A CASE STUDY EXPLORING FORENSIC MENTAL HEALTH CARE USERS’ OCCUPATIONAL ENGAGEMENT IN EASTERN CAPE, SOUTH AFRICA

BONGISA S SHUMANE
UCT MASTERS CANDIDATE – SUPERVISED BY PROF ROSHAN GALVAAN
FORT ENGLAND HOSPITAL OCCUPATIONAL THERAPY - GRAHAMSTOWN

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OUTLINE

• INTRODUCTION
  • Forensic Mental Health Services in SA
  • From Institution to Community: The Challenge of Transitioning

• RESEARCH QUESTION

• RESEARCH DESIGN & METHOD
  • Selection criteria
  • Participant profile

• DATA ANALYSIS

• PROVISIONAL INSIGHTS
INTRODUCTION

- Forensic mental health (FMH): Interface of law and psychiatry (Swanepoel, 2015)

- Dual objective:
  - Treat and rehabilitate the forensic mental health user (FMHU) (O’Connell & Farnworth 2007)
  - Safely integrate into a community

- Forensic psychiatry vs. FMH
  - Forensic psychiatry – medical/illness model
  - FMH – rehabilitative/health model (Rogers & Soothill, 2008)
• Mental Health Care Act 17 of 2002, Chapter IV:
  Informed by the Criminal Procedures Act 51 of 1977
  sections 77, 78 & 79
• Research in Gauteng:
  At time of admission to FMH system, 59% of FMHUs had a
  known psychiatric history and 71% had a history of substance
  abuse (Marais & Subramaney 2015)
• Clinical services managed by health establishment:
  Behaviour Modification Programme (BMP) => Leave of Absence (LoA)
• Rehabilitation interventions:
  Substance Abuse Treatment Unit, OT, MDT groups i.e. insight-oriented, life skills, anger management,
  BMP information sessions, health talks
EASTERN CAPE, S.A.

- Second largest province in South Africa with a population over 6 million
- Rural farming province with two porting metropolitan municipalities along the Indian ocean (StatSA, 2016)
- Inequitable distribution of mental health services due to legacy of segregation of resources (Sukeri et al., 2014)

Homeland states:
- Eastern region less developed (Transkei)
- Central region (part Free State) & Western region more developed (Ciskei)
Eastern Cape: High levels of poverty and inequality

43.3% poverty intensity in 2016, reflecting increase of 2% since 2011 (StatSA, 2016)

Coping with poverty and with a psychiatric disability are conflated experiences

Dealing with deprivation, adversity and enduring financial constraints (Duncan, et al., 2011)

FMHUs are at increased risk of sliding into (or remaining in) poverty

Increased health expenditure, lost income and/or employment, reduced productivity and social exclusion due to stigma (Flisher, et al., 2007)
• Inadequate preparation for community living
  • Follow-up aftercare is seldom mandated
  • No set tariff for the length of detention, unlike prisoners (Coffey, 2013)

• Very little research in S.A. regarding outcomes for FMHUs
  • Duration of hospitalisation and discharge
  • Reclassification details
  • Rate of abscondment
  • Relapse, re-hospitalisation and recidivism rates

(Marais and Subramaney, 2015)
How do FMHUs experience engaging in occupations when transitioning from a secure forensic health establishment to living in a community for predetermined periods in the Eastern Cape, South Africa?
RESOURCES DESIGN

- Qualitative, explorative instrumental case study positioned in social constructivism
- FMHUs’ occupational engagement during the forensic LoA process
- Case study (Yin, 2003): FMHUs’ actions and situations, as bounded in context (Eastern Cape), time and phenomenon (initial forensic LOA)
  - Role players:
    FMHUs as the main participants, health establishment MDT and clinical notes, FMHUs’ custodians
SELECTION CRITERIA

- **FMHU:**
  - Admission date, first LoA, accessibility, mental state

- **Key-informant:**
  - MDT who work directly with FMHUs in the recruitment ward
  - Custodians of FMHUs in the community

- **Documents:**
  - FMHU clinical files with forensic observation report, social work report, record of in-patient intervention (psychopharmacy, rehabilitation) and custodial LoA report
<table>
<thead>
<tr>
<th>Participant</th>
<th>Forensic LoA: return from</th>
<th>Substance use</th>
<th>Gender</th>
<th>Age</th>
<th>Highest level of education</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anga</td>
<td>1 month</td>
<td>Cannabis, ethanol, methaqualone, methamphetamine use disorder, since early teens</td>
<td>M</td>
<td>22</td>
<td>Grade 10</td>
<td>East London: Township</td>
</tr>
<tr>
<td>Bulelani</td>
<td>3 months</td>
<td>Cannabis, ethanol, methaqualone, methamphetamine, volatile inhalants use disorder, since mid-teens</td>
<td>M</td>
<td>25</td>
<td>Grade 12</td>
<td>Port Elizabeth: Township</td>
</tr>
<tr>
<td>Cebo</td>
<td>6 months</td>
<td>Cannabis use in full remission (&gt; 1 year); last used before the offence</td>
<td>M</td>
<td>36</td>
<td>Grade 9</td>
<td>East London: Peri-urban</td>
</tr>
</tbody>
</table>
Data analysis follows the process for thematic analysis:

- Coding, identifying mutually exclusive & inclusive categories, and discovering themes and sub-themes (Creswell, 1998)

Goal of analysis:

- To develop the essential structure of FMHUs’ occupational engagement during forensic LoA developed by Colaizzi (1978)

Goal of this study is not to identify individual variation but rather to elicit and describe those aspects of the phenomenon that are common to all
• Accessibility of resources

Cebo’s sister:
“yes, sometimes his dates are around the twentieth..., and there isn’t money yet at that time.”
**Engaging with friends**

Anga:

“Most of them offered me weed, I told them I can’t do weed, so they just gave me money, like R50, be safe, and then left me again.”
Engaging with family

*Bulelani:* “They feel happy that they see that I’m busy with school..., I don’t smoke..., I’m back on time at home ..., everything, you see..., no they are alright staff.”
ENKOSI
Thank you
SIYABULELA

Fort England Hospital, Art group
National Research Fund
EC, Department of Health
OTASA, EC – OTASA

Friends & Fam
&
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