took notes of the responses made by the participants seeking clarification where there was need to do so. The interviews with participants ranged from thirty to forty five minutes. Similarly in the group discussions the same procedure of explaining the reasons for the study and why it was important for the group members to take part in the study were observed in addition to explaining that there was no need for the participants to be afraid of expressing their views in the presence of their colleagues and that they were to speak through the researcher who chaired these discussions so that there was some form of control.

3.11 Ethical Considerations

Researchers are expected to observe ethical issues when conducting research studies. Ethics refer to doing well and avoiding harm (Orb, Eisenhauer and Wynaden. 2000). It is therefore important for researchers to apply appropriate ethical principles when conducting research to prevent harming the research participants. Mclntyre. (2008) postulates that it is critical to maintain ethical consideration when conducting a research study because the information about the behaviour, interests and intentions of participants raise a lot of legal and ethical questions. Burns and Groves. (2003) emphasize the importance to observe the rights of respondents which are privacy, anonymity and confidentiality. The researcher observed the autonomy of the participants by giving the respondents full information pertaining to the research study and highlighting to them that they are not forced to participate in the study. Autonomy of the respondents entails observing the right of the participants to freely and voluntarily decide to take part in the research study after they have been given full information pertaining to the research study and the right to withdraw from the study when they feel like without fear of being penalised (McIntyre. 2008). Kvale. (1996) further states that for participants to show that they have voluntarily agreed to participate in the study they should sign an informed consent which should be continuously renegotiated. Respondents were asked to sign the consent form after they had been given full information concerning the study as a sign that they had voluntarily decided to participate in the study.

The second ethical principle that the researcher observed in this study was the principle of beneficence which entails doing good and preventing harm to the participants (Orb, Eisenhauer and Wynaden. 2000). The principle of beneficence was observed by maintaining the confidentiality and anonymity of the participants so that their identities and contributions were not linked back to them hence having a negative effect on their personalities. To ensure confidentiality and anonymity, the researcher used codes to identify the respondents and pseudonyms were used in the final project. Jelsma and Clow. (2005) note that with qualitative research the context where the study took place may be familiar to other people as well as the events and experiences described hence people may be able to identify the participants which may lead to stigmatisation and victimisation at times. Therefore there is need to protect the individuals who take part in the study.

The other principle that was observed by the researcher was that of “justice”. The principle of justice entails, being fair to the participants avoiding exploiting and abusing respondents (Munhall. 1998). Oliver and Fishwick. (2003) note that, the researcher must ensure that the participants are not exploited or disempowered by the research process. The research process gives the researcher more power than the participants which creates unbalanced power relations between the two. This may make it difficult for the participant to withdraw from the study. To prevent this, the researcher empowered the research participants with information and emphasised to them that they are not forced to take part in the study and were allowed to withdraw from the study anytime they felt like. The phone numbers of the supervisor were also provided to the participants so that at any stage when they felt like being coerced by the researcher they could contact the supervisor. To observe the privacy of the participants, the researcher conducted the individual interviews in private places (in rooms on a one to one basis).

The researcher also sought permission from the authorities at St Joseph Central Hospital to conduct the study and the findings were reported correctly and objectively avoiding manipulation of results. The researcher gave the participants his contact details so that they were able to call him if they had questions relating to the study. Work obtained from other authors used in this research study was acknowledged by referencing it.

3.12 Data management

It refers to planning, organisation and preservation of the evidence of all research conclusions (Imperial College London. 2016), while Whyte and Tedds. (2011) describe research data management as the organisation and description of data from its entry to the research cycle through to the dissemination and archiving of valuable results. Good data management is important as it facilitates the verification of research results thereby making it easier for other researchers to build on the existing research (Corti et al. 2011). The researcher made sure that information collected from the respondents was correctly entered into the appropriate sections in the interview guide and that all the questions were attended to, this was to ensure completeness of data entered in the interview guide. Data from the respondents were analysed using identified themes. Proper data management reduce the risk of data loss as data can be lost in a number of ways, from a systems malfunction to losing a laptop to thieves, therefore planning for the storage and preservation of data ensures that it is safe and secure (Corti et al. 2011). To ensure that research information was not accessed by unauthorised individuals from the laptop the researcher created a password which was known by him only which he changed from time to time. The researcher also used codes and pseudonyms to ensure the confidentiality and privacy of the respondents on the individual interview guides so that if information accidently leaked it could not be traced back to the respondents. The individual interview scripts were locked in a personal cupboard of the researcher to prevent them from being seen by people who did not have anything to do with the research. Memory sticks and hard copies were used as back up methods in-case the laptop malfunctioned, to prevent loss of research data.

3.13 Data presentation and analysis.

‘‘Data analysis in qualitative research refers to the transformation of data collected from the participants into clear, understandable, insightful, trustworthy information (Best and Khan. 2006:270). ‘‘It involves establishing the themes and patterns from the raw data’’ (Cohen et al. 2007:461). Data analysis can be ‘‘inductive or deductive, it involves reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data reveal’’ (Creswell. 2013:44). Best and Khan. (2006: 270)

identified three steps of analysing data; the first step in analysing data involves organising data which differs depending on the research strategy and data collection techniques, this is followed by the second step which is referred to as the description where the researcher seeks to describe the various pertinent aspect of the study which include the settings, individuals being studied, the purpose of the activities examined, the view points of the participants and the effects of any activities on the participants. The last and final step is ‘‘the interpretation which involves the explanation of the findings, answering why questions, attaching significance to particular results and putting patterns into an analytic framework’’ (Patton. 2002: 434).

Scott and Usher. (2011: 89) note that qualitative analysis may include the following aspects; coding and classifying field notes, observations or interview transcripts by either inferring from the words being examined, what is significant or from the repeated use of words or phrases whether a pattern is developing. This helps to identify the relationships between them and understanding these relationships in general terms so that they have credibility beyond the boundaries of the case being examined. The next aspect is making explicit these patterns, commonalities and differences. It involves making sense of the data and making these now more developed theoretical constructs into fields to test or refine them. This is followed by elaboration of a set of generalisations, which suggests that certain relationships hold firm in the setting being examined and affirming that those cover all the known eventualities in the data. Lastly, there is the formalisation of the theoretical construct and making inference from them or others cases in place and time.

Wilkinson. (2004) notes that data in focus group discussions is coded and then emerging themes are presented. These themes yield important and interesting information which can be analysed. In this study, data from the semi-structured interviews and focus group discussion were analysed using the constant comparison analysis method and the emerging theme or themes from each group was developed. The recurring statements and narratives were then summarised. Data in this study was presented in the form of narratives according to identified themes which were derived from the research questions.

3.14 Summary

This chapter looked at the research methodology which included the, research paradigm, research design, case study, population, sample, sampling technique, research instruments, trustworthiness of the study and this looked at credibility, dependability, conformability and repeatability, data generation procedures, ethical considerations, data management and data analysis and presentation. The next chapter focussed on data analysis and interpretation

Chapter 4

Data presentation and analysis

4.1 Introduction

This chapter presents the findings from the study on the implementation of health education to psychiatric patients towards improvement of quality of life at St Joseph Central Hospital. The research findings are presented in a narrative form using the identified themes which were derived from the research questions. These thematic areas are as follows;

a) conceptualisation of health education of psychiatric patients by the respondents,

b) focal areas that health education for psychiatric patients focuses on,

c) procedures and teaching methods used by the respondents to deliver health education to psychiatric patients,

d) challenges encountered by the respondents when delivering health education

e) perceived impact of health education to the psychiatric patients, the hospital and the family members of the patients.

The researcher included some conversations and discussions that were made during both the individual and group discussions to highlight the views of participants. The researcher used pseudonyms to protect the respondents as highlighted in the ethical principles discussed in chapter three.

4.2 Presentation of research findings

Research findings were presented according to themes drawn from research questions that guided this study.

4.2.1 Conceptualisation of health education for psychiatric patients by the participants

Data from both individual interviews and focus group discussion revealed that health education played a critical role in the management of psychiatric patients as it helps the patients to become knowledgeable about their mental illness, adhering to their medication, refraining from using substances that trigger their relapses hence reducing their frequent admissions. This is highlighted in the discussion that the researcher (M.M) had with senior psychiatric nurse Tom who is the acting charge nurse of C12 ward.

M. M: Psychiatric nurse Tom, tell me why you think psychiatric patients should be given health education and how do you feel about the provision of health education in this institution.

Tom:

> *Health education is important in managing psychiatric patients because it makes patients to be knowledgeable about their condition, how to take their medicines and what makes them to have relapses leading to their readmissions.*

The sentiments of psychiatric nurse Tom were echoed by most respondents in both the individual and group discussion interviews. The views of the respondents clearly illustrated that they are fully aware of the role health education plays in the management of psychiatric patients and the roles that they are supposed to play but are hindered to play their roles effectively by the shortage of both the material and human resources. The above findings were in consonance with what was observed by Bhattaejee et al. (2011) who state that health education has become an important treatment modality which help people to understand mental illness, and makes them to be actively involved in its management. In support of the above observation by Hogarty et al. (1991) believe that health education to both family members and patients help to address issues relating to medicine adherence and the general care of patients in modern psychiatry.

4.2.2 Focal areas of health education for psychiatric patients

4.2.2.1 Content covered when giving health education to psychiatric patients

Most respondents in both individual interviews and group discussions agreed that the content for the health education for psychiatric patients covers, the explanation of the patient's condition, its causes, the signs and symptoms, treatment, the side-effects of treatment, warning signs of relapses, importance of owning review dates. This is revealed in the conversation that the researcher had with the sister in-charge Tsitsi (SIC) of C11 ward.

M.M: Sister in-charge Tsitsi, Which information do you cover when delivering health education to psychiatric patient?

SIC Tsitsi:

> *We cover a lot of areas, remember we look at our patients holistically, we cover the causes of mental illness which include heredity, medical causes and substance abuse, the signs and symptoms of mental illness which help both the patient and relatives to see if they are relapsing, the importance of taking their medication as prescribed and the dangers of defaulting treatment as well as the side effects of the psychiatric medicines and they are suppose to do when the patient has side-effects and finally the importance of coming to collect their medicines and when to come for their reviews*.

The views of SIC Tsitsi and other respondents on what should be covered in the health education of psychiatric patients agrees perfectly well with the views of Sakallari (2014) who postulated that, the health education for psychiatric patients should include the condition, causes, signs and symptoms, treatment modalities and that the health educator should clear the myth and misconceptions about the condition. Only two respondents added the importance of educating psychiatric patients on personal hygiene and creation of interpersonal relationships. This is shown by the conversation he researcher had with senior psychiatric nurse Vuma, who had this to say,

> *Most psychiatric nurses come to hospital with self care deficit, therefore it is important that nurses also emphasise on the importance of hygiene to prevent*

communicable diseases like diarrhoea, they also should be told to refrain from taking illicit substances so that they prevent relapses so that they become acceptable in the society.

Mackin et al (2007) noted that health education for psychiatric patients should include poor self care deficit and physical problems. This is because most psychiatric patients neglect their hygiene which may be a source of other physical illnesses. No respondent talked about the importance of psychiatric patients observing other physical diseases which the literature emphasised since most psychiatric patients' die of curable illnesses. This was alluded to by Acquier et al (2006) who note that most patients with schizophrenia are prone to die early than the rest of population because they neglect their physical health.

4.2.2.2 Benefits of health education to psychiatric patients

Data generated from the respondents on the benefits of providing health education to psychiatric patients revealed the following benefits; improving their understanding of their mental illness, improving their self management upon discharge, adherence to their medication, reduction of relapses and readmissions, improved family relations and improved chances of the patients being reintegrated into his or her community as well as improved independence and that the patient becomes a productive citizen. For example Sister in-charge Tsitsi, when she was asked by the researcher revealed the benefits of health education to both patients and their relatives thus,

M.M: SIC Tsitsi, do you think all this information you give to the patient is useful to t hem and their relatives.

SIC Tsitsi: Absolutely' she said confidently and continued,

knowledge is power, patients and relatives are empowered with the knowledge about mental illness, which prevents frequent readmission because the patient is able to take care of her/himself which creates a sense of independence to the patient, how to identify signs of relapsing and what to do so as to help the patient and that health education helps in reducing stigmatisation of patients suffering from mental illness.

Participants from both focus group discussion and individual interviews concurred with what SIC Tsitsi said, that the patients and their next of kin should be empowered with detailed information on the disease process and its management so that they are able to self manage upon discharge from hospital. They believed that health education had the potential to enable patients to be independent and take responsibility of their own lives and become productive members of their communities. The points raised by the participants agreed very well with the observations of Nagel. (2008) who found that health education for psychiatric patients helps to improve their quality of life. This is also in consonant with the studies by Atkinson et al. (1996) in Australia, which revealed that a group of psychiatric patients who had received health education on their conditions and management showed great improvement in the quality of life than the control group.

4.2.2.3 Benefits of health education to caregivers of psychiatric patients

The majority of participants in individual interviews and focus group discussions agreed that family members and relatives of psychiatric patients should be given health education on mental illness since they form the support system for the patient. This information was clearly and eloquently articulated by the medical social worker who said;

> *Family members of patients and their relatives form the support system of the patient as such they should not be left out when giving information about the patient's condition, they need to be knowledgeable so that they are able to assist the patient at home.*

These sentiments were also echoed by Rahmani et al. (2015) who state that family members of patients suffering from mental illness play a critical role in the management of patients as caregivers. When the researcher further probed the medical social worker on the reasons for relatives and family members to be given health education, she said;

> *Relatives become knowledgeable about the patient's condition, they also gain the skills to cope up with the condition of the patient, they become knowledgeable on how to help the patient with taking his/her medication and remind them of their review dates, health education also reduces*

stigmatisation and the relatives get to understand why they have to assist the patient financially when going for reviews and in purchasing of medication which may be out of stock in hospital.

Again these observations by the participants were confirmed by Hogarty et al (1991) who argued that health education to family members of psychiatric patients plays a pivotal role in modern psychiatric treatment and rehabilitation as it helps to solve problematic areas related to medicine adherence.

4.3.3 Procedures and methods used in delivering health education to psychiatric patients

4.3.3.1 Steps followed when delivering health education

Data from interviews indicated that the steps followed when delivering health education depended on the orientation and training of different health care professionals. Data obtained from the participants indicated that psychiatric nurses, occupational therapist and medical social worker followed the following steps;

a) preparation of information to be given,

b) creation of rapport with the patient(s) through introductions to allay anxiety,

c) setting of ground rules to be followed during the session especially if it is a group discussion,

d) introducing the topic,

e) brain storming on the topic,

f) information giving,

g) question and answer session and then concluding.

This is highlighted by the discussion that the researcher had with the one occupational therapist, Ms Ndlovu, who said,

That one has to prepare the venue where the education session is going to be held by ensuring that there are adequate chairs for patients to sit on, then prepare the materials needed where necessary and when the clients or

patients have arrived one has to greet them, welcome them to the health education session (building a rapport), this is done to make patients at ease so that they are free to say out their concerns, this is followed by the establishment of ground rules such as lifting up your hand when one wants to speak and only speak when asked to do so then the introduction of the topic is done, followed by brainstorming and discussion, then finally the evaluation of lessons learnt and closure of the health education session.

The steps which were alluded to by Ms Ndlovu were similar to what other participants also highlighted, especially the occupational therapist, psychiatric nurses and medical social workers. Doctors and psychologists said they did not follow well laid down steps but did a patient analysis and addressed the problems as they were identified. For example, one psychologist said, ‘‘*we do not follow any steps when doing our health education(psycho-education) we do a patient analysis to identified the needs of the patient and intervene according to the identified problem’’*.

WHO. (2012) posit that health education to patients living with mental illness should be structured and it must not be given in an ad hoc random manner. The above sentiments by WHO are supported by Cornet. (2006) who posits that health education for patients should start with an introduction followed by the body and then a conclusion. In the introduction the health educator, identifies self to the patients and articulate his or her purpose and the expected outcomes of the health education session. The body mainly consists of information giving and discussions while the conclusion identifies whether the expected outcomes were met. This again is supported by Cooper et al. (2001) who observe that health education for psychiatric patients should be a planned experience. By and large all the participants had steps that they followed when delivering health education to psychiatric patients.

4.3.3.2 Venues and length for delivery of health education

Information gathered from the participants on the venues for conducting health education for psychiatric patients and their relatives included; the courtyard, outpatients department, doctor’s room, lounge, treatment room, dining hall, offices (psychologists, medical social workers), Occupational therapy department, treatment rooms and duty rooms. This was highlighted by Ms Ndlovu the occupational therapist who revealed that, ‘health education is conducted in recreational facilities

such as the recreational hall, ‘‘*that health education is done at the outpatients department, treatment rooms, duty rooms, doctor’s rooms, the courtyard, in the lounge and the dining hall”.* WHO. (2012) does not specifically indicate the appropriate venues but rather generalise these into hospitals, schools and communities. This implies that one could deliver health education anywhere as long as the place was conducive to do so.

The length of health education sessions differed according to different health professions and they ranged from three minutes to an hour. The health education sessions for doctors were the shortest ones which ranged from three to five minutes. When asked by the researcher why their health education sessions were the shortest, one participant drawn from the doctors vehemently said, *“my duty is to identify the problem that the patient has and refer to the appropriate department be it nursing, psychology, occupational therapy or medical social work”*. The health education sessions by psychiatric nurses ranged from ten to thirty minutes and those for the psychologists, occupational therapist and medical social workers being the longest, ranged from thirty to forty-five minutes, sometimes stretching to an hour depending on the issues under discussion. This is shown by the response that the researcher got from one psychologist participant when asked why their sessions take longer she said,

> *Our sessions depend on the issue under discussion, some may take a few minutes but some are so complicated. For a example, an case of para-suicide where a patient attempts to take away his or her life, one has to make sure that he or she addresses all the pertinent issues so that the patient is given effective coping skills instead of killing self when encountered with social problems*.

Generally the lengths of health education session were very long as compared to what the literature recommends. Cornet. (2006) postulates that the recommended time for health education sessions should be between five to ten minutes so that patients do not lose interest and attention because of long sessions. Most participants conducted health education once or twice on the same group of patients depending on the staffing levels and the activities being done. A few wards delivered health education two to six times a week. This is shown by the response the

researcher got from Ms Ndlovu, the occupational therapist who stated that; ‘‘*health education sessions are done once every day, but generally health education is incorporated in all patient activities”.*

4.3.3.3. Documentation of health education sessions

Data generated from psychiatric nurses indicated that they use health education book to document the health education sessions, and in their documentation they included; the date when the session was delivered, the facilitator(s), patients that took part, brief contents of the topic, level of participation from the patients. The conversation that the researcher (M.M,) had with psychiatric nurse Tom on documentation of health education showed the general consensus what the psychiatric nurses do, to record the health education sessions.

M. M: Psychiatric nurse Tom, how do you documentation your health education sessions?

Psychiatric nurse Tom: ‘‘*We use the health education book”*.

M.M: What exactly do you document in the book?

Psychiatric nurse Tom:

> *We enter the date when the session was delivered, the name of facilitator(s), the main topic and its subheadings, level of participation of the patients or clients this helps us to see which topics we have covered and to identify if there is need to repeat the health education session if the patients did not grasp the content of the topic.*

The researcher had an opportunity to see the health education book which was divided into columns for entering the dates, name of facilitator, topic covered and level of participation and below the level of participation in one of the columns was written ‘‘*patients displayed a lot of knowledge on the topic”*.

On the other hand data generated from participants from the doctors, psychologists, social workers and occupational therapist showed that the patient’s files were used to document the content and solutions they arrived at, and proposed therapies instead of health education books. Despite the fact that these health care providers

recorded in different documents, there was evidence that documentation was being done which was crucial for reference sake and for continued care. This agrees very well with what the Australian Institute of Primary Care. (2003) state, that there should be record keeping of the health education sessions delivered on patients on an on-going basis and this documentation should include the topic covered, the teaching materials used during the session which may include the audio-visual aid or pamphlets and the level of participation of the patients.

4.3.3.4 Teaching methods used to delivery of health education

Information gathered from the participants identified five teaching methods used to deliver health education to both patients and their relatives, and these included the lecture method, group discussion, role plays, demonstrations and a combination of lecture and discussion. The researcher interviewed senior nursing officer Nkiyo responsible for health promotions department on the methods they employed in delivering health education and he had this to say, '*'In the clinical area nurses uses a number of teaching methods which include the lecture method, group discussion, role plays and demonstration".*

However data gathered from the psychiatric nurses in the clinical area showed that they used mainly two teaching methods when delivering health education, and these were the lecture method and group discussions. The most frequently used teaching method being the group discussion. The reasons cited for using the group discussion more frequently were that it allowed for active participation of the patients and their relatives, and those delivering health education were able to assess the level of understanding of psychiatric patients as well as correcting the myths and the misconceptions that they may have had regarding psychiatric illness. This was revealed by what psychiatric nurse Tom said when asked by the researcher why he preferred group discussion to other teaching methods, this is what he had to say, ''*group discussions allows patients and relatives to ask questions and contribute to the discussion in a free environment, health care professionals are also able to correct the myths and misconceptions that the patients have concerning mental illness".* This supports observations by Jeste et al. (2008) who say that group discussion makes patients to take an active role in the teaching-learning situation.

Evidence from psychiatric nurse participants showed that role plays were difficult to implement as most patients were not willing to take part and that demonstrations required them to have the teaching aids and gadgets which they do not have. Data obtained from the respondents from the occupational therapist and psychologists indicate that teaching methods such as role plays and demonstrations were being effectively used in their health education sessions in addition to the lecture and group discussions. However, the views of senior nursing officer Nkiyo were generally shared by most respondents even though some preferred other teaching methods. Data collected from the respondents on teaching methods to be employed when delivering health education to patients and their relatives agrees with the views of Gilberth et al. (2011) who state that the teaching methods that can be used to deliver health education to psychiatric patients include the lecture method, group discussion, role plays and demonstration methods The most frequently used teaching methods were group discussion and the lecture methods.

4.3.3.5 Importance of using different teaching methods

Data generated from the participants revealed the following advantages of using different teaching methods; to enhance patients' understanding of concepts being taught, enable full participation of patients when using teaching methods such as group discussions, accommodating patients with different learning abilities, giving of expert information through the use of methods like the lecture and that different methods help the facilitator to learn from the patients as well and gives the facilitator the opportunity to correct misconceptions and some myth about certain beliefs that psychiatric patients and their relatives have. Senior nursing officer Nkiyo further explained thus;

> *Our patients are composed of different levels of education, some did not attend school at all, some stopped at lower grades and some are university graduates, therefore there is need to use different methods to accommodate all our patients, again when patients come here some have a lot of information about their illness so 'we' as practitioners, learn from the patients as well for example in group discussions they may tell you the street names of drugs they use which you may not know as a nurse and when you use*

different teaching methods you increase the chances of understanding on the patients.

This agrees with the observations of Friedman et al. (2009) who state that the use of multiple teaching strategies enhances the understanding to patients. When the researcher (M.M) asked senior nursing officer Nkiyo on the most effective teaching method when delivering health education, he had this to say,

Well it depends on the topic under discussion. Some teaching methods best suit certain topics. For example when you want patients to be able to identify substances of abuse, the demonstration method will be ideal where you show patients real items but in this hospital the preferred teaching method is the group discussion.

Participants concurred with senior nursing officer Nkiyo, that group discussion was the most effective teaching methods of delivering health education to psychiatric patients because it is interactive. It allowed the facilitator to learn from the patients, give patients the opportunity to actively participate in the discussion, gives the facilitator the opportunity to correct some myth and misconceptions that both patients and their relatives have about mental illness. The views of the participants were also echoed by Jeste et al. (2008) who state that the group discussion method allows patients to seek clarification, challenge and reflect on the subject being discussed. One participant identified role play and demonstration teaching methods as very effective in delivering health education. However it should be noted that although the participants identified their preferred teaching methods. Friedman et al. (2009) are of the view that each teaching method has its own advantages depending on the subject being taught.

4.3.3.6 Teaching materials and gadgets used in delivering health education

Evidence generated from participants showed that most participants did not use any teaching materials when delivering health education as these were not available or were not provided by the hospital. One participant from the medical social work department was not hesitant to show her frustration and boldly said, ‘‘*There are no teaching materials or gadgets being provided by the hospital, we do not have*

resources to use to deliver health education effectively this frustrates us, How do they expect us to work?''

When the researcher further probed the participants on why they did not have the teaching aids and gadgets, the response the researcher got was that the hospital did not have the funds to procure such essential gadgets and materials for delivering health education. The frustrations of the participant from the medical social work department were echoed by most participants some of whom did not have kind words for the management for their failure to provide the teaching materials and gadgets. For example one participant from the psychiatric nurses said,

> *The hospital management are turning a blind eye on essential activities that makes the hospital tick and concentrate on their personal incentives. Every time they buy themselves newspapers, airtime and fuel coupons while we do not have essential tools to do our work.*

The absence of teaching materials and gadgets compromised the effectiveness of the health education sessions delivered to psychiatric patients since teaching materials enhances their understanding. Teaching materials and gadgets play a critical role in the effectiveness of health education delivery. Santo et al. (2005) observe that if teaching materials are correctly used they enhance patients' understanding by simplifying the medical terms thereby helping patients to adhere to their treatment. Only a few participants used pamphlets, posters and charts. Some participants used real objects like medicines (capsules, condoms) when they delivered health education. No participant used any audio-visual gadget for delivering health education to psychiatric patients since they were not available in their respective departments. This is contrary to the observations of Friedman et al. (2009) who observe that, each health institution must have a clear and comprehensive policy delivering health education and should provide the teaching materials and gadgets to be used by the health professionals to deliver health education.

4.4.5 Challenges encountered in delivering health education to psychiatric patients

Data from the participants revealed the following as challenges encountered by health care professionals when delivering health education to psychiatric patients;

a) That most psychiatric patients have a short and poor attention span, this is due to their mental illness hence at times they just leave the health education session before the health educator has finished delivering the sessions,

b) Shortage of human and material resources

c) Lack of adequate knowledge and skills of delivering health education properly.

These challenges were summed up by the in-charge of one admission ward Sarah when asked on the challenges they encounter when delivering health education. Her response was;

> *We have a host of challenges that we encounter when delivering health education. Chief among them are shortages of resources both human and material, we do not have the teaching materials and gadgets, we have few nurses and sometimes the shift is covered by only two nurses who obviously have to concentrate on more urgent nursing activities leaving out health education. Our venues are also not ideal for delivering health education as there are a lot of disturbances from other acute patients some patients do not even want to listen as they will be agitated.*

The problems of short attention span among the psychiatric patients were also observed by Mackin et al. (2007) who state that people who suffer from mental illness may exhibit problems such as poor attention and memory and executive functioning. Most participants concurred with the observations of charge nurse Sarah. Even those from other departments that is, the psychology and social work departments cited shortages of staff and material resources as the stumbling block to effective delivery of health education. For example data showed that the psychology department is manned by two permanent staff hence they relied on student psychologists on attachment who also needed supervision and mentoring. Most of the venues that the health professionals used when delivering health

education were not ideal as they exposed them to a lot of disturbances during health education sessions, for example in the courtyard, treatment room and the lounge. Shortage of human resource was another challenge cited by the participants as one of the major challenges as this affected the frequency of health education delivery. Instead of having health education sessions daily sometimes they were done twice a month or never. Almost all the participants noted that the hospital did not have any teaching materials for them to use during health education session. The above findings are the similar to those echoed by Adewaya and Oguntande. (2007) who note that in most African institutions delivery of health education is affected by shortage of staff which led to limited time for health education. Furthermore, limited funding and shortage other resources needed in delivering health education such as teaching materials and gadgets affected the provision of health education. Those participants working in geriatric wards revealed that most patients in their wards had memory and hearing impairment owing to their advanced ages, and this negatively impacted their comprehension of the messages being delivered during the health education sessions. This was revealed by Sister-in-Charge Goto who is responsible for looking after the female geriatric patients when asked of the challenges they encountered in their ward when delivering health education. She said, ‘‘*Most of our patients have problems with their sight and hearing, they cannot see what is reflected or put up on the wall in most sometimes. This makes it difficult to teach them ”*.

Lack of knowledge and skills of proper delivery of health education was among the challenges encountered by the participants as data showed that some of them were never trained on how to deliver health education while for those who were trained they felt that they needed refresher courses on health education delivery owing to the time that had lapsed since they left training at the Department of Mental Health Education. This was revealed by the data obtained from one medical social worker when asked by the researcher how they got the knowledge and skills of delivering health education she had this to say, *‘‘We were never taught how to deliver health education, we learnt it through doing it and it is unfortunate that in this hospital they do not organise in-service training or workshops to teach us”*.

This was the same view held by the participants though psychiatric nurses indicated that they got the knowledge and skills of delivering health education during their

training at the department of mental health education. This challenge was also observed by Arnold and Mitchell. (2008) who observed that, in some hospitals the health professionals become frustrated because of the knowledge gaps or skills deficit they have in delivering health education to psychiatric patients leading to feelings of inadequacy and professional dissatisfaction.

4.4.5.1 Effects of the challenges on the delivery of health education

The researcher further probed the medical social worker on how the challenges cited above affected the delivery of health education, and the response was as follows;

> *If there are no resources, for example say few staff, it means health education is not done or is hurried and without teaching materials the quality of health education is compromised, and if health education is poorly done then we will receive more patients for re-admissions. If the staffs are not knowledgeable and skilled it affects the quality of health education delivery as well making to staff to be frustrated.*

In addition to what the medical social worker cited, other participants revealed that the short attention span of most psychiatric patients made them to be restless, hence made it difficult for them to continue delivering the health education sessions. They indicated that sometimes they failed to finish what they would have prepared or the session got rushed and this affected the comprehension of messages being delivered. WHO. (2012) states that when patients abandon health education sessions it negatively affects the recovery of the patient.

Absence of teaching materials made the delivery of health education to be less effective since some of the patients failed to comprehend what was being said. This led to reduced understanding by the patients of the important aspects of health education. The low level of staffing in most departments caused the delivery of health education to be less frequent as the available staff attended to more urgent activities like bathing patients, feeding and medicine administration. As already alluded to, by Adewaya and Oguntande (2007) this leaves less time for health professionals to deliver comprehensive health education to psychiatric patients. This lead to patients being discharged before they are well prepared leading to relapses and re-admissions and overcrowding in wards. Poor venues were seen as reducing

the effectiveness of health education since the participants and the patients are frequently disturbed by other patients who are mentally unstable leading to loss of attention of patients attending the health education session.

4.4.5.2 Solutions to the challenges faced when delivering health education

Data generated from both individual interviews and focus group discussions suggested the following as the solutions to the challenges encountered when delivering health education;

a) that the hospital authorities should try to boost man power to cover up for shortages of manpower through lobbing for additional staff or to bring back locum duties which helped to increase staffing levels,

b) the hospital to provide the teaching materials such as chalkboards, flip charts, pamphlets charts audio-visual gadgets to help the respondents to effectively deliver health education to psychiatric patients.

c) that the hospital should organise in-service training through workshops to capacitate participants on how to effectively deliver health education since some of them did not receive such training during their professional training and most psychiatric nurses cited that they had lost some skills owing to the time that have lapsed since they left the Department of Mental Health Education and as such they needed current information on health education delivery.

d) that the hospital authorities should renovate some rooms in the wards to be solely responsible for health education where there will be little disturbance. This was revealed by Sister in-charge Sarah when asked by the researcher on what she thinks could be done to solve the challenges they encountered when delivering health education. She had this to say, *"the hospital has to provide both human and material resources, if these are availed I believe our health education will be very effective and we are likely to witness low numbers of in-patients"*

The views of sister in-charge Sarah on the solutions to the challenges they encountered when delivering health education were the same views shared by most participants. The above solutions were in agreement with the sentiments echoed by Friedman et al. (2011) who say that hospitals and clinics should provide the teaching

materials and gadgets for delivering health education and WHO. (2012) who posit that the health care professionals dealing with psychiatric patients should always update themselves with the current information pertaining to psychiatry.

4.3.6 Perceived impact of health education on psychiatric patients

Participants agreed that health education has a positive impact on the patient, hospital and the family members of the patient. Data generated from both individual and focus group interviews indicated that health education helped psychiatric patients to understand their illnesses, the dos and don'ts of their illnesses which ultimately reduces their re-admissions. This was revealed by senior nursing officer Nkiyo who said that,

> *Health education plays a critical role in improving the quality of life of the patient because the patient adhere to their medication and abstain from the use of substances which worsen their conditions. This reduces the frequencies of relapses on the patients and re-admissions, it leads to improved family relations since the patient will be stable most of the time, health education also leads to reduced time spent by the patient in hospital as they will be adhering to the treatment therapies which are enforced indirectly by health education*.

This was in agreement with the views of Nutbeam. (2000) that health education has the power to give psychiatric patients both cognitive and emotional power over their conditions, give them accurate information and correct previous misinformation. WHO. (2012), suggests that health education enable psychiatric patient to take better responsibility of their care leading to reduced relapses and readmissions. Senior nursing officer Nkiyo further elaborated that, *"the patient becomes independent since they will be mentally stable hence are able to take control their lives and they become productive members in the society since they will be able to fend for themselves"*. This meant that the overall benefit of health education to psychiatric patients is the improvement of the general quality of life.

Impact of health education to the hospital

Data from the participants indicated the following as benefits of health education to the hospital;

a) that delivery of health education keeps the health professionals up-to date with the current trends in the medical field as they are forced to read all the time.

b) helped to reduce overcrowding in the hospital since there will be few re-admissions.

c) through the reduction of hospital costs since there will be few admitted patients.

d) reduction of the workload imposed to the health professionals who are overwhelmed by very high numbers of admitted patients

e) that few patients allowed the health care professionals to provide quality care to patients which will lead to the good image of the hospital since there will be fewer incidents and more patients will be recovering

The impacts of health education to the hospital were eloquently revealed by psychiatric nurse Tom when the researcher asked him about the impact of health education to the hospital. He had this to say,

> *Health education to psychiatric patients reduces their chances of relapsing which means reduced chances of re-admissions. This means fewer patients in the hospital hence less costs of looking after patients. The staff-patient ratio is improved which reduces staff burn-out. Improved staff patient ratio can translate to improved quality care to patients reducing their time patients spend in hospital and this improves the image of the hospital.*

The above impacts were also observed by WHO. (2012) who state that health education helps patient to be knowledgeable about their conditions leading to fewer patients relapsing and getting admitted. The above views by WHO were supported by Evans et al. (2005) who pointed out that health education to psychiatric patients help health institutions to produce better patient outcomes and enhance quality care and reduce the health care cost of looking after the patients.

Impact of health education on caregivers

Evidence from both individual and focus group discussion revealed that health education made family members to be knowledgeable about the patient's condition and helped them to cope with the condition of the patient since they are given information on mental illness in general, its management and on what to do in case the patient relapses. This was clearly said by one participant from the occupational therapist who said, *"that health education to family members helped to reduce stigmatisation since the family members will be fully aware of the condition of the patient and it makes them to be supportive to the patient financially and in terms of monitoring".* These observations were similar to those of Rahmani et al. (2015) who state that health education to family members equips them with the requisite knowledge and skills for looking after the mentally ill, Atikson et al. (1996) added that health education to relatives of patients with mental illness help to reduce stigma from family members hence making them to be supportive to the patient.

How to improve the delivery and benefits of health education

Data generated from the participants indicated the following as ways that can be done to improve the delivery and benefits of health education; conducting in-service trainings to equip the health professionals with the knowledge and skills in the delivery of education, provision of tailored rooms for health education where there will be minimal disturbances and adequate staffing of all departments. This was revealed by psychiatric nurse Navison when asked by the researcher on how the delivery and benefits of health education can be improved. He had this to say, *"in-service training, proper funding of health education programmes by providing adequate material resources and staffing can greatly improve the provision of health education in the institution".* This is in consonant with the observations of Gilbody. (2003) who noted that health care professionals should be trained on the new guidelines which are used to deliver health education. This will help the health professionals to deliver health education effectively.

4.4 Summary

This chapter looked at data presentation and analysis using the following subheadings, conceptualisation of health education for psychiatric patients by participants, focal areas of health education for psychiatric patients, benefits of health education to psychiatric patients, procedures and methods used when delivering health education, the challenges faced in the delivery of health education and the impacts of giving health education.

Chapter 5

Summary, conclusion and recommendations

5.1 Introduction

This chapter gives a summary of the study, the conclusion of the research study and the recommendations based on the findings of the research study.

5. 2. Summary of the research study

This research study sought to explore the implementation of health education to psychiatric patients towards improving their quality of life. The attempted to answer the following research questions in this study;

How is health education for psychiatric patients at St Joseph Central Hospital implemented?, How do participants conceptualise health education for the mentally ill?, What were the focal areas for health education for psychiatric patients?, The procedures and methods used to deliver health education and the Challenges that were met by the health personnel in delivering health education.

The literature review looked at the conceptualisation of health education by the health care professionals, the content that should be included in the health education of psychiatric patients, the procedures and methods used in delivering health education, benefits of health education to psychiatric patients, their relatives and the health institution and lastly the impact of health education to psychiatric patients.

The research study adopted the interpretivist research paradigm, the research design used in this study was the case study and the sampling technique was the purposive sampling. To collect data from the respondents, the researcher used the semi-structured interviews on thirty respondents and group discussions which were done on two groups comprising 8 and 10 respondents in each group respectively.

The major findings from this research study were that; health education played a pivotal role in empowering both the psychiatric patients and the caregivers with knowledge and skills to self-manage themselves upon discharge. This was also observed by Bhattaejee et al. (2011), who state that health education can be used to significantly improve the level of understanding of people about mental illness which

helps both the psychiatric patients and their caregivers to take an active role in the treatment and this also ensures that psychiatric patients were accepted by their caregivers.

The study also identified that the focal areas for health education for psychiatric patients included information on the general condition of psychiatric patients, that is, the causes of psychiatric disorders, signs and symptoms and treatment modalities. This is in consonant with the observations of Sakelleri. (2014), who posits that, health education for psychiatric patients should include the disease process, its management [treatment] and should as well highlight the myths and misconceptions associated with mental illness. The study also revealed that health education should include information on the effects of substance use on mental illness, the importance of personal hygiene and seeking of treatment for physical illnesses early by people suffering from mental illness. The above findings were also alluded to by Acquire et al. (2006), who observed that health education for psychiatric patients should include information on personal hygiene since most psychiatric patients have self-care deficit and that information on seeking treatment for physical illnesses early should be included in their health education as psychiatric patients are associated with a high mortality rate compared to the general population due to neglect of these physical conditions.

The other finding drawn from the study was that there were laid down procedures followed when delivering health education at St Joseph Central Hospital which included preparation of the health education session, introducing the staff delivering health education and topic to be discussed to the patients, information giving and discussions and finally conclusion of the health education session which was followed by recording of the health education session in the health education book. This was supported by Cornet. (2006) who says that health education for patients should be systematic and should include the introduction, body and conclusion. The study findings also revealed that health care professionals at St Joseph Central hospital used different teaching methods to deliver health education to psychiatric patients. Friedman et al. (2011), observe that the use of multiple teaching strategies help to enhance the understanding of psychiatric patients.

Last but not least evidence from the study identified the following challenges that health care professionals encountered when delivering health education to psychiatric patients; shortage of teaching materials and gadgets, knowledge gaps and skills deficit on the delivery of health education by health care professionals and venues which were not ideal for delivering health education. Fernandos et al. (2010), agree with the above observations from the study that most health care staff did not have adequate knowledge and skills to handle and engage in a therapeutic communication with patients suffering from mental illness. This was also observed by Arnold and Mitchell. (2008) who state that in some health care settings the frustrations of health care professionals emanated from knowledge gaps and skills deficit related to handling psychiatric patients.

Lastly the study found out that health education can have positive significant impact on the patients, caregivers and the hospital. Health education empowered patients with knowledge and skills of self-managing themselves which reduced their frequency of relapsing and re-admissions. This greatly improved their quality of life as they became independent and responsible for their lives. The caregivers were given knowledge on how to assist the psychiatric patients with their treatments this helped to reduce the stigma from caregivers on psychiatric patients. Health education also reduced the costs the hospital incurred from taking care of patients since there were few readmissions and the quality of care rendered to patients improved since the staff patient ratio was improved. The study also revealed that health education assist the health care providers and organisations to produce better outcomes by enhancing quality of care and has the potential to reduce the rise in health care costs by reducing expenses to the hospital which help patients to manage the pricy chronic conditions (Evans et al. 2005)

5.3 Conclusions

The following were conclusions made from the research study;

This study revealed that health education has the power to greatly improve the quality of life of psychiatric patients if delivered properly with all the needed resources. It empowers the psychiatric patients with the knowledge and skills of self-managing themselves upon discharge. This ability to self-manage themselves reduces their chances of relapsing and getting readmitted into the hospital. Health

education also empowers psychiatric patients to be able take responsibility of their lives making them to be independent and productive members of the society as well as making them to be acceptable in the society.

The study also found out that relatives and family members of psychiatric patients should be given health education to empower them with understanding of the patients' condition and how it is managed so that they support the patients upon discharge. The study also revealed that education helps to reduce or totally remove the stigma and improve the attitudes of relatives towards the psychiatric patients. However despite the importance of health education to psychiatric patients, the study revealed that health education delivery at St Joseph Central hospital is below the recommended standards.

On the health professionals the study revealed that there is need for them to be capacitated with knowledge and skills of delivering health education through in-service trainings and that the hospital should come up with a standard guideline for health education delivery which will be used by all departments so that there is uniformity.

Evidence generated from the individual interviews and focus group discussions revealed that the hospital is poorly resourced with both teaching materials and gadgets used in health education hence the need for sourcing them, the infrastructure was also found to be not ideal for delivering health education.

The staffing levels were found to be low which affected the frequency of health education delivery hence the need for more staff especially in the psychology and medical social work departments. This made the delivery of health education to be erratic in some departments owing to the shortage of staff.

5. 4 Recommendations

The recommendations made here are based on the findings of the research study. They are as follows;

5. 4. 1. The hospital management has to organise in-service training for all health professionals in-order to capacitate them with knowledge and skills of effectively delivering health education to psychiatric patients.

5. 4. 2. The hospital management has to ensure that they identify the material resources and gadgets needed in the delivery of health education and secure them for the health educators on the ground.

5. 4. 3. Health professionals are also encouraged to make use of the internet to get more current information on how health education is delivered especially for psychiatric patients so that they keep themselves updated instead of waiting for hospital authorities to organise workshops.

5. 4. 4. The Ministry of Health and Child Care should work hand in hand with the Universities and colleges that train health care professionals and lobby for the inclusion of a module on health education on all health related programme so that graduands are equipped with the knowledge and skills of delivering health education to their clients.

5. 4. 5. Health education sessions are supposed to be included in the daily activity programme of all departments that deal with the psychiatric patients directly.

5. 4. 6. That further studies are suppose to be done on the implementation of health education to psychiatric patients so as to continuously improve the delivery of health education in-order to reduce overcrowding in most psychiatric institutions in the country.

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Information sheet and Consent form

Dear participant

You are hereby invited to participate in the study entitled “Implementation of health education to psychiatric patients towards promotion of quality life”. A case of St Joseph Central Hospital. Before you decide to take part, it is important for you to understand why the study is being done. Please take time to read the following carefully and feel free to ask if there is anything which is not clear or if you would like more information.

My name is Maxwell Mathuthu, Student Registration Number R175227M, a student at Midlands State University. This study is in partial fulfilment of the requirements of a Master of Adult Education degree and aims to contribute to a body of knowledge on how health education can be used to promote the quality of life of psychiatric patients.

All the information that is collected from you during this study will be kept confidential and your name(s) will never be mentioned in any analysis or dissemination of the findings. Also be informed that participation in this study is purely voluntary, if you do not wish to take part you are not forced to and should you decide to discontinue during the course of the study you are free to do so. However your participation and information that you shall provide is highly valuable to the study.

If you wish to contact me or my supervisor, you can do so on the following numbers;

Mathuthu Maxwell 0775102975

Dr Dzimiri 0773632903

Thank you very much

I participant confirm that I have been given a full explanation about the study. I have read and understood the information sheet. I voluntarily agree to take part in the study.

Signature……

Date……

Semi structured interview guide

Topic: Implementation of health education to psychiatric patients towards promotion of quality life. A case of St Joseph Central Hospital.

Section A

Biographic data

Age ☐20- 30 ☐30-40 ☐40-50 ☐50 and above

Sex ☐Male ☐Female

Marital status ☐Single ☐Married ☐Divorced ☐Separated

Designation ☐Doctor ☐Psychiatric nurse ☐Occupational therapist ☐Social worker ☐Psychologist

Experience ☐1-5 ☐6-10 ☐11 and above

Section B

Conceptualisation of health education to psychiatric patients by the participants

1. How do you perceive the delivery of health education to psychiatric patients at St Joseph Hospital?

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2. How are the health care workers capacitated to deliver health education to psychiatric patients?

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Section C

Focal areas of health education to psychiatric patients

1 What content do you cover when delivering health education to psychiatric patients?

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2. How does the information covered in health education sessions help psychiatric patients?

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3. Do you think there is any need for relatives to be given health education? If yes, state why

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Section D

Procedures and methods used in delivering health education to psychiatric patients

1. What steps do you follow when delivering health education?

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2. Indicate venues where you deliver your health education sessions.

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3. How long are your health education sessions?

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4. How often do you hold health education sessions with a single group of patients in a week?

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5. How do you document the health education sessions?

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6. Which teaching methods do you employ when providing health education?

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7. Why do you think it is important to use different methods when delivering health education?

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8. Among those methods stated above which ones do you find effective, and why?

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9. State the teaching aid materials or gadgets you use when delivering health education sessions?

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Section E

Challenges encountered in delivering health education to psychiatric patients

1. What challenges do you encounter when delivering health education to psychiatric patients?

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2. Describe how the above challenges affect your delivery of health education sessions?

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3. What can be done to solve the challenges being faced?

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Section F

Perceived impact of health education on psychiatric patients

1. What are the benefits of giving health education to psychiatric patients?

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2. What benefits does the health institution accrue from the delivery of health education to psychiatric patients?

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3. How do family members/relatives benefit from health education for psychiatric patients?

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4. What can be done to improve delivery of and benefits from health education for psychiatric patients?

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Focused group discussion guide

Implementation of health education to psychiatric patients towards promotion of quality life; A case of St Joseph Central Hospital.

Section A

Focal areas for health education on psychiatric patients

1. What is the content of health education curriculum for psychiatric patients?

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2. How does the information covered in health education sessions help psychiatric patients?

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3. Do you think there is any need for relatives to be given health education? If 'Yes', state why?

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Section B

Procedures and methods used in delivering health education.

1. What steps do you follow when delivering health education?

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2. Indicate the venues where you deliver your health education sessions.

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3. How long should health education sessions take?

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4. Which teaching method(s) do you employ when providing health education to psychiatric patients?

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5. Amongst the methods stated above which ones do you find effective and why?

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6. Indicate the advantages of using different teaching methods when delivering health education?

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7. State the teaching aid materials or gadgets used when delivering health education sessions?

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Section C

Challenges faced when giving health education to psychiatric patients

1. What are the challenges that you encounter when delivering health education sessions to psychiatric patients?

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2. Describe how the above challenges affect the delivery of health education sessions to psychiatric patients?

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3. What can be done to solve the challenges being faced?

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Section D

Perceived impact of health education to psychiatric patients

1. How does health education benefit psychiatric patients?

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2. How do family members/relatives benefit from health education for psychiatric patients?

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3. What benefits does the health institution accrue from the delivery of health education to psychiatric patients?

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5. What can be done to improve delivery of and benefits from health education for psychiatric patients?

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