Patients, Family or Care Givers and Treatment Factors that Influence Relapse Among Patients with Mental Illness Being Treated at Mbale Regional Referral Hospital Psychiatric Unit.

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DOI: 10.29322/IJSRP.14.03.2024.p14707
https://dx.doi.org/10.29322/IJSRP.14.03.2024.p14707

Paper Received Date: 16th January 2024
Paper Acceptance Date: 24th February 2024
Paper Publication Date: 6th March 2024

Abstract- The study was designed to determine the factors that influence relapse of mental illnesses among patients being treated at MRRH psychiatric unit. This study was chosen due to high cases of readmission into the psychiatric unit of MRRH and it was conducted under the following specific objectives; to determine the patient factors that influence relapse among patients with mental illness, to investigate the family/care givers factors that influence relapse in patients with mental illness, and to identify the treatment factors that influence relapse in patients with mental illness.

Prospective descriptive study that involved the use of questionnaires filled by the patients was used in which 73 patients were sampled, 10 respondents were selected daily and the data collected with a help of the staff nurse of the unit who played a big role in identifying those who were fit for the study and the data obtained was analyzed using a simple calculator and the findings were presented in tables, pie charts and bar graphs.

The study found out that males had more cases of relapse compared to females that is to say 42/73(57.5%) and females 31/73(42.5%), people with low economic status had more relapse of symptoms as compared to those with relatively stable financial status that is peasant farmers 18/73(24.7%), young adult patients experienced more relapses 40/73(54.8%) as compared to the elderly 7/73(9.6%), stressful life factors like loss of a job 24/73(32.9%), bereavement 17/73(23.3%), self -termination of treatment due to side effects of the medicines 20/73(27.4%), after some improvement 17/73(23.3%), substance abuse 39/73(53.4%), were all associated with relapse in mental illness. The study revealed that there was a good relationship between health workers and clients 70/73(95.9%) and recommended that they were being treated well while 3/70(4.1%) suggested that there is still need for the health workers to adjust towards their conduct.

The researcher concluded that young age, male sex, poverty, drug abuse, downward changes in life, stigmatization, self-termination of treatment, shortage of medicine are highly responsible for relapse of psychiatric symptoms in patients with mental illness.

The researcher recommends that the MOH should constantly supply psychiatric medicines to psychiatric unit, develop strict laws on drug abuse, continuous health education of follow up patients from psychiatric unit harmonious living of the community with mentally ill patients.

Index Terms- Patients, Family or Care Givers and Treatment Factors, Relapse, Mental Illness.

I. INTRODUCTION

Mental illness is a general term for group of illnesses that may include psychotic or changed mood symptoms. Mental illness can make it difficult for someone to cope with work, relationships and other demands WHO report (2001), .It is characterized by symptoms such as hallucinations, delusions, disorganized communication, poor planning, reduced motivation, and blunted affect (McGrath, Saha, Welham, Saadi, MacCauley & Chant, 2004).

In this chapter, the problem of mental illness is defined as the basis for which the research proposal will be conducted. The objectives to be achieved, the guiding research questions and the subsequent justification of the study are all captured herein.

1.1 Background

According to WHO report (2001), It is estimated that the global burden of disease with Disability Adjusted Life Years (DALYs) show that mental and neurological disorders, depression for largest proportion of the burden which is high among women than men Four other mental disorders figure. In the top ten causes of disability in the world namely alcohol abuse bipolar affective disorders

(BAD), Schizophrenia and obsessive-compulsive disorders and the number is expected to rise to 15% of DALYs lost by year 2020. World wide, of the 50million people suffering from epilepsy; 80% live in low and middle income countries; of the 66 million people suffering from depression; 85% live in low and middle income countries; of the 24 million people with an alcohol related problems; 82% live in low and middle income countries, of the 1million people commit suicide each year ;84% of these suicides are committed in low and middle income countries WHO (2009).

Mental illness is often accompanied by relapse even while on treatment (Gelder, Lopez-Ibor & Andreasen, 2000). Relapse has been defined as a worsening of psychopathological symptoms or re-hospitalization in the year after hospital discharge (Schennach, Obermeier, Meyer, Jäger, Schmauss & Laux,et al.,2012). Individuals with chronic schizophrenia constituted a large proportion of all residents of mental institutions in the past and still do where these institutions continue to exist (WHO report, 2004).

An international survey was done to shed light on experiences and insight so family caregivers of individuals with schizophrenia, bipolar disorders and schizoaffective disorder. Relapse was seen to have been a major concern for caregivers because of its devastating consequences for family members of people living with mental illness. Care givers from Australia, Canada, Germany, France, Italy, Spain, United Kingdom and United States participated in the survey. Of the 502 (51.12%) caregivers who said their family members topped taking medication despite doctor's advice, 91% claimed that this led to relapse for their family member. 838 (85.34%) caregivers said their family members experience av relapse. As a result of relapse their loved ones were un able to work (72%), were hospitalized (69%), attempted suicide (22%) and imprisoned (20 %). More than one third of caregivers said that their family members relapsed five or more times since becoming diagnosed, leaving a majority of care givers to often worry about their relatives relapsing (World Federation for Mental Health & Eli, Lilly & Company, 2008)

A few studies regarding relapse and schizophrenia have been done in Africa. Studies done in South Africa have found that presence of a co-morbid depressed mood, poor adherence due to a lack of patient insight, and medication side-effects appear to be the factors most likely to increase the risk of a relapse (Kazadi, Moosa & Jeenah, 2008). Other factors that have been identified include: lack of social support, grief following the loss of a close family member, and lack of employment.

Mental disorders generally respond to psychological and social interventions and to medications. At the district and primary care levels, problems with medication procurement and distribution hamper the ready of psychotropic medications, which is aggravated by a lack of resources, poor advance planning, and stigma about the need for mental health interventions by those involved in the distribution process. Basic psychosocial support is readily deliverable at the primary care level if teams are given appropriate general training. More complex psychotherapies, such as cognitive-behavioral therapy and interpersonal therapy, require more extensive training and sustained supervision. Thus, it will be some time before adequate human resources exist to make these treatments generally available on a national population basis in sub-Saharan Africa (Jenkins et al., 2010).

Relapse may result in hospitalization, treatment resistance, and cognitive impairment due to progressive structural brain damage, personal distress, incarceration and interference with rehabilitation efforts (Piggot,Carson, Saha, Torbeyns, Stock &Ingenito, 2003).

1.2 Problem Statement

According to WHO (2004), about 450,000,000 people suffer from mental illness and behavioral disorders world-wide which is estimated to increase to 15% by the year 2020. In a survey carried out by British and Uganda psychiatrists (2006) revealed that, out of 1,200 adults assessed in Gulu, Amuru districts had more than 54% people suffering from mental disorders due to the previous wars, displacements, natural calamities, homelessness (Disease burden indices 2010) in which Easten part of Uganda is part of these problems. According to the MOH, HMIS report (2010). MRRH has 12,480 patients with mental illness handled in psychiatric unit with some out patients being re admitted. Records in MRRH indicate an up surge in the number of patients with mental illness over the last 5 years. In financial year 2010/11 there were 3,079 cases of mental illness of which 50 were new cases, 2011/12 there were 5,442 cases and 53 new cases. In 2012/13, there were 6,312 cases and 84 new cases (Ugandaradionetwork.com/a/story.php?). Besides new admissions, there is also increasing prevalence of re-admission of the out patients into the unit creating need to investigate the possible causes of relapses among out patients.

In 2003, there were 28 relapses in which BAD was the leading readmission with 14 patients, epilepsy 4, psychosis 4, schizophrenia 3 patients and others. While in 2014 the number is estimated to rise because from January up to 9th/04/2014, there were 11 re-admissions of which BAD 2 patients, epilepsy 1, psychosis 3 and schizophrenia 4. (from the hospital record books of readmissions psychiatric unit) with an estimated increase of more than 50 patients by the end of this year.

1.3.0 Research Objectives

1.3.1 General objective

To determine patients, family or care givers and treatment factors that influence relapse among patients with mental illness receiving treatment from MRRH Psychiatric unit.

1.3.2 Specific objectives

To achieve the main objective, the research specifically looked at the following objectives"

1. To establish the patients' factors that influence relapse among patients with mental illness receiving treatment from MRRH Psychiatric unit.

2. To investigate the family or care givers factors that influence relapse among patients with mental illness receiving treatment from MRRH Psychiatric unit.
3. To identify treatment factors that lead to relapse among patients with mental illness receiving treatment from MRRH Psychiatric unit.

1.3.3 Research questions

The following questions guided the conduction of the research as the baseline for achieving the objectives;

1. What are the patients' factors that influence relapse among patients with mental illness receiving treatment from MRRH Psychiatric unit?
2. What are the family or care givers factors that influence relapse among patients with mental illness receiving treatment from MRRH psychiatric unit?
3. Which treatment factors can lead to relapse among patients with mental illness receiving treatment from MRRH psychiatric unit?

1.4 Significance of the study

In Uganda, there is so far little published data regarding factors influencing relapse among patients with mental illness. Mental health care services are faced with a lot of challenges which in one way or another affects mental health service users. This is made worse by patient's, family or caregivers and medication factors that can exacerbate symptoms which eventually lead to relapse.

This study is important because it will shine light on factors influencing relapse in patients with mental illness in the current context. These findings will provide a foundation for designing effective nursing interventions and help shape caregivers' perceptions and their understanding of patients' concerns and experiences about mental illness relapse. Knowledge of these factors will help mental health service providers to improve the standards of mental health care and interventions that are currently applied in caring for in-patients and outpatients with mental illness at our setting and the whole country at large.

1.5 Justification of the Study

This study will set a foundation for future research on relapse in mental illness. Basing on evidence-based practice, future research will enable, mental health service providers to identify new interventions for caring for mentally ill patients and thus reduce relapse rates in patients with mental illness. This study has the potential to help influence health policy makers in improving mental health and reducing the burden of relapse in patients with mental illness, their families and community as a whole.

1.6 Conceptual Framework

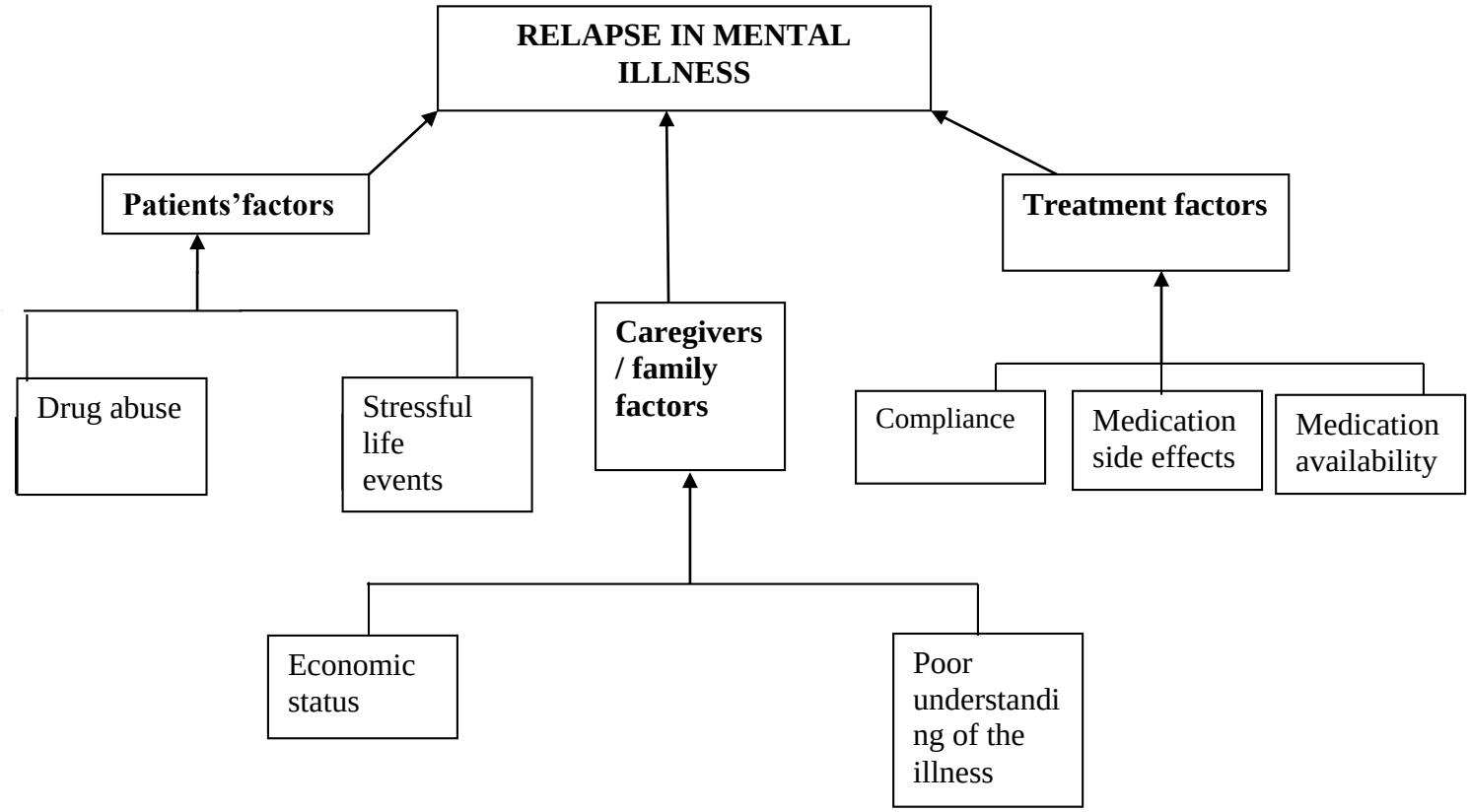


Figure 1: Conceptual frame work

This study sought to address personal, caregivers/ family and treatment factors that influence relapse in mentally ill patients. In this model of mental illness relapse and illness course, increase in either personal factors or environmental stressors or decrease in protective factors are viewed to result in relapse. This model was used throughout data collection, analysis and discussion of the findings of this study.

1.7 Scope of the Study

The study was carried out only among patients and caregivers at the metal health unit of MRRH.

II. Literature Review

2.1 Patient factors that contribute to relapse in mental illness.

2.1.1 Substance use

A report from the agency for health care research and quality (AHRQ) finds that almost one in eight of the 95 million visits to hospital emergency department made by adults in the United States in 2007 were due to mental health and / or substance abuse problem. The most common reason for these visits was a mood disorder (42.7%); followed by anxiety disorders (26.1%); alcohol –related problems (22.9%); and drug disorders (17.6%). WHO report (2001) states that Psychosis is a disorder in which a person's mental state or sense of reality is impaired (Queensland Health, n.d.). The condition is a symptom of several mental illnesses for example schizophrenia, depression, and bipolar disorder (Canadian Drug-induced psychosis, also called substance-induced psychotic disorder, is a condition where psychotic symptoms arise as a result of drug use. Symptoms usually occur when a person is intoxicated, but stop when the drug is no longer in the body (Poole &Brabbins, 1996, p. 136). However, symptoms may last for several days or weeks depending on the type of drug that is used (Poole &Brabbins, 1996). Psychotic symptoms may persist or re appear during periods of high stress in an individual's life (Sweeting & Dore, 1996). Psychotic effects can occur during intoxication, withdrawal, and after withdrawal symptoms have ended. The Phase in which symptoms occur is dependent on which drugs are used (Friedreich, 2007). Frequency and duration of drug use affects the likelihood of developing drug-induced psychosis. Prolonged drug use is said to be the main cause of the disorder; however, researchers have found evidence that drug-induced psychosis can occur with moderate and little use (Crieghton, Black, & Hyde, 1991, p. 714; Fraser Health, 2006.

Mental Health Association, 2000). Many drugs can lead to psychosis or cause a relapse of existing psychotic illness; however, stimulants and cannabis are often associated with psychosis (see Table 2). Drugs can also trigger the illness in individuals who are vulnerable to developing psychosis (Poole & Brabbings, 1996; Fraser Health Authority, 2006)

2.1.2 Stressful life events

Patients with schizophrenia are more sensitive and more susceptible to the negative effects of even minor stressors. A study in Nigeria found that these stressors included lack of employment (17%), grief following loss of a close family member (20%), and lack of social support (20%). Others involved chronic interpersonal stress, stigma, poverty homelessness and criminal victimization (Mwaba& Molamu,1998, as cited in Kazadiet al.,2008). Stressful if events are often associated with the onset of a psychotic relapse, usually in the 3weeks prior the relapse (Murray & Castle, 2000, as cited in Kazadi et al., 2008).

2.2 Caregivers/family factors that influence relapse in mental illness.

2.2.1 Economic status

In ea research carried out in the USA, 0.7% of the patients with mental illness in poor physical low economic status (Csemansky et al, 2002) often were accompanied by relapse even while on treatment (kazadi et al 2003) because of lack money for extra costs for readmitting the patients. Prolonged therapy which may lead drug resistance so will need adjustments and paying extra costs of the health workers.

2.2.3 Poor understanding of the illness

Studies from several countries have consistently found that even after a family member has developed clear-cut signs of a psychotic disorder, on average it is over a year until the unwell person first receives assessment and treatment (Black et al., 2001, Compton, Kaslow, & Walker, 2004; Johannessen et al., 2001). A survey of almost 10,000 adults in the USA has added more detail to this picture. The results showed that the majority of 114 G. People with mental disorders eventually contact treatment services, but they often wait a long time before doing so: With average delays before seeking help of eight years for mood disorders, and at least nine years for anxiety disorders. People who wait longer than average before receiving care are more likely to be young, old, male, poorly educated, or a member of a racial/ethnic minority (Wang et al., 2005a). Where do people go to try to find help? The detailed US survey just mentioned also asked this question and produced some surprising answers. Only about a third (41%) of people who had experienced mental illness in the previous year had received any treatment: 12% from a psychiatrist, 16% from a non-psychiatric mental health specialist, 23% treated by a general medical practitioner, 8% from a social services professional, and 7% from a complementary or alternative medical provider. In terms of treatment adequacy, mental health specialists providing care that was at least reasonable in about half (48%) of the cases they say, while in primary care only 13% of people treated received care that was adequate from health or social Discrimination in health care against people with mental illness 115 Care care agencies (Al-Krenawi, Graham, Dean, & El Taiba, 2004).

2.3 Treatment factors that lead to relapse in patients with mental illness.

2.3.1 Compliance factors

Non-compliance with oral or depot (injectable**)** anti-psychotic medication combined was associated with increased frequencies of relapses, being persistent psychotic, and an increased risk of being admitted to the hospital in patients with recent onset schizophrenia (Morkenet al., 2008). In this study it was demonstrated that the Odds Ratio (OR) of having a psychotic relapse was 10.27 among non-adherent patients. A summary of the above information is provided on the table below:

Table 1: Patients' Non-compliance to Antipsychotics and Relapse Rates in schizophrenia

Study country	Authors/ Date	Respondent (N)	% of non compliance	% of relapse
South Africa	Kazadi et al (2008)	217	63.59% (n=138)	80.4% (n=107)
China	Li & Arther (2005)	89	35.95% (n=32)	56.25% (n=18)
German	Schennach et al (2012)	200	Not specified	52% (n=104)

2.3.2 Medication side effects

A study was done to compare a newer, atypical antipsychotic drug, Risperidone, and an older, conventional neuroleptic drug, Haloperidol, in terms of the rate of relapse in patients, with schizophrenia and schizoaffective disorder. Randomly assigned adult outpatients in stable condition with schizoaffective disorder were grouped to receive treatment with flexible doses of either Risperidone (n=177) or haloperidol (n=188) for a minimum of one year. The Kaplan–Meier estimate of the risk of relapse at the end of the study was34%for the Risperidone group and 60% for the Haloperidol group. Patients in the Risperidone group had greater reductions in the mean severity of both psychotic symptoms and extra pyramidal side effects than those in the Haloperidol group (Csernansky, Mahmoud

&Brenner, 2008). Medication side effects such as tremors muscle rigidity, slurred speech restlessness, painful muscle spasms and importance contribute to poor adherence of mentally ill-patients to their treatment leading to poor insight. This is in accordance to the study carried out from mental health out-patient clinics in Johannesburg who had attended the clinics between the period of January 1995 and June 2005 found out that factors which were most likely to increase the risks of relapse in mental illness included comorbid depressed mood and poor drug adherence that was commonly caused by patient's poor insight contributed 5.2 times increase in the risk of relapse in Individuals with poor drug adherence and medication side effects. (kazadi et al 2008).

2.3.3 Medication availability

Unmet needs were greater for the poor: Older people, minority ethnic groups, those with low incomes or without insurance, and residents of rural areas (Wang et al., 2005b). The study concluded that 'most people with mental disorders in the United States remain either untreated or poorly treated' (Wang et al., 2005b). On what basis do people judge where to go for help? A large national survey in Germany described vignettes of people with depression or schizophrenia and asked about how to find help. Revealingly the general public thought that mental health staff are useful for treating people with schizophrenia, but not for depression. The reason for this is that most people felt that schizophrenia was caused by biological or uncontrollable influences, while they understood depression to be a consequence of 'social disintegration' (including unemployment, drug or alcohol misuse, martial discord, family distress or social isolation) so that people with depression were more often recommended to seek help and social support from a friend or confidant (Angermeyer, Matschinger, & Riedel-Heller, 1999). Even under better resourced conditions, it known that most people with a mental illness in the United States do not seek assistance. An early national survey found that fewer than one third of all mentally ill people received assessment and treatment, although the rate rose to 60% for people with a diagnosis of schizophrenia (Narrow, Regier, Rae, Manderscheid, & Locke, 1993; Regier et al., 1993; Wang et al., 2005b;). Over the last decade the occurrence of mental illnesses each year in the United States has not changed (29.4% between 1990 and 1992, and 30.5% between 2001 and 2003). On the other hand, relatively more people with mental illness were treated, rising over this decade from 20.3% to 32.9%. It is a paradox that even though two thirds of adults with a mental illness went untreated, a half of those who did receive treatment did not have a clear-cut mental illness (Kessler et al., 2005). Interestingly the idea that conditions which are less stigmatized (for example depression compared with schizophrenia) are those which are seen to be more treatable is not supported by the findings of these surveys (Mann & Himelein, 2004). So no single factor is enough to explain complex patterns of help seeking. Nevertheless, the weight of evidence does suggest that even when there are no major financial barriers to care, many people do not seek help or minimize their contact with services in an attempt to avoid being labeled as mentally ill (Corrigan, 2004b; Keating & Robertson, 2004). The interplay of these factors produces the contradictory situation in which black groups may have higher rates of many mental illnesses, lower rates of general referral and treatment, but higher rates of compulsory treatment and forensic service contact (Keating & Robertson, 2004; National Institute for Mental Health in England, 2003

III. Methodology

A methodology is foundational to all research undertakings. This section presents the research design used in the study. Specifically, it deals with the study area, data source, and the proposed data analysis techniques. It also details on ways in which the analysis was carried out to meet the various objectives.

3.1 Study Design

The study used a qualitative descriptive design. This design was selected because it gave the researcher a chance to explore in-depth, factors influencing relapse in patients with mental illness.

Respondents included patients with mental illness and their caregivers. The design enabled the researcher to capture and understand the participants' social world from these two different points of views on factors influencing relapse in patients with mental illness. The design was seeking meaning and understanding which was to be described in narrative form.

Qualitative design involved the systematic collection and analysis of subjective narrative materials using procedures in which there tends to be a minimum of researcher imposed control. The design attempted to understand the entirety of some phenomenon rather than focus on specific concepts. The researcher explored the multiple realities as experienced by patients with mental illness and their caregivers regarding factors influencing relapse of psychotic symptoms in their patients.

3.2 Study Setting

This study took place in Mbale district in Eastern Uganda, which has a psychiatric unit in Mbale referral hospital.

3.2.1 Site

The study took place at MRRH Psychiatric unit, in the out-patient department. MRRH is also the training station for clinical officers of Mbale College of Health Sciences, and medical students of Busitema University.

The MRRH Psychiatric Unit provides services for clients coming from all over the Eastern part of the country. It provides services to referral cases from districts such as Manafwa, Sironko, Kapchorwa. The unit is divided into several departments including;

Occupational Therapy, Social Work and Clinical Psychology. Services offered include; Inpatient and outpatient services, child and adolescent services. The inpatient consists of an acute ward which is partitioned for both male and female acutely ill.

3.3 Study Population

The population consisted of out-patients with mental illness attended at the MRRH Psychiatric Unit for follow up visits and their caregivers.

3.4 Study variable

Two types of variables were used in the study; dependent and independent variables.

Table 3.1; Showing dependent and independent variables.

Types of variables	Variables
Dependent	• Factors influencing relapse of mental illness
Independent	• Patient factors that influencedd relapse among metally ill patients. • Family factors that influenced relapse among mentally sick patients. • Medical factors that influenced relapse among mentally sick patients.

3.5 Selection criteria

3.5.1 Inclusion criteria

3.5.1.1 Patient respondents

1. Diagnosis of mental illness according to DSM-IV criteria.
2. Age range between 19 and 65years
3. Previous history of ≥2 psychiatric hospitalization to a psychiatric hospital
4. Diagnosis of mental illness for more than 6 months

3.5.1.2 Care-giver respondents

1. Caregivers was to be the key caregivers
2. Caregivers was to be more than 18years
3. Caregivers was to have lived with the patient in the same household for more than 6 months

3.5.2 Exclusion criteria

3.5.2.1 Patient respondents

- First episode of mental illness.

3.5.2.2 Patient respondents

Caregivers with less than18years of age.

3.6 The sample size

The sample size was calculated using Kish and Leslie formula of 1965 as below

$$N = \frac{Z^2P(1-P)}{D^2}$$

Z – standard deviation value corresponding to 95% confluence interval (1.96)
D- absolute error between the estimated and true value =5% (0.05)
P- The prevalence of mentally sick patients studied (unknown, 5% is the assumption)
N- minimum sample size that was required ie

$$N = \frac{1.96^2X0.05(1-0.05)}{0.05^2}$$

= 73 participants

3.7 Sampling technique

All patients with a diagnosis of mental sicknesses who had understanding and were on OPD treatment and had met the inclusion criteria were sampled until the required number was reached.

3.8 Sampling procedures

Sampling of participants who were to be enrolled in the study took place at MRRH Psychiatric Out-patient Department. The psychiatric clinical officers, nurse in-charge of OPD psychiatric unit was informed about the aim and procedures of the study and asked to help in identifying participants for the in-depth interviews.

With the help of OPD mental health nurse, participants were selected by going through files of patients with appointments that day, to identify those who met the criteria for inclusion in the study. Selection of caregivers was done by identifying caregivers who had escorted the identified patients to the Psychiatry Out-patient Department. Patients and caregivers who met the inclusion criteria were explained briefly the nature of the study before being requested to participate. This was done after they were attended to by a psychiatric clinical officer for their follow up visit. Those who agree to participate were interviewed.

3.9 Data Collection

Eligible participants were given full explanation of the study, and the importance of the study. They were also informed of the data collection procedures for gathering information that they were going to be given during the in-depth interviews (IDIs).

Demographic information was obtained from the 15 participants to describe the population. This process was to help build rapport between the participants and the researcher before the in-depth interviews. Interviews were conducted in one of the rooms at the Psychiatric Unit Out-patient Department. IDIs was conducted to obtain information about participants' perceptions on factors that influence relapse in mentally sick patients. In these interviews, questions were asked about factors that caused relapse in mental illness. Interview questions were unstructured and designed to promote open ended responses. Interviews with participants preferably took between 30 minutes and 45minutes long. To obtain individual perceptions from participants, patients and their caregivers were interviewed separately, one after the other. Throughout the process of data collection patients were interviewed first, followed by their caregivers to avoid tiring them. Data was collected from participants until saturation was achieved. Saturation was to be considered reached when the information gathered by the researcher doesnot provide new insight or understanding (DePoy & Gitlin, 2005). Interviews were conducted in both English and Luganda.

3.10 Ethical consideration

Ethical clearance was granted by SOCO. Also, permission to conduct the study was obtained from the MRRH authorities, and finally from the head of department Psychiatric Unit.

Participants who agree to participate in the study were requested to complete the written informed consent form, and arrangements for an interview with each potential participate was then made. Written informed consent was obtained and the participants assured of confidentiality, and freedom to withdraw at any time during the study. To ensure confidentiality, names of the patients were asked for.

3.11 Project management

Data was collected by the researcher and research assistant where data was recorded on pre corded questionnaires, typing and analyzing were done by the researcher with the aid of a computer and then supervised by the research supervisor as allocated in the table below;

Table3.2; Showing responsibilities/ roles of researcher, research assistant and supervisor.

Title	Roles/Responsibility
Researcher	• Designed data collection tools • Collected data • Analyzed data • Reported data
Research assistant	• Assisted in identifying patients eligible for the study.
Supervisor	• Reviewed data

3.12 Data analysis

Demographic information was analyzed descriptively and put into tables. Information was typed and entered on computer for report writing and publication. The researcher checked the accuracy of the recorded interviews and corrected minor mistakes. The interview transcripts were examined in totality, to obtain an overall sense of the content of the responses by the participants to various issues.

English transcripts were used for analysis to maintain the originality of the data. Analysis of data was following the qualitative content analysis by using relevant computer assisted qualitative data analysis software. Transcribed data was first saved in Microsoft word. Then the researcher imported the transcribed interview (sources) into the software for analysis.

Each source was then coded to gather material into the categories

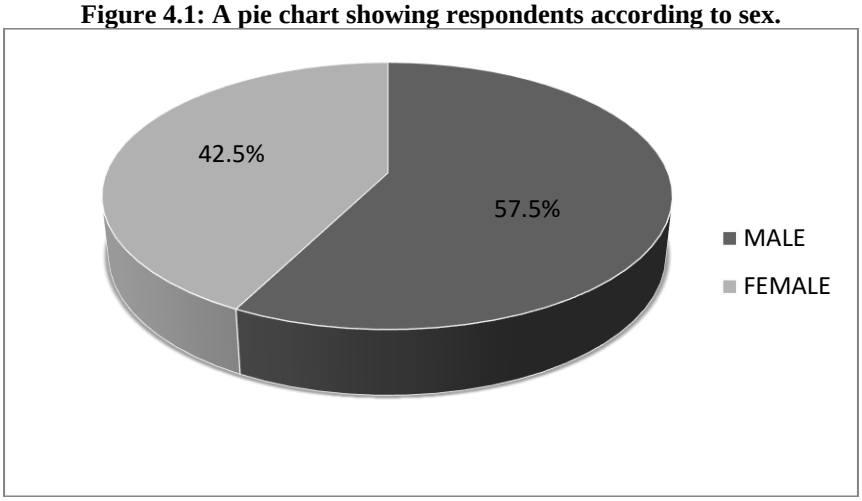
Results of this research was disseminated to MRRH,

IV. RESULTS

In this section, there is data presentation and relevant interpretations according to the study findings and specific objectives.

4.1 Demographic characteristics.

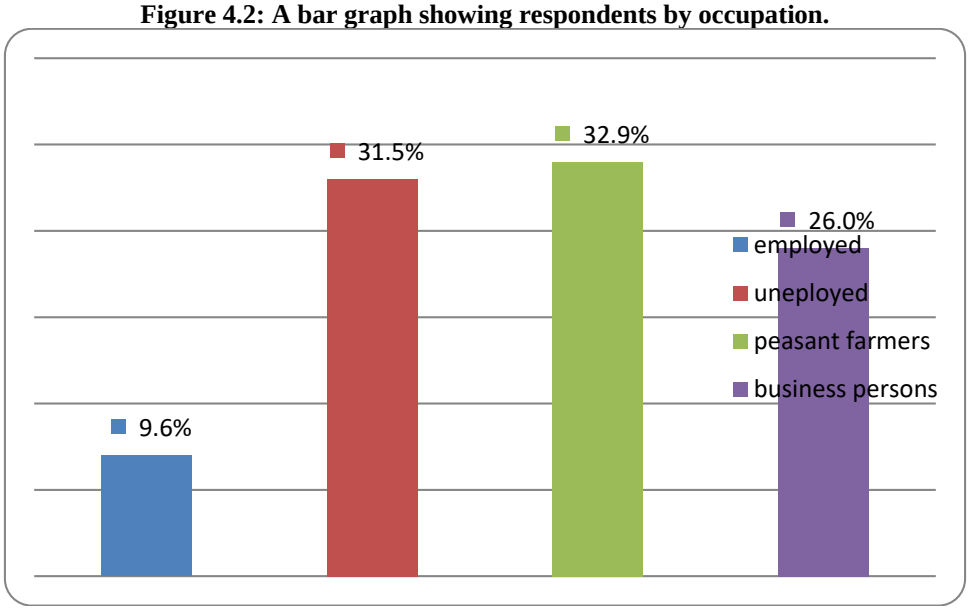
Figure 4.1: A pie chart showing respondents according to sex.



Primary data source, 2023.

From figure 4.1 above, there were more male patients with mental illness 42/73(57.5%) than their female counter parts who were 31/73(42.5%) .

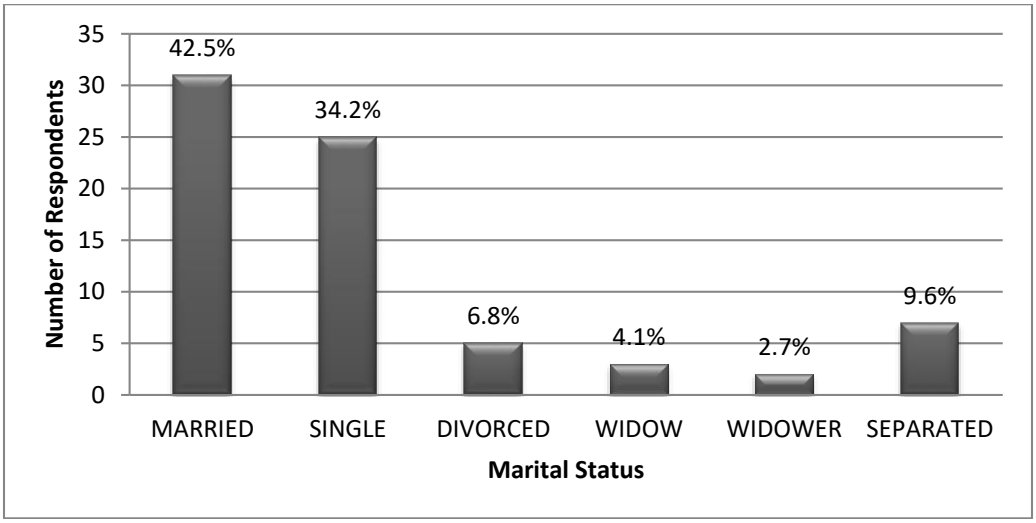
Figure 4.2: A bar graph showing respondents by occupation.



Primary data source, 2023.

Results from the above figure 4.2 showed that there were more peasant farmers with mental illness that is 24/73(32.9%) than the rest of the occupations. This was followed by 23/73(31.5%) unemployed patients with mental illness, 19/73(26.0%) business persons with mental illness and lastly 7/73(9.6%) employed patients with mental illness.

Figure 4.3. A bar graph showing respondents by Marital status



Primary data source, 2023

From figure4.3 above, more married patients (42.5%), single (34.2%) were all associated with relapses in mental illness.

Table 4.1: A table showing the education level of the respondents.

Education level	Frequency (n=73)	Percentage (%)
Never went to school	10	13.7
Primary	19	26.0
Secondary	23	31.5
Tertiary	21	28.8
Total	**73**	**100**

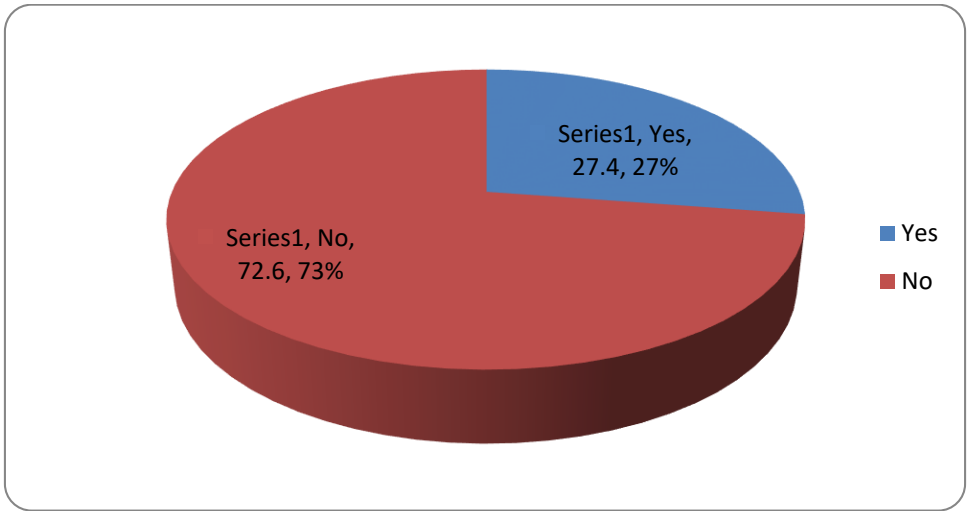
Primary data source, 2023.

In the above table 4.1, indicates a large number of individuals with mental illness who reached secondary level 23/73(31.5%), 21/73(28.8%) reached tertiary level followed by 19/73(26.0%) mentally ill patients who had reached primary level and lastly 10/73(13.7%) patients who had mental illness never went to school.

4.2 Treatment factors that lead to relapse in mental illness.

Figure 4.5; A pie chart showing patients adherence to their medicines since they were discharged from hospital

n =73

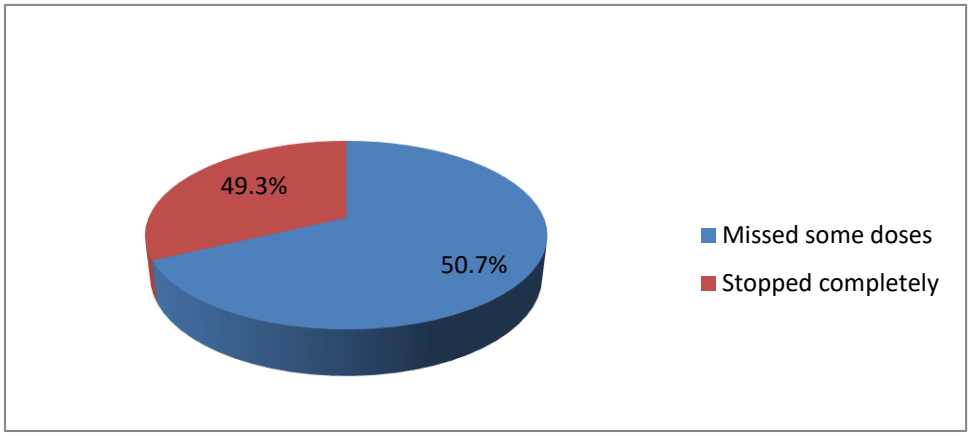


Primary data source, 2023.

The figure 4.5 above shows that 53/73(72.6%) of the patients did not swallow medicines as prescribed while only 20/73(27.4%) patients knew that they were to continue with their medicines.

Figure 4.6: A pie chart showing values of patients who had stopped or missed some doses

n=53



Primary data source, 2023.

The above figure 4.6, indicates that 36/53(50.7%) missed some of their doses and few about 17/53(49.3%) had completely sopped on taking their medicines.

Table 4.2; Shows results of Patients reasons who stopped taking medicines

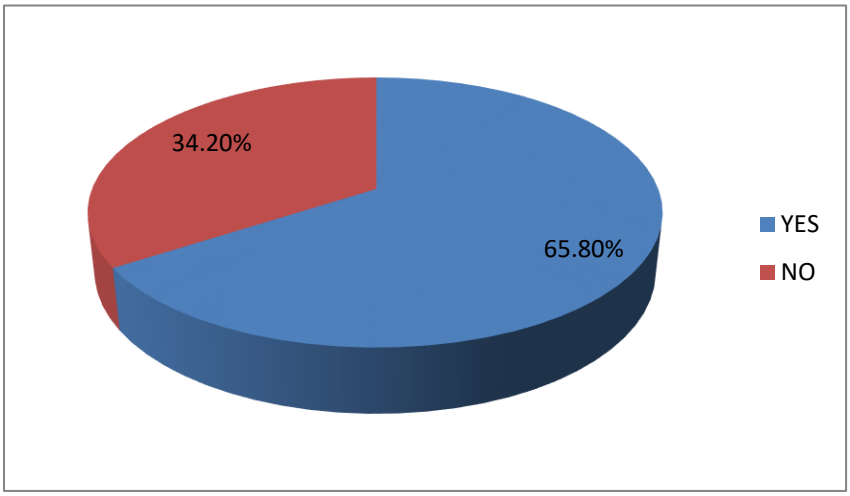
Reasons for terminating the drugs.	Frequency (n=73)	Percentage(%)
Drug side effects.	20	27.4%
Improvement of sypmtoms.	17	23.3%
Ran short of drugs.	36	49.3%
Total	**73**	**100**

Primary data source, 2014.

From table 4.2, 36/73 patients had ran short of drugs, 20/73(27.4%) left taking their meicines because of drug side effects, and lastly 17/73(23.3%) left their medications because of slight relief of symtoms.

Figure 4.7; A pie chart indicating medicine availability for the patients in the unit.

n =73



Primary data source, 2023.

From the above figure 4.14, a large proportion of patients had ever come there were no medicines and they were 48/73(65.8%) while 25/73(34.2%) patients had been getting all their medications from the unit

4.3 Patients factors that influence relapse in mental illness.

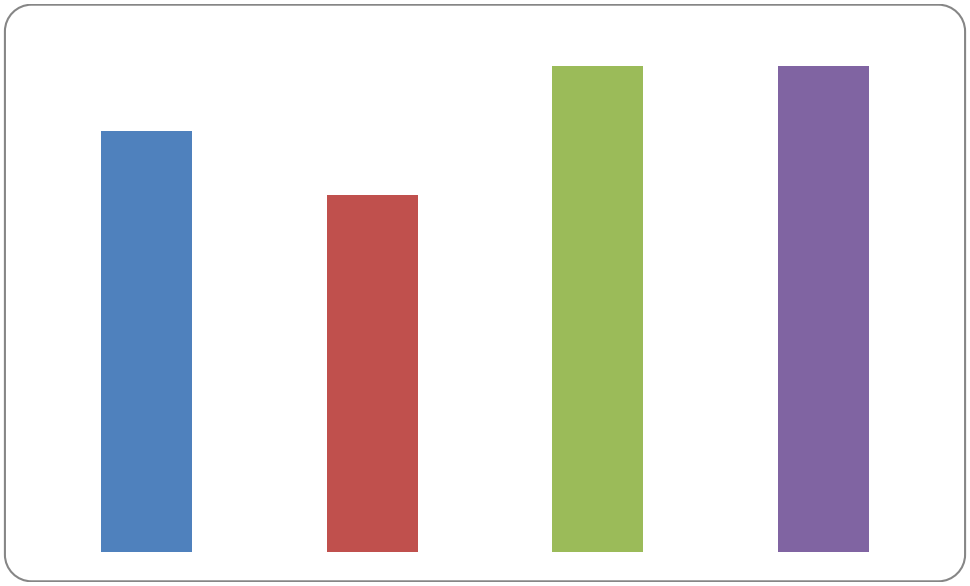
Table 4.3; Shows the people the patients stay with.

Patien stays	Frequency(n=72)	Percentage(%)
Alone	9	12.3
with family	54	74.0
Others	10	13.7
Total	**73**	**100**

Primary data source, 2023

Table 4.3 above shows alarge number of patients who stay with their families with a number of 54/73(74.0%), followed by 10/73(13%) patients who live with their relatives or with other people and lastly 9/73(12.3%) patients who stay alone.

Figure 4.8; A graph showing various family support received by mentally ill patients.
n =73

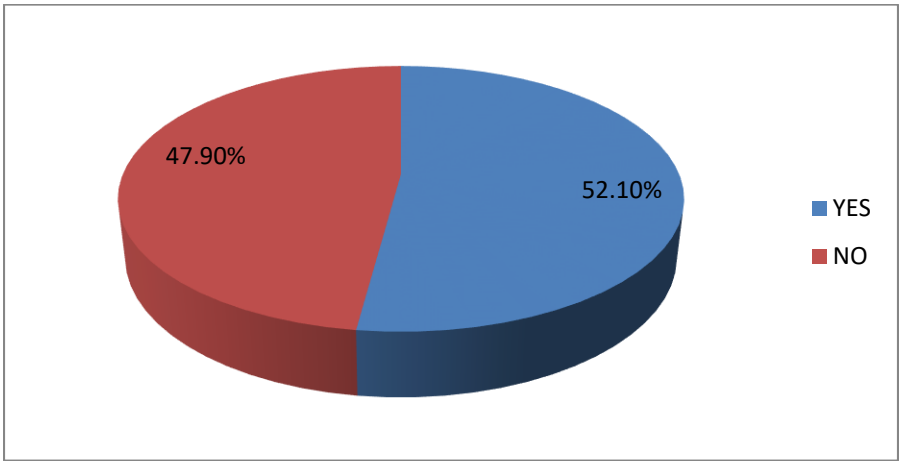


Primary data source, 2023.

From the figure 4.7 above, it shows that many caregivers were getting medication for their patients 15/75 (27.8%), followed by 13/73(24.0%) patients who were emotionally motivated and lastly 11/73(20.4%) patients who were financially supported by their family members.

Figure 4.9; A pie chart showing stigmatization of the mentally ill patients by the community.

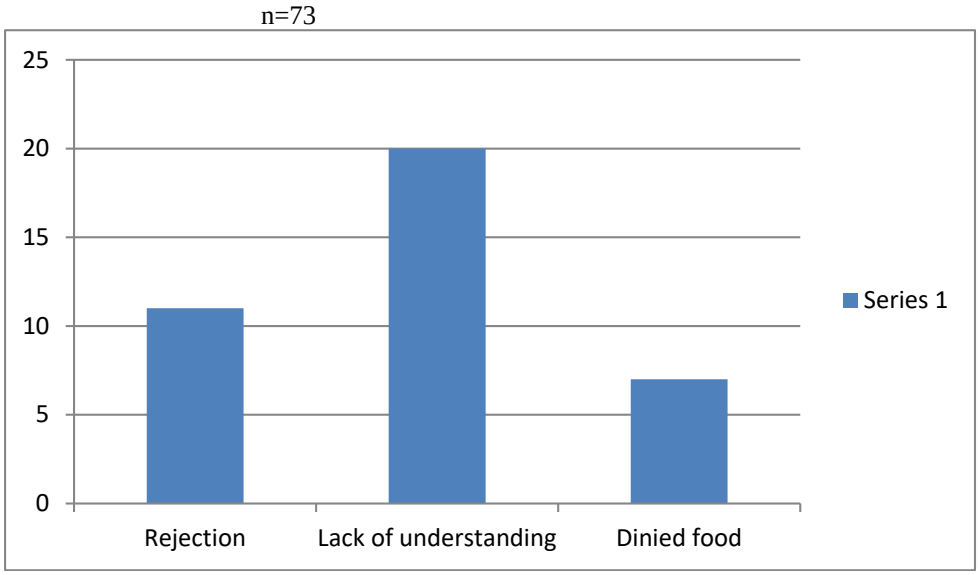
n=73



Primary data source, 2023.

From the above figure 4.8, 38/73(52.1%) patients were stigmatized by their families and communities while few patients felt not stigmatized by their surroundings, that is 35/73(47.9%).

Figure 4.10; A graph showing how mentally ill patients are stigmatized by the community.



Primary data source, 2023.

The above figure 4.9, showed that there were 20/38(52.6%) of the patients were highly not understood by their communities, secondly followed by 11/38(28,9%) patients who were experiencing being rejected by their communities and lastly 7/38(18.4%) who reported to having been denied food.

Table 4.4; Shows difficult life events experienced by patients since their last admission.

Difficult life event experienced	Frequency (n=73)	Percentage (%)
Bereavement	17	23.3
Divorce	10	13.7
Loss of job	24	32.9
Physical illness	22	30.1
Total	**73**	**100**

Primary data source, 2023.

From tabulated results in table 4.4 above, 24/73(23.3%) patients lost their jobs, 22/73(30.1%) patients suffered physical illness,17/73(23.3%) had bereavement and lastly 10/73(13.1%) had divorced.

Table 4.5; Shows the impacts of the problems experienced by mentally ill patients.

Impacts of the problems	Frequency (n=73)	Percentage (%)
Relapse	39	53.7
Rehospitalization	32	44.4
Others	2	1.9
Total	**54**	**100**

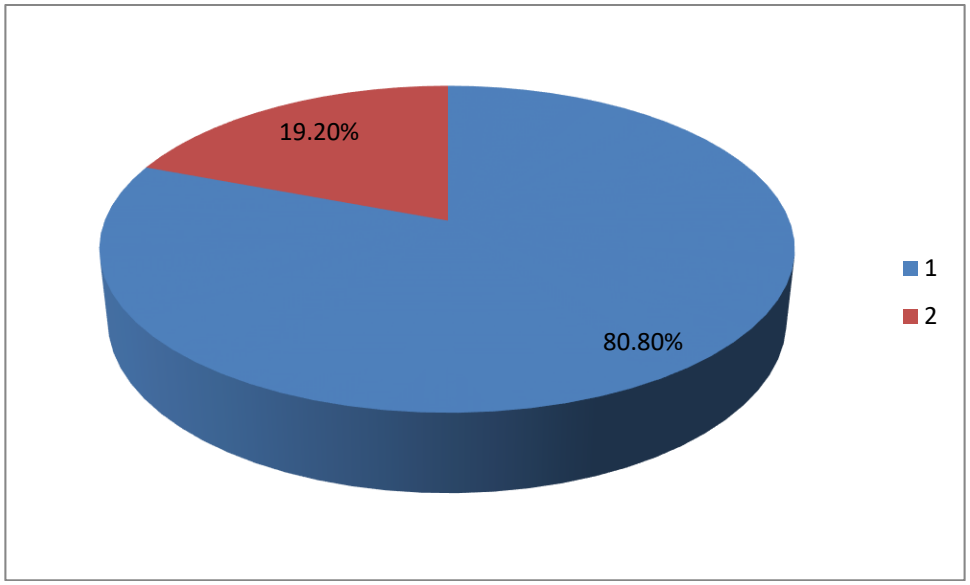
Primary data source, 2023

Table 4.5 above 39/73(53.7%) patients had relapse, 32/73 had been frequently hospitalised.

4.3 Patients factors that lead to relapse of mental illness

Figure 4.11; A pie chart indicating intake of enjaga by the patients.

n=73



Primary data source, 2023.

From figure 4.10 above, few patients had been taking enjaga that is 14/73(19.2%), and a large majority of the patients ,59/73(80.8%) had never taken enjaga.

Table 4.6; Displaying the number of times patients have been taking enjaga

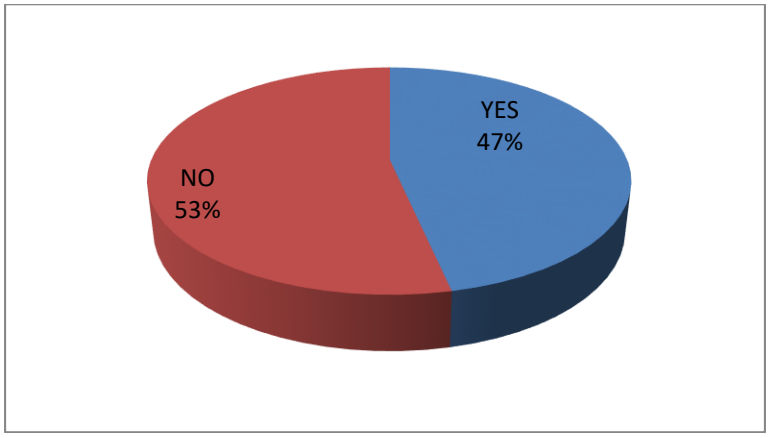
Frequency of enjaga intake	Frequency (n=14)	Percentage (%)
Once a day	7	50.0
Twice a day	2	14.3
Thrice a day	O	0
Occationally	4	28.6
More often	1	7.1
Total	**14**	**100**

Primary data source, 2023

From the above table 4.6, a large number of respondent that is 7/14(50.0%) were taking enjaga once in a day, next were 4/14(28.6%) patients who used to take it occasionally, followed by 2/14(14.3%) patients who used to take enjaga twice a day, only 1/14(7.1%) patient used to take it more often and lastly no patient was taking it thrice a day.

Figure 4.12; A pie chart showing Alcohol intake by mentally ill patients.

n=73

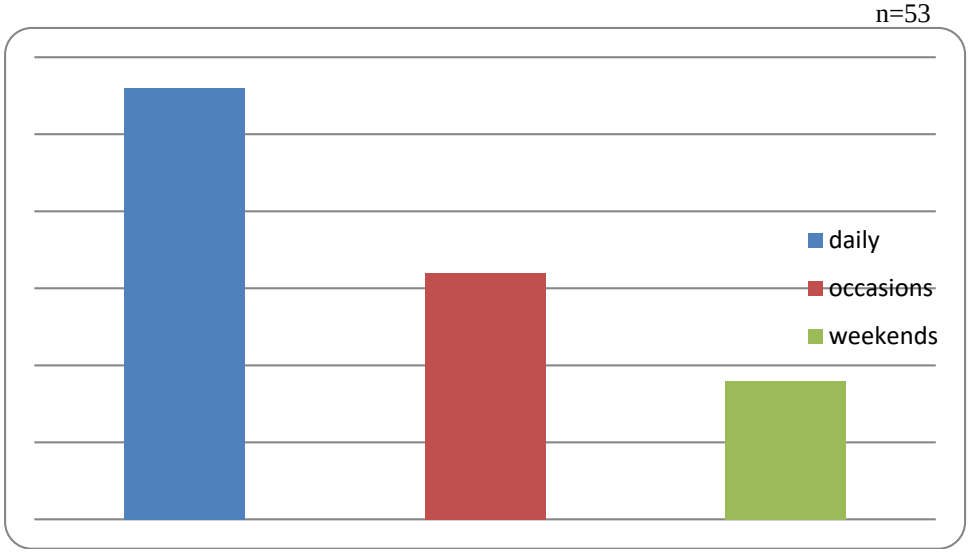


Primary data source, 2023

From the above figure 4.11, many patients were not taking alcohol that is 39/73(39%) while 34/73(47%)were taking alcohol

Figure 4.13; A graph showing frequency of alcohol intake by mentally ill patients.

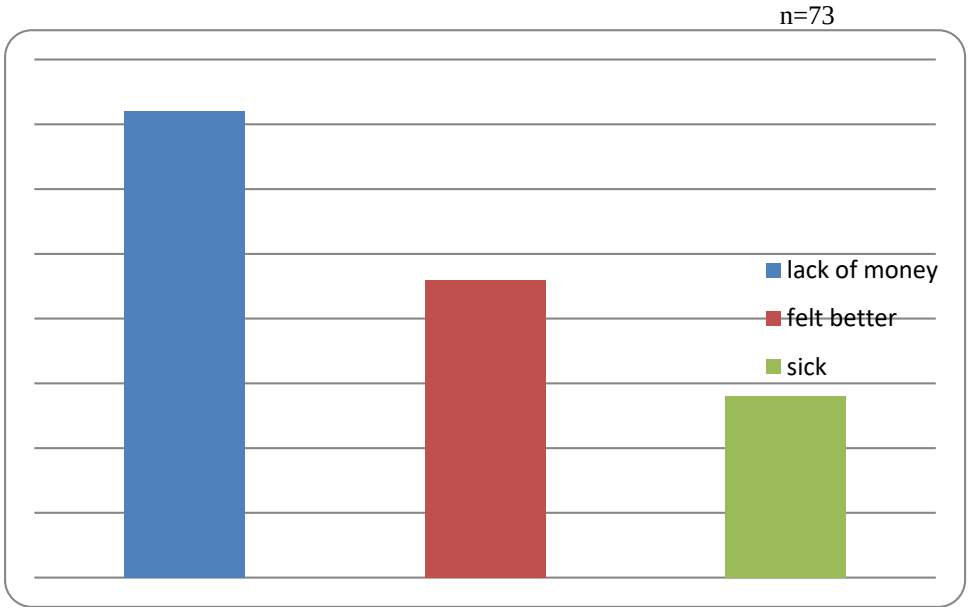
n=53



Primary data source, 2023.

The figure 4.12 above shows that there were more patients who were drinking alcohol daily that is 28/53(52.8%), 16/53(30.2%) on weekends and on occasions that was 9/53(17.0%) on occasions.

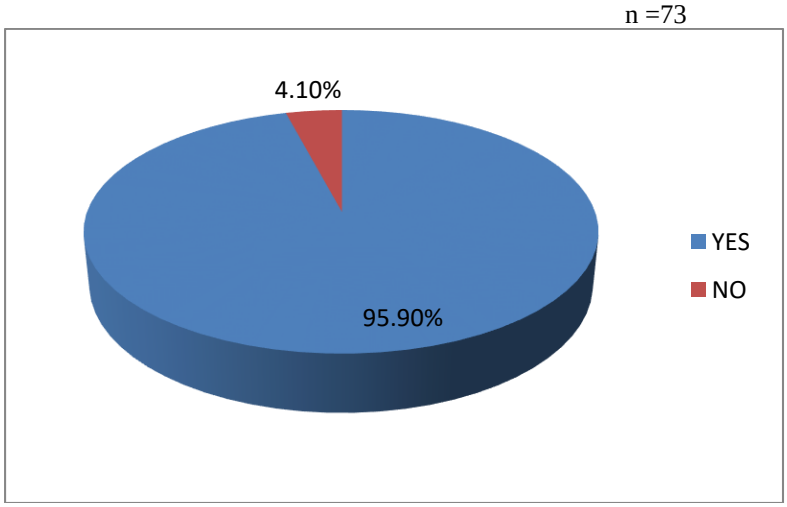
Figure 4.14; A graph showing why the mentally ill patients irregularly come for their follow up.



Primary data source, 2023.

From the above figure 4.13, 36/73(49.3%) patients had not been coming for follow-up due to lack of money, 23/73(31.5%) patients had not been coming to the clinic because they felt better and lastly 14/73(19.2%) of the patients had not been coming for their follow up because of other illnesses.

Figure 4.15; A pie chart indicating the feeling of mentally ill patients about the hospital staff of psychiatric unit.



Primary data source, 2023.

In the above figure 4.15, 70/73(95.9%) of the patients felt welcome by the psychiatric staff while only 3/73(4.1%) had ever felt not welcome by the psychiatric staff.

V. Discussion of Findings

This chapter discusses the research finding in relation to specific objectives and literature review stated in chapter two. The study was aimed at determining the factors which influenced relapse of mental illness among patients receiving treatment from MRRH psychiatric unit.

5.1 Socio demographic characteristics

A total of 73 people were sampled and males had more relapses than females that is males 42/73(57.5%), females 31/73(42.5%). This could be that males tend to involve themselves in activities like drinking alcohol which is a precipitating factor to relapses compared to females. This is in agreement with WHO report (2001), which showed that there more 85% patients in poor and middle-income countries were having alcohol related relapses.

The study also revealed that there were many peasants who were re-admitted to the unit that is 18/73(24.7%), students were 17/73 (23.3%), those always had a lot of stress from the books especially at times of examinations, poor economic status which seemed to be a precipitating factor to the relapse. Poor compliance to treatment due to lack of transport to the unit for follow up visits, lack of drugs in the unit. This study is in pipeline with the research carried out in USA by (Csemansky et al 2002) which showed many incidences of relapses among patients in low economic status. The finding showed more relapses among the young adults that is between 18-30 years 40/73(54.8%) as compared to the elderly that is above 50 years 7/73(9.6%). This might be due to their risky life styles like substance abuse, high exposure to stressful factors for example attaching themselves to football teams which puts them at a depressed state when their teams' loos. Unlike to the elderly who do not involve themselves in such activities hence reduced risk of relapses. This is in relation with the finding got by Yusuf et al (2008) in USA where many cases were of relapses were among young adults.

5.2 Patients factors that influence relapse of symptoms among mentally ill patients.

5.2.1 Drug abuse.

The study revealed that alcohol and enjagga abuse played a big role towards relapses as many had history of alcohol use after they had registered improvement while taking drugs 39/73 (39%). This was in agreement with the study made from the Agency of Health care research quality (AHRQ) which showed that almost one in eight of the 95 million visits to hospital emergency department made were due to substance abuse problem.(Crieghton, Black and Hyde 1991) and also depends on the frequency in which the patient abuses these drugs that is 7/14(50.0%) were taking enjagga daily were more, those taking alcohol daily were also many that is 28/53(52.8%) which exposed them to increased intoxication hence increased relapse and development of psychotic symptoms which is in line with (Freudenreich, 20070).

5.2.2 Stressful life events.

The study showed that stress is a significant contributing factor to mental illness many being registered from loss of jobs,24/73 (32.9%), divorce 10/73 (13.7%), bereavement 17/73 (23.3%) and physical illnesses 22/73% (30.1%) all resulted into relapses and re-admissions . This considers with the study carried out in Nigeria which showed that these stressors like lack of employment, grief after losing a close friend resulted into relapses and readmissions. (Mwaba and Molamu, 1998 as cited in Kazadiet al. 2008).

5.3 Caregivers/family factors that influence relapse of symptoms among mentally ill patients.

5.3.1 Economic status.

The study showed that peasant farmers 18/73(24.7%) had more of the relapses re-admitted to the psychiatric hospital followed by those who are unemployed 17/73(23.3%), an indication that patients with low economic status is more associated with relapse of psychotic symptoms. This is because they are unable to meet the costs of buying drugs not available in the hospital, extra costs for specific investigations, consultation costs hence no proper diagnosis hence relapse of psychotic symptoms. This is in line with study carried out in USA in which 0.7 % of the patients with mental illness were of low economic status (Csemansky et al..,2002), also cited by (Murry and Castle, 2000).

5.3.2 Poor understanding of the ill patient.

The study showed that 38/73(52.1%) patients felt stigmatized by the community, denied their basic needs by their family members and at worst not being understood by their caregivers therefore felt isolated and discriminated hence relapse of psychiatric symptoms and is in line with (Al-krenaw,Graham,Dean,and Eltaiba 2004) and study carried out in US in which a large percentage of patients with mental illness were treated by non-psychiatric specialists (Black et al..,2001) hence patients being poorly diagnosed and treated.

5.4 Treatment factors that influences relapse of psychotic symptoms among patients.

5.4.1 Compliance factors

The study showed that termination of treatment due to different reasons like side effects 20/73(27.4%), registering slight improvement 17/73 (23.3%) demoralized the patients to continue with the follow up treatment hence relapse. This was similar with the finding in Johannesburg by Kazadi al, (2008) where many cases of re-admissions among patients with schizophrenia was associated to termination of the drugs due to side effects, others due to slight registered improvements.

5.4.2 Medication availability in the hospital.

The study also revealed that 48/73(65.8%) have ever come to the mental psychiatric unit and they were not availed with medicines and had also become demoralized to continuously going for follow up hence re appearance of psychiatric symptoms and this is in line with the study carried o ut by (Wang et al..,2005) in United States in which many patients remained untreated or poorly treated.

Lastly the study found out that there was good relationship between patients and health workers as the majority 95.9% of the patients recommended that health workers were treating them with humanity and kindness and very few responded that health workers need to still to adjust towards their conduct.

VI. Conclusions and Recommendations

From the study findings, the following conclusions and recommendations have been made.

6.1 Conclusions

The study revealed the following findings.

6.1.1 Demographic characteristics.

1. Males had more relapses of psychotic symptoms than females due to their risky behaviors,
2.More relapses were among individuals of low economic status because of poor compliance tendencies like peasants
3.Young adults due to their risky lifestyles were associated with several cases of relapses as compared to the elderly.

6.1.2 Patients factors that influence relapse of symptoms among mentally ill patients.

More relapses are associated with increased frequency of alcohol abuse because many use alcohol as a means of reducing stress hence relapse of mental illness while enjagga even when taken occasionally is associated with increased relapses.
Alcohal is the mostly abused drug by all localities because Ugandan laws are not strong against it.
Stressful factors like losing a beloved family member, loss of jobs among others, contributed to increased relapse of mental illness since this is associated with life style changes hence break down.

6.1.3 Caregivers/family factors that influence relapse of symptoms among mentally ill patients.

Poverty increases the risk of relapse of psychiatric symptoms possibly due to inability to afford daily needs hence hunger and tiredness
Stigmatization, discrimination and denial of basic needs to the patients is associated with increased relapses among psychiatric patients.

6.1.4 Treatment factors that influences relapse of psychotic symptoms among patients

Termination of medicine intake by patients due to several reasons like mostly side effects, others after registering some improvement played a great part in relapse of symptoms among patients with mental illnesses.
Shortage of medicines from psychiatric unit made a large number of mentally ill patients to stop going for their follow up hence aggressive return of symptoms.
There were good relationships between health workers and clients.

6.2 Recommendations;

The researchers recommend the following;

To MOH

The MOH should avail essential drugs to the various psychiatric hospitals.
The MOH should educate sensitize people on various causes, precepting factors to mental illness and lay out various preventive measures like creating strict laws on drug abuse.

To DHO

District health officer should work together with medical staff to ensure effective delivery of services to the patients and delivering information to the MOH.

To MRRH

Hospital administration should motivate the psychiatric health team through words of appraisals, appreciations so as to maintain hard working spirit.
Psychiatric health workers should continuously health educate the patients whenever they come for follow up on effects of drug abuse, adherence to medicine therapy.

To the community

The community should not stigmatize, discriminate individuals with mental illness.
The family members/caregivers should provide basic needs to their relatives who are mentally ill.

Acknowledgements

The Researchers wish to acknowledge the different personalities and stakeholders that provided technical, moral and financial assistance during the study, most especially; Mbale College of Health Sciences, School of Hygiene-Mbale, the community and staff of Mbale Regional Referral Hospital, and Mbale district health Office, and the participants who volunteered to take part in this study.

Competing Interests

None declared.

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APPENDIX I: Questionnaire

For Out-patients and their caregivers

Question Number	Demographic Data	Coding Categories (Tick Where Applicable or In Space Provided	Scale
1	Sex	Male Female	1 2
2	Occupation	Employed Unemployed Farmer Business person Student Others specify	1 2 3 4 5 6
3	Marital status	Married Single Divorced Widow Widower Separated	1 2 3 4 5 6
4	Age	19 30 31 49 50 65	1 2 3
5	Education level	Never went to school Primary Secondary Tertiary	1 2 3 4

Compliance			
6	After last discharge did you take drugs as prescribed?	Yes No	1 2
7	If no did you continue on medication but missed some doses or did you stop completely?	Missed some doses Stopped completely	1 2
8	If stopped what was the reason?	Side effects Did not want to go for follow up I did not think I needed drugs Did not know where to get drugs Did not know I had to continue with the drugs	1 2 3 4 5
Stressful life events			
9	Who do you live with?	Alone With family Others	1 2 3
10	If you live with family, what type of support do you get from them?	Emotional Financial Practical support Getting medication	1 2 3 4
11	Do you feel stigmatized by the community?	Yes No	1 2
12	If yes, how exactilly are you stigmatized?	Rejection Lack of understanding Denied basic needs	1 2 3
13	What difficult life events did you expirence since last admission?	No difficulties Bereavement	1 2

		Divorce Loss of a job Expelled from school Physical illness Others	3 4 5 6 7
14	Do these problems have had an impact on your mental illness?	Yes No	1 2
15	If yes, what has been the impact?	Relapse Rehospitalization Others	1 2 3
History of drug a buse			
16	Do you take enjaga?	Yes No	1 2
17	If yes, how often?	Once a day Twice a day Thrice a day Occasionally More often	1 2 3 4 5
18	Do you drink alcohol?	Yes No	1 2
19	If yes, how often?	Daily Weekends On occasions	1 2 3
Access to health care			
20	How long does it take you to get to a clinic?	Less than 30 minutes A bout an hour More than an hour	1 2 3

21	Does some body accompany you to the clinic?	Yes No	1 2
22	If you do not regularly go to the clinic, what is the reason?	Sickness Lack of money Felt better	1 2 3
23	Do you ever attend the clinic andthey had run out of the medication?	Yes No	1 2
24	Do you feel welcome by the clinic staff?	Yes No	1 2
25	Diagnosis of the patient	BAD Schizophrenia Epilepsy Drug induced psychosis Dementia	1 2 3 4 5

APPENDIX II: Project Time Frame

Sn.	Activity	Time Bound In Months								
		2022				2023				
		Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
1.	Problem Identification									
2.	Review of Literature									
2.	Proposal writing									
3.	Pre-testing Data collection tools									
4.	Data Collection									
5.	Data analysis and write-up									
6.	Consultations									
7.	Submission of write-up									

APPENDIX III: Consent Form

Consent Form

REGISTRATION NUMER | | | | | | | | | | |

Consent to participate in a study about factors influencing relapse among individuals with mental sickness in MRRH

Greetings! We are working on a research project with the objective of exploring perceived factors influencing relapse among individuals with mental illness in MRRH Psychiatric Unit.

Purpose of the Study

The purpose of the present study is to explore factors influencing relapse among individuals living with schizophrenia. This will enable mental health service providers and caregivers improve and identify new interventions for caring for mentally ill patients and thus reduce relapse rates in people living with mental illness

What Participation Involves

If you agree to join the study, you will be interviewed and the information that you are going to give will be captured questionnaires. During the interview you will be asked about demographics, and your perceptions about factors influencing relapse in individuals with schizophrenia. It will take about 50-60 minutes to complete the interview.

Confidentiality

All information we collect will be entered into computers with only the study identification number. All information that will be collected from you will be protected. The study will not include details that directly identify you, such as your name. Only a participant identification number will be used in the interview. Only a small number of researchers will have direct access to the interview. If this study is published or presented data scientific meeting, names and other information that might identify you will not be used.

Risks

We do not expect that any harm will happen to you because of participating in this study.

Rights to Withdraw and Alternatives

Taking part in this study is completely your choice. You are free to skip any question if you feel uncomfortable to disclose information. If you or your relative chooses not to participate in the study or if you decide to stop participating in the study you or your relative will continue to receive all mental health services that you would normally get from this unit. You can stop participating in this study at any time, even if you have already given your consent. If you refuse now, but wish to enter the study later, we will be ready to accept you. Refusal to participate, or withdrawal from the study, will not involve penalty or loss of any benefits to which you are otherwise entitled.

Benefits

There are no direct benefits to you. However, if you agree to participate in this study, your contribution will be useful in improving interventions that are currently applied to prevent relapse among individuals with mental illness. Your participation will also help in formulating new interventions which will be used to minimize relapse in individuals with mental illness.

Signature:

Do you agree to participate?

Participant agrees …… Participant does NOT agree……

I, _____ _____ have read the contents in this form.

My questions have been answered. I agree to participate in this study.

Signature of participant __

Signature of witness (if person/caretaker cannot read)

Signature of Research Assistant ___ Date___

APPENDIX IV: Patients' In-Depth Interview Guide

Patients'in-Depth-Interview Guide

Patients who have consented to participate in the study will be asked by the researcher to provide their demographic information. This will describe the population and also help to build rapport between the participants and the researcher before the in-depth interviews.

Demographic Data ID NO…….. Age…… Sex……

Level of education…….. Occupation…….. Marital status……

Relationship with care giver…….. Client's diagnosis……...

Type of antipsychotics taken…….. Number of previous relapse episodes……

In-depth interview guide

1. What would you say are the reasons for you to experience relapses?

2. What assists you to cope with this illness that could protect you from relapse? (Probe: Medication, mental health care, friends, religious faith, family support, work, lifestyle or other).

3 What makes it difficult for you to cope with this illness? (Probe: Medication side effects, poverty, unemployment, violence, family conflict, shame, communication, substance use).

4 What suggestions would you like to make to the mental health nurses regarding relapse reduction or prevention.

APPENDIX V: Relatives' In-Depth Interview Guide

Relatives' In-Depth Interview Guide

Caregivers who have consented to participate in the study will be asked by the researcher to provide their demographic information. This will describe the population and also help to build rapport between the participants and the researcher before the in-depth interviews.

Demographic Data

IDNo…… Age…… Sex……

Level of education…….. Occupation…… Marital status…….

Relationship with patient……..

Number of previous relapse episodes ……

In-depth interview guide

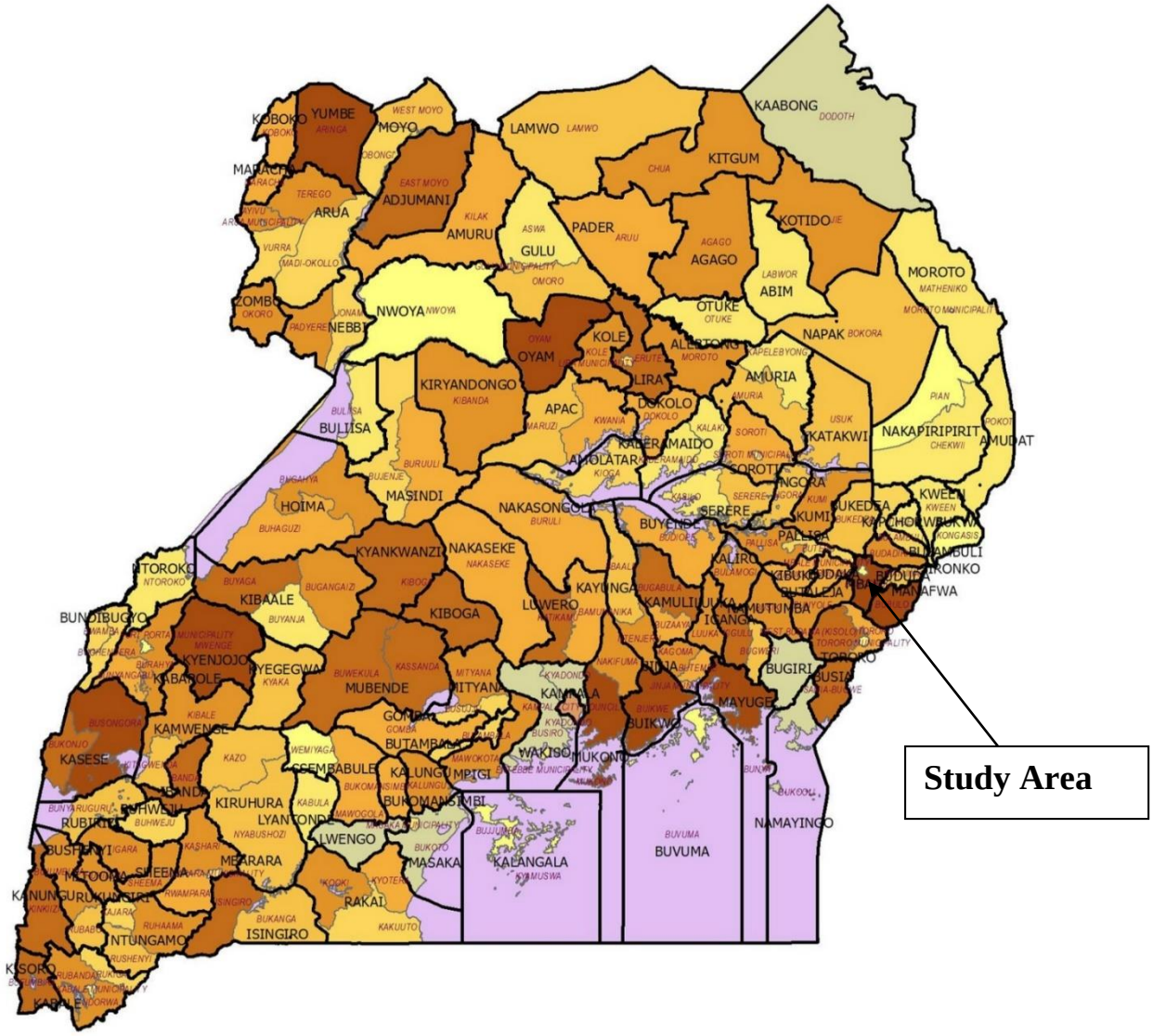
1. What would you say are the reasons for your relative to experience relapses?

2. What assists your relative to cope with this illness that could protect him/her from relapse? (Probe: Medication, mental health care, friends, religious faith, family support, work, lifestyle or other).

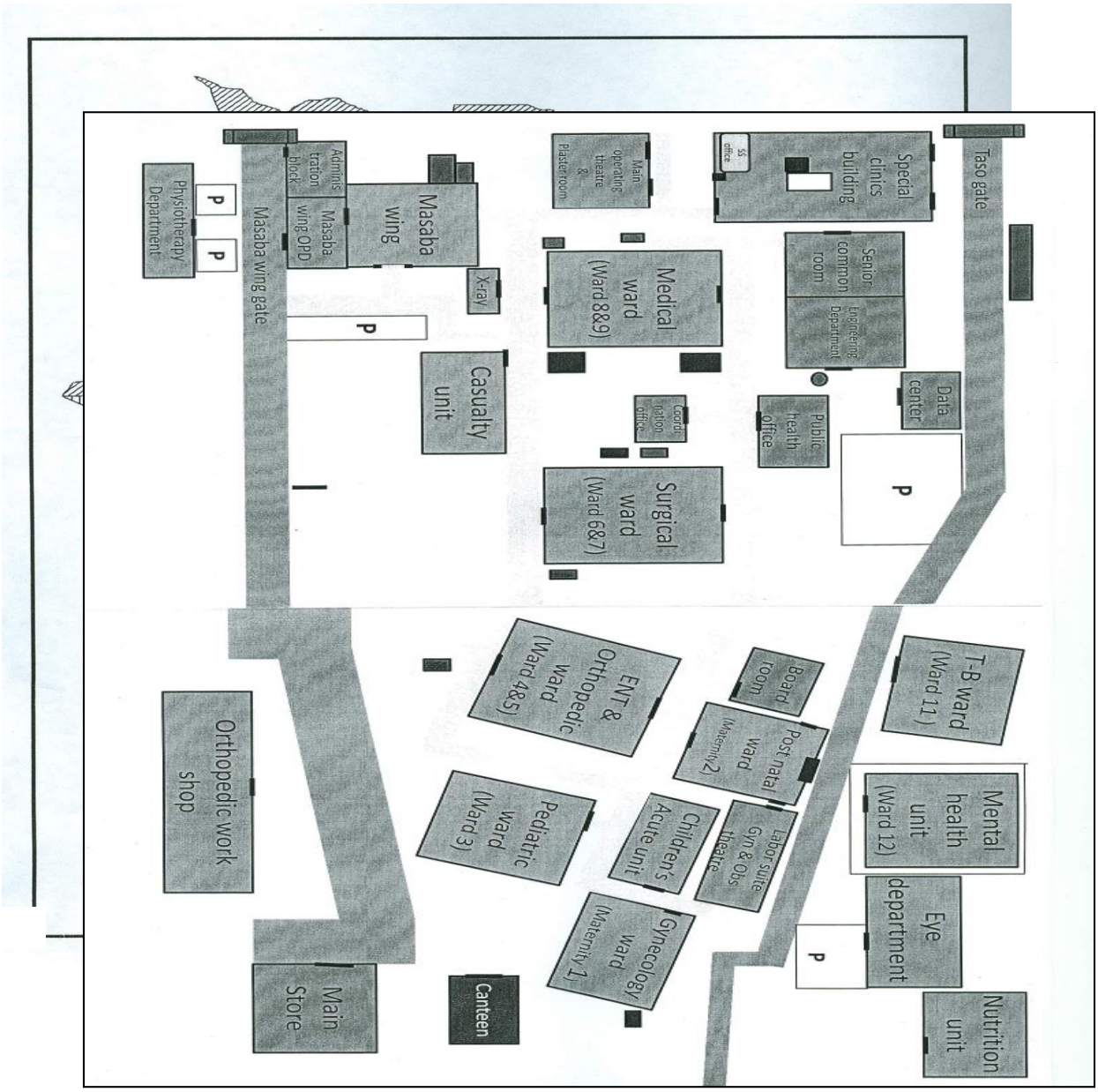
3. What makes it difficult for the patient to cope with this illness that could contribute to relapse? (Probe: Medication side effects, poverty, unemployment, violence, substance use, family conflict, shame, communication)

4. What suggestions would you like to make to the mental health nurses regarding relapse

APPENDIX VI: Map Of Uganda-Locating Mbale District



APPENDIX VII: Map of Mbale Municipality



APPENDIX VIII: Mbale Regional Referral Hospital-Psychiatric Unit

APPENDIX IX: Approval Letter

Telephones: General Line: 0352280584

E-mail: mrhirc@gmail.com

MINISTRY OF HEALTH
MBALE REGIONAL HOSPITAL
P.O. BOX 921
Mbale – Uganda

In any correspondence on this Subject, please quote: REIRC IN - COM 093/2014

THE REPUBLIC OF UGANDA

Date: 2nd June 2014

MRHIRC ACCREDITED BY THE UNCST, REGISTRATION NUMBER UG-IRC-012

Dear Mr. Okiror Emmanuel,

Re: Approval of Research: "Patients Family or Care Givers and Treatment Factors that Influence Relapse among Patients with Mental Illness being Treated at Mbale Regional Referral Hospital, Psychiatric Unit".

The Mbale Regional Hospital Institutional Review Committee (MRHIRC) has reviewed the proposal

"Patients Family or Care Givers and Treatment Factors that Influence Relapse among Patients with Mental Illness being Treated at Mbale Regional Referral Hospital, Psychiatric Unit".

I am pleased to inform you that the committee has approved & granted permission for the study to proceed. However, as a requirement for the MRHIRC to monitor the progress of all research approved by the committee, I wish to inform you that the team will visit your study site to monitor your research from time to time to find out its correspondence to the ethical considerations as per proposal.

At the end of the study, we will require that you submit a copy of your study findings to our office.

On behalf of the Mbale Regional Hospital Institutional Review Committee, I wish you the best of luck in your study.

Yours sincerely,

OFFICE OF THE CHAIRMAN
APPROVED
APPROVED DATE EXPIRY DATE
02 JUN 2014 01 OCT 2014
MBALE REGIONAL HOSPITAL INSTITUTIONAL REVIEW COMMITTEE (MRHIRC)

Dr. Crispus Tegu

MRHIRC Chairman