FACTORS CONTRIBUTING TO INCREASED RELAPSES AMONG MENTALLY ILL PATIENTS ATTENDING MENTAL UNIVERSITY TEACHING HOSPITAL

BY

MUHINDO SCOVIA

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A RESEARCH REPORT SUBMITTED TO UGANDA NURSES AND MIDWIVES EXAMINATION BOARD AS A REQUIREMENT IN PARTIAL FULFILLMENT FOR THE AWARD OF DIPLOMAIN NURSING SCIENCES

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ABSTRACT.

Relapse in mental illnesses is a major clinical event globally (Moran, M, 2009). There is insufficient knowledge regarding readmissions due to relapses or how best to solve the problem, given the scarcity of human and material resources (Salleh Mohad, 2010). Similarly at Kampala international university, overwhelming numbers in psychiatry department have been contributed by relapses.

A quantitative descriptive cross-sectional study employed convenient purposive sampling to assess social-economic, psychiatry and other medical conditions as well as personal and community factors associated to relapses among the mentally ill patients that had had an episode of relapse who were in the unit.

The results from the study indicated that; male clients were majority (59.7%), mean age group was 20-40 %( 52.7%). Social economic factors associated with relapses include single (56.9%) and divorce 23.6%. relapsing patients reported poor relationships with their family members (51.3%). Relapsing was common in low social depicted by peasants (77.7%), semi-permanent house (54.1%) and affording 2 meals per day. Working hours were long 7-12(70.8%) and earning is less <100,001(73.5%). Majority (59.7%) did not have social group. patients with thought disorders relapses (36.1%) followed by bipolar disorders (26.3%), while other conditions associated with relapses were HIV (33.3%) and Malaria (16.6%). Patient diagnoses 3-4years relapsed highly (36.1%) and so were those that did not have insight about their previous illness (56.9%). 59.8% of those that relapsed had poor adherence to treatment, major reason for poor adherence (44.2%) being when the symptoms subsided, and also alcohol abuse (38.8%). Patients (52.2%) freely socialized with community members before they relapsed, however, (97.2%) mental health care in their communities.

Conclusion from the study were; social economic factors associated with early adulthood age, poor family support, an low social economic status of patients, stress related to low social involvement. Diagnoses associated with relapses were thought disorders while other medical conditions associated with relapses were HIV and malaria. Personal factors associated with relapses were long period with diagnosed mental illness, poor insight towards illness, poor adherence to treatment mainly when patients feel better and stop against medical advice, and
drug abuse mainly among alcoholics. Also was due to lack of community based mental health support within patients’ communities.

Improving economic status of mentally ill patients and encouraging good family support, counseling of patients with most relapsing diagnoses like thought disorders on adherence to treatment while in community, and controlling drug abuse following discharges, and empowering community based mental health promotion could greatly reduce occurrence in relapses.
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AUTHORISATION

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Author

Sign………………………………… Date……………………………………

MUHINDO SCOVIA

Signed…………………………………… Date …………………………….

MS. MUSIIMENTA PAMELA

(University supervisor)

Signed…………………………………… Date …………………………….

MS.KABANYORO ANNET

(Dean School of nursing)
DEDICATION

I dedicate this research work to my beloved supervisor Mis Musiimenta Pammela, my parents Mr And Mrs. Kule James for their tireless efforts through my education since pre-school up to now, I also dedicate it to classmates especially Apili Norah and Nasaali Scovia for their encouragements during this course.
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The Mental Patients and their caregivers for freely sharing their views, which resulted into this work.
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>EE</td>
<td>Expressed Emotion</td>
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<tr>
<td>FEP</td>
<td>First Episode Psychosis</td>
</tr>
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<td>KIUTH</td>
<td>Kampala International University Teaching Hospital.</td>
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<tr>
<td>MDD</td>
<td>Major Depressive disorder</td>
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<td>PHC</td>
<td>Primary health care</td>
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<tr>
<td>WHO</td>
<td>World Health Organization.</td>
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<td>WFMH</td>
<td>World Federation of Mental Health</td>
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<tr>
<td>YLD</td>
<td>Years lived with a disability</td>
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<tr>
<td>HIV</td>
<td>Human immune deficiency virus</td>
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DEFINITION OF TERMS

Caregiver: A care giver is the person that provides the most unpaid support to an individual and helps with physical care or emotional or psychological support.

Culture beliefs: Is a form of traditional thinking, convictions or behavior which is characteristic of a given society of a certain area (Karger. 2008).

Insight means: Recognition of one’s own condition (mental illness). It refers to: the conscious awareness and understanding of one’s own psychodynamics and symptoms of maladaptive behavior.

Mental disorder: A psychological syndrome or behavioral pattern that is associated with subjective distress and/or objective impairment.

Mental illnesses: Mental illnesses are characterized by alterations in thinking; mood or behavior (or some combination thereof) associated with significant distress and impaired functioning over an extended period of time.

Mental relapse: A relapse means to “become ill again after apparent recovery or the return of ill health after an apparent or partial recovery (Collins English Dictionary 1991).

Perspective: Particular attitude toward or way of regarding something; a point of view.

Refractoriness: Resistant to treatment as for the disease.

Relapse Is the re-emergence or the worsening of psychotic symptoms (Zewdu et al., 2014)
CHAPTER ONE

1.0 INTRODUCTION

This chapter presents the background of the study, problem statement and significance of the study, general objectives of the study, specific objectives, and research questions and justification of the study.

1.1 Background

Mental relapse means to “become ill again after apparent recovery or the return of mental illness after an apparent or partial recovery” or a return of symptoms to the full syndrome criteria after an episode (Finseth PI 2014)

The burden of mental illness on health is known throughout the world. Around 450 million people currently suffer from such conditions, placing mental disorders among the leading causes of ill-health and disability worldwide. Schizophrenia, depression, epilepsy, dementia, alcohol dependence and other mental, neurological and substance-use disorders make up 13% of the global disease burden, surpassing both cardiovascular disease and cancer. It is projected that by 2030, depression will be the second highest cause of disease burden in middle-income countries and the third highest in low-income countries (WHO, 2012).

A number of factors have been cited to contribute to the cause of relapse for example in Australia, it was found that some patients refuse treatment because of a resultant weight gain while in South East Asia, patients with psychiatric disorders like depression or post-traumatic stress were unwillingness to take treatment because the drugs are very strong, have physiological and psychological side effects, and even stigma attached to psychiatric treatment were the most prevailing factors(Tolliver BK, 2010).
Based on World Bank criteria, Uganda is a low-income country with the average per capita income of USD 300, with 31% of the population living below the poverty line. These economic situations have implications for mental health and such as poverty, have a dialectical relation, reinforcing and exacerbating each other (Kigozi, et al., 2010) and a precipitant to mental relapses.

Patients with mental disorders are prone to relapses even after a short period following discharge from a mental hospital. In a study on care givers view on the causes of mental relapses by Lilly (2008), more than one third of care givers reported that their patients relapsed five or more times after being diagnosed of having a mental disorder, leaving a majority of care givers to often worry about their patients relapsing.

In the same study it is noted that other factors leading to relapse included lack of social support, grief following the loss of a close family member, lack of employment, poor procurement processes, lack of resources, poor planning, stigma and lack of specialized psychotherapies at primary health care level. Relapses of mental disorders in the psychiatric wards continue to be a source of frustrations and distress to treating teams, patients, caregivers and their families at large despite the efforts made to manage these disorders worldwide.
1.2 Problem statement

Relapse in mental illnesses is a major clinical event globally, and commonly affects the personal and social functioning of the person. Relapses are associated with a high economic burden to both family members and country at large. Its prevention has become an important goal (Moran, M, 2009).

Clients who are mentally ill are characterized by frequent readmissions for acute inpatient treatment. We have insufficient knowledge regarding magnitude and factors responsible for frequent and increased cases of readmissions or how best to solve the problem, given the scarcity of human and material resources (SallehMohad, 2010).

KIU-TH and Mbarara regional referral hospital are the only hospitals with a psychiatric department in western Uganda and over flooded by new and re-admitted cases of mental illnesses.

Unpublished report from KIU-TH records cohort study from September 2016-January 2017 indicated that 57.4% of all patients admitted in psychiatry unit had been at one point in life been admitted for the mental illness related cases either from KIU-TH as a re-admission, or from other health facilities.

The overwhelming numbers are more contributed by Re-admission of relapsing cases. These also worsen disability and increase refractions to future treatment. Therefore, this study was intended to elucidate factors contributing to increased relapses as to further help the institution plan strategies in reducing relapse rate.
1.3 Purpose of the study

The purpose of this study is to establish the factors contributing to increasing relapses among mentally ill patients attending mental health unit at Kampala international university teaching hospital Ishaka Bushenyi.

1.4 Specific objectives

i. To assess the social-economic factors associated with relapses among patients who receive mental treatment at Kampala International University teaching hospital.

ii. To ascertain psychiatric disorders and other medical conditions associated with relapses among patients with relapses at mental unit Kampala International university teaching hospital.

iii. To assess personal and community factors associated with relapses among mentally ill patients.

1.5 Research questions.

The research wished to answer the following research questions:

1. What are the social-economic factors that are associated with relapses among patients who receive mental treatment at Kampala International University teaching hospital?

2. What are psychiatric disorders and co-illnesses that are associated with relapses among patients with relapses in Kampala International university teaching hospital mental health unit?

3. What are other personal and community factors that are related to relapses?
1.6 JUSTIFICATION OF THE STUDY

Successive relapses can reduce the degree and duration of the next re-admission; worsen mental capacity, reduce positive contribution that was supposed to be provided by a relapsing patient to his community and increase refractions incompliancy to future treatment.

Such frequent readmissions are disabling the hospital from providing its services to the best quality to all new patients demanding its services, and this is creating a huge gap in the quality of the hospital’s service provided to mentally ill patients.

To nursing practice

The findings will help the practicing nurses in finding a research based strategies in reducing risk factors associated with relapses thereby avoiding occurrence of relapses.

Nursing education

The study findings will help nursing education to develop curriculum with evidence based knowledge that will fully address relapses and their management there by promoting complete healing among mentally ill.

Nursing research

It will help nursing researchers to site further areas of study regarding relapses that will broaden the existing knowledge on relapses, their occurrence and possible prevention measures.
CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This chapter discusses the literature related to the factors contributing to increased cases of relapse among mentally ill patients at Kampala International University Teaching Hospital Ishaka Bushenyi.

This chapter again will show the related literature by other scholars, news papers, citations by people will be on factors contributing to increased relapses among mentally ill patients.

General overview on mental illness relapses

Mental relapse means to “become ill again after apparent recovery or the return of mental illness after an apparent or partial recovery” or a return of symptoms to the full syndrome criteria after an episode (Finseth PI 2014)

Mental disorders are generally characterized by a combination of abnormal thoughts, perceptions, emotions, behavior and poor relationships with others. These mental disorders are often accompanied by relapse even while on treatment (Simhandl C 2014)

Major mental disorders associated with relapses include: depression, bipolar affective disorder, schizophrenia, drugs and substance abuse. Other forms of psychoses like dementia, intellectual disabilities and developmental disorders including autism are also associated with mental relapses. Major factors contribute to theses relapses (Weret et al. 2014).

The bio-demographic factors contributing to the increased cases of relapse among mentally ill patients

African context, a study conducted in south Africa for instance (Kazadi et al, 2008), indicated that from a total of 217 patients with mental illnesses, 61.8% of the study population were patients who relapsed, i.e. had a history of at least one relapse and the mean age of patients
who relapsed was 42.5 years (min 21 years and max 75 years) while that of patients who did not relapse was 49.3 years (min 21 years and max 83 years). About 30.6% of patients who relapsed had achieved a primary level of education, and 48.5% a secondary level of education. On comparison, 15.7% of the patients who did not relapse had achieved a primary level of education and 72.3% a secondary level education.

According to the research conducted on prevalence and associated factors for relapse among mentally ill inpatients at Emmanuel Mental Specialized Hospital revealed that the mean age of the respondents was 31 years (Yihunbelay Dinku, 2014),

A study on causes of relapse by Slade et al found out that psychiatric patients may not consent to sharing information with caregivers, which also tend to complicate the relapse rates among patients with mental disorders. (Slade et al., 2007)

2.1 Socio-economic factors associated with increasing relapses among mentally ill patients.

Almost recent study by (Gathaiya et al, 2011) confirmed that most common factor associated with relapse in Schizophrenia at Mathari Hospital Kenya was non drug compliance and failure to attend and failure to attend follow up clinic due to lack of social support and poor insight regarding mental illness, side effects of antipsychotic drugs and lack of knowledge on the course of the mental disorders

The burden of the mental disorder, being much more common in Sub-Saharan Africa, can create staggering social and economic cost, especially in poor countries (Silberberg 2009, Altevogt, et al., 2010).

In addition, rise in poverty rate, occurrence of natural disasters and wars, and other forms of violence or social unrest are major causes of psychosocial problems, increased burden of diseases, disabilities and death (WHO, 2012).
Uganda, ranked 106th in the world gross domestic product (GDP) ranking of nations, has majority of its people live below two US dollars a day and a high incidence rates of mental and neurological disorders (World Bank 2013, WHO 2010, Ssebunnya, et al., 2012).

The burden posed by these disorders on the mentally ill persons, the care givers (parents, family members) and the health workforce, as well as the requirement for resources, may further worsen the already poor economic conditions of the people and many families. Therefore most of the families for patients with mental disorders cannot afford maintaining therapy appointments or the cost of their medications hence increased rates of relapses (Ssebunya, et al., 2012).

2.2 The psychiatric diagnoses and other medical conditions which are associated with relapses

It was found that factors such as psychiatric anxiety disorder, bipolar disorders, depression, and self-report history of previous admission were statistically significant risk factors in the number of relapses and readmissions (Barekatain, et al., 2013).

This is supported by (Kane, et al., 2013) who also found out that in the case of individuals with psychotic disorders, there are a number of unique challenges for example lack of insight or lack of awareness of the illness itself is a particular challenge in mental illnesses. In addition, the cognitive impairment frequently seen in psychotic disorders and present to some degree in a majority of individuals with schizophrenia is another important factor for poor adherence to treatment. This however shows much research done for schizophrenia and little done for general mental disorders.
Studies had reported that people with severe mental illnesses suffer more from serious health problems than those without mental disorders, and they are likely to receive medical help. Substance abuse is a significant factor in this higher risk (Newcomer, J.W, 2007).

In South Africa studies, alcohol abuse and cannabis abuse were reported as significant factors that contributed to relapse in all mental illness, and cannabis, methaqualone and alcohol abuse as having contributed to relapse in acute psychotic states (Kazadi, NJB:Moosa, MYH: et al, 2008).

In study by (Emsley et al, 2013) in the United Kingdom on the evidence for illness progression after relapse in schizophrenia, patients with First Episode Psychosis (FEP) have a high rate of relapse in their first year after the onset. In another study carried out in China by (Xiao, et al., 2015) relapse is common in schizophrenia, and seriously impacts patients’ quality of life and social functioning.

In many African countries, the most frequent presentation of psychosis is acute or sub-acute: acute transient psychoses, paranoid psychoses, psychoses resulting from cerebral involvement in infectious diseases, like malaria, typhoid fever or human immunodeficiency virus (HIV) infection all of which have relapse tendencies. 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).

There are several factors that lead to relapses. These factors associated with relapse included substance abuse, co-morbid psychiatric illness, co-morbid medical and/or surgical condition, stressful life events, treatment setting, and poor adherence with antipsychotic medications being a major cause of relapse. (Weret and colleagues 2014)
### 2.3 Personal and community factors.

Non-adherence is highly influenced by patient knowledge, attitudes towards their illness and the medication, as well as past experiences with their illness and its treatment. In particular, the perceived risks and benefits of the treatment and of the illness that is illness insight play a major role in adherence behaviors (Kane, *et al.*, 2013).

In another study on medication adherence and substance abuse (Magura, *et al.*, 2013) found out that substance misuse is usually associated with poorer psychiatric medication adherence among psychiatric patients and closely associated with relapse and re-hospitalization (Magura, *et al.*, 2013).

To counteract such effects of medication on patients with mental disorders, family caregivers play a major role. Adherence is encouraged by family caregivers through support in reminding clients with mental illness to take their medications regularly. It is therefore assumed that clients depend heavily on family caregivers to adhere to their treatment (Mahamba ND 2010).

Various determinants such as nature and duration of therapy, disease characteristics, medication side-effects, cost of treatment, characteristics of health service facilities, the relation between the physician and patient, patient characteristics such as socioeconomic factors, patient’s perspective about the illness and therapy have been reported to influence adherence. Adherence to treatment was considered to be poor if there was failure to fill any prescription, refusal to take medication, stopping treatment prematurely, and reports of taking medication at the wrong time and/or incorrect dosage (Moosa, *et al.*, 2008).

The World Health Organization (2013) categorized the determinants of non-adherence into five dimensions: Social-economic, health system-related, therapy-related, condition-related, and patient-related.
Partial adherence to treatment remains a therapeutic challenge in mental health care. A study in Johannesburg, South Africa on factors associated with relapses in schizophrenia patients indicated adherence rate of 64.2%. The factors associated with poor adherence to treatment in the diagnostic group under review were medication side-effects and lack of insight. Poor insight contributed to a 5.2-times increase in the risk of relapse (Kazadi et al., 2008).

Furthermore (Kane, et al., 2013), found out that lack of support systems contribute to non-adherence and (Magura, et al., 2013), reported that low friends’ support for drug/alcohol abstinence and lack of more recovery-promoting behaviors, contribute to relapses among individuals with substance abuse problems.

One research finding from Asia-Pacific, a strong stigma towards mental patients and the influence of traditional leaders aggravates the adherence problem (Razali, et al., 2010). Among South Africans, cultural and social attitudes and belief systems are speculated as common reasons for increased cases of relapse (Kazadi, NJB, Moosa, MYH., et al., 2008).

The study to identify factors that contributed to relapse among mentally ill patients located in the rural areas of the Eastern Cape was conducted in the Nkonkobe Local Service Area at Debe nek and zihlahleni clinics in the eastern cape province, South Africa, the researcher observed that factors that contributed to relapse included lack of transport to conduct home visits, the stigma attached to mental illness. (Nosipho 2008)
CHAPTER THREE: METHODOLOGY

3.0 Introduction.
This chapter presents the study design, study setting and the study population, sample size and sampling procedure, inclusion and exclusion, definition of variables, research instruments, data collection, data management and quality control, data analysis, ethical considerations and limitation of study, dissemination of results

3.1 Study design and rationale
The study adopted a descriptive cross-sectional design that employed both qualitative and quantitative methods of data collection. The study was concerned with factors contributing to increased relapses among mentally ill patients attending mental health unit at Kampala international university teaching hospital. This design allowed data to be obtained only on first contact with the respondents and no follow up was needed since it required short period of time for data collection.

3.2 Study setting and rationale.
The study was conducted in inpatient and out Patient Mental unit departments of Kampala International University Teaching Hospital (KIU-TH)Bushenyi district.KIU Teaching Hospital is located in Ishaka - Bushenyi approximately 360 km/220 m, along Kasese-Mbarara high way, southwest of Kampala. The hospital has several units like maternity, surgical, medical, pediatric, orthopedic, physiotherapy, mental health among others.

The hospital acts as referral point for most of the patients with mental disorders from the districts of Bushenyi, Sheema, Rubirizi, Mitooma, Ntungamo and Kasese. It admits about 120 patients with different psychiatric disorders per month.
On average, the daily attendance ranged from 40-60 patients. The Mental out Patient department is run by Three Psychiatrists, three Psychiatric Clinical Officers and three Psychiatric Nurses, and the services offered included reviewing old cases for treatment adjustments, psycho-education, individual, and family counseling/therapy, drug reviews, assessment and admission of mental patients. According to the monthly mental health records Kampala International University Teaching Hospital mental clinic serves a population of about 70 in patients 7 admissions 4 readmissions and 1 transfer in patients on a daily basis

3.3 Study population.

Study population targeted was the patients in mental out patients and inpatient with history of relapse following discharge from hospital for mental disorder.

Sample Size determination

The sample size was determined using Fisher’s formula developed in 1990.

\[ n = \frac{Z^2Pq}{d^2} \]

Where \( n \) = sample size

\( Z \) = standard deviation at confidence level of 95% which is 1.96

\( P \) = proportion of population with the desired characteristics

\( q \) = proportion of population without desired characteristics q=1-p

\( d \) = level of significance or measure of anticipated error taken as 0.05

Therefore, for this study:

\( n \) = desired sample size of patients that relapsed

\( z \) = standard deviation at confidence level of 95% = 1.96

\( p \) = proportion of the population who relapsed 50% = 0.5

\( q \) = 1-p i.e. 1-0.5=0.5
\[ d = \text{level of anticipated error of } 5\% = 0.05 \]

Substituting the values into the formula

\[ n = \frac{Z^2pq}{d^2} \]

\[ n = 1.96^2 \frac{(0.5 \times 0.5)}{(0.05)^2} \]

\[ n = 384 \]

384 who relapsed

However, since my study targeted population less than 10,000 it necessitated to further reduce the sample size.

Where \( n \) is the sample size and \( N \) is the total population

\[ n\sum = \left( \frac{n}{1 + \frac{n}{N}} \right) \]

\[ n\sum = \left( \frac{384.16}{1 + \frac{384.16}{90}} \right) \]

\[ n\sum = 72.4 \text{ patients} \]

Therefore, sample size considered was 72 patients that had relapsed.

**3.5 Sampling procedure**

The researcher used convenient sampling technique where by a simple history taken from either caretakers or patient if he was in sound mind as source of data regarding the patient under study. This was continued on daily basis on both mental health OPD and to all inpatients in
KIU-TH psychiatry unit from 10th-16th July 2017 till researcher got sample equal to 72 patients that had relapsed from the population of 139 respondents encountered in mental outpatient department and inpatient unit by purposive convenient sampling. Those that had relapsed were considered as a sample to determine factors associated to relapses in this study population.

**3.6 Inclusion criteria.**

This study included mental health clients who were stable that had been re-admitted at Kampala International university teaching Hospital mental Health clinic.

All patients with a history of relapses that had insight and were willing to consent, and those that had no insight, but had caretaker willing to consent and clarify information given on their behalf.

**3.7 Exclusion criteria.**

This study excluded patients who lacked a caretaker to consent on their behalf since its unethical to consent under unsound mind.

Patients attending Hospital mental health clinic for the first time and those that have never had an episode of relapsing.

Critically ill patients at Kampala International hospital university teaching mental health clinic and those whose caretakers did not consent on their behalf.

**3.8 Definition of variables.**

The **dependent variable.** This is the factor that depends on other circumstances for its occurrence. And for this particular case, its occurrence of relapses among mental patients at Kampala International University Teaching Hospital.

**Independent variables.** These are factors that directly or indirectly influence pattern of occurrence of other factors, for this particular study, they are those that determine occurrence
of relapses. They include; socio-economic factors, adherence to medications, Bio-demographic factors, medication and the common co-morbidities related to mental illnesses.

3.9 Research instruments.

The study adopted a semi-structured questionnaire. The questionnaire was designed in a way that patients answered closed ended questions. The questionnaire was written in simple language and easy to read in English and was administered to participants/their caretakers by the researcher.

3.10 Reliability and validity of the research instruments.

Questionnaire was pretested from Kampala International University Teaching Hospital with at least 10 patients with history of mental relapses a week before data collection and any observed inconsistency of the questions was corrected to meet the intended objectives before time of data collection.

Items in the instruments were adequately and appropriately organized according to the objectives of the study. The data collection instrument was further discussed with the research supervisor to ensure accuracy and appropriateness. For consistent and reliable results from the research, the instruments were constructed using a simple language and appropriate vocabulary for easy understanding for the selected respondents. The tool was pre-tested on 6 mental patients with history of relapse in a period of one year. Thereafter the tools was edited to fill in all the missing gaps. All ambiguous questions were removed for accuracy and appropriate.

3.11 Data collection methods / procedures

The researcher introduced herself to participants and their caretakers, and read to them consent form that detailed the title and purpose of the study as well as the rights of the participant. Whenever a participant/his or her caretaker agreed to be interviewed he/she was asked to
provide written consent by signing or fingerprinting. After obtaining informed consent, patient
and caretakers were interviewed using researcher administered questionnaire. The researcher
entered responses given by the participant by ticking the appropriate response and entering the
same number in to the coding box. The process of data collection continued until every effort
to contact every study participant/his or her caretaker in the sample was exhausted. All
completed questionnaires were kept safe by the researcher until time of analysis.

3.12 Data management and quality control
The filled in questionnaires were checked for validity before leaving the data collection site.
Data was coded and entered correctly in the computer. The questionnaires were kept properly
in a locker to avoid access by unauthorized personnel and losses.

Data obtained was kept in safe custody and treated with respect and confidentiality. Coding
and sorting at the end of data collection process was done to ensure adequacy, completeness
and correctness of information collected.

3.13 Data analysis
Quantitative data from the questionnaire was analyzed using SPSS version 8 and Microsoft
Excel. Data was presented in figures, tables and charts. All the above data was interpreted to
give meaningful information.

3.14 Ethical consideration.
The proposal was presented to the ethical and research committee at KIU-TH school of nursing
and midwifery for approval and there after an introductory letter was obtained and presented
to the Management of Kampala International University Teaching Hospital for a permission.
Once permission was granted, data collection was done. The respondents were asked to consent
before being interviewed. Interviews were conducted in a manner that enabled every
respondent responds freely and openly in the absence of any other tension raising persons for
confidentiality. Names of the respondents were not included in the data to ensure confidentiality.

3.15 Limitations.

The researcher was limited by finance since it involved printing, typing, and stationary, however this problem was solved by mobilizing financial resources from relatives, friends and parents. The researcher faced a challenge in obtaining consents from two individuals that is the caretaker and patient, in that during data collection, caretakers and patient sometimes reacted to a call to participate in the study differently.

3.8.1 Dissemination of results

Three copies of the study findings were produced and given to; The Uganda nurses and midwives examination board for award of a diploma in nursing, Kampala international university western campus library for other scholarly review, the researcher stayed with the copy for future referencing and publication purposes in case financial mean
CHAPTER FOUR: FINDINGS FROM THE RESEARCH STUDY.

4.0 Introduction
This chapter presents the study findings which have been analyzed and presented following the objectives of the study. Data collected is presented in graphs, tables, pie charts to give more precise and meaningful presentation.

4.1 Social demographic characteristics.
Table 1: demographic characteristics.

<table>
<thead>
<tr>
<th>characteristic</th>
<th>frequency n=72</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>43</td>
<td>59.7%</td>
</tr>
<tr>
<td>Female</td>
<td>29</td>
<td>40.2%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-20</td>
<td>07</td>
<td>9.7%</td>
</tr>
<tr>
<td>21-40</td>
<td>38</td>
<td>52.7%</td>
</tr>
<tr>
<td>41-60</td>
<td>24</td>
<td>33.3%</td>
</tr>
<tr>
<td>&gt;60</td>
<td>1</td>
<td>1.3%</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>30</td>
<td>41.6%</td>
</tr>
<tr>
<td>Protestant</td>
<td>26</td>
<td>36.1%</td>
</tr>
<tr>
<td>Pentecostals</td>
<td>10</td>
<td>13.8%</td>
</tr>
<tr>
<td>Muslims</td>
<td>04</td>
<td>5.5%</td>
</tr>
<tr>
<td>Others specify</td>
<td>02</td>
<td>2.7%</td>
</tr>
<tr>
<td>Tribe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Munyankole</td>
<td>46</td>
<td>63.8%</td>
</tr>
<tr>
<td>Mukiiga</td>
<td>18</td>
<td>25%</td>
</tr>
<tr>
<td>Mutooro</td>
<td>01</td>
<td>1.3%</td>
</tr>
<tr>
<td>Muganda</td>
<td>02</td>
<td>2.6%</td>
</tr>
<tr>
<td>Others.</td>
<td>5</td>
<td>6.9%</td>
</tr>
<tr>
<td>Level of education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>03</td>
<td>3.9%</td>
</tr>
<tr>
<td>Primary</td>
<td>49</td>
<td>68.0%</td>
</tr>
<tr>
<td>Secondary</td>
<td>16</td>
<td>22.2%</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

Majority of respondents were males with 59.7%, while females were only 40.3%.
Age 21-40 formed the majority (52.7%) of the respondents, while those >60 were the least with 1.3%.

Majority of the study participants were Catholics with 41.6%, followed by Protestants who were 36.1%.

Majority of participants were Banyankole with 63.8%, followed by Bakiga with 25% of the participants.

Majority of the respondents (68%) had had primary level of formal education, and only 5.5% of the participants had had tertiary education.

4.2 Social-economic factors.

The social economic factors are some of factors that affect mental well being of an individual, therefore, those factors that are deemed to directly or indirectly affect the health of an individual were considered. Social economic factors were assessed on the following, marital status, relationship with the wife and children, housing quality, feeding, occupation, number of working hours, working conditions, pay, groups and peers and their effects on social involvement, drug abuse including alcohol, cannabis, cart, and cigarette and tobacco smoking. The findings were as follows

Figure 1: marital status.
Most of the study population were single (56.9%) followed by divorced and married with 
(23.6% and 18.0%) respectively, while only 1.3% had separated but not divorced with their 
spouses.

**Figure 2: relationship with family members.**

Relationship with the family members were also assessed basing on whether the care taker 
think that it’s good, fair of not good, and the following were findings
Most of participants (51.3%) did not have good relationship with their family members, followed by (31.9%) who had a good relationship with the family members, while 19.4% had a fair relationship with their family members.

Table 2; Showing housing condition, number of people per room where patient lives, and feeding in meals per day

<table>
<thead>
<tr>
<th>Social economic factor</th>
<th>Frequency n=72</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Housing condition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Of mud, trees and grass</td>
<td>02</td>
<td>2.6%</td>
</tr>
<tr>
<td>Of trees, mud and iron sheets</td>
<td>39</td>
<td>54.1%</td>
</tr>
<tr>
<td>of bricks, sand and iron sheets</td>
<td>20</td>
<td>27.7%</td>
</tr>
<tr>
<td>plastered bricks, iron sheets and cemented floor</td>
<td>11</td>
<td>15.2%</td>
</tr>
<tr>
<td><strong>Number of people per room where patient live</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>47</td>
<td>65.2%</td>
</tr>
<tr>
<td>2</td>
<td>15</td>
<td>20.8%</td>
</tr>
<tr>
<td>more than 2</td>
<td>10</td>
<td>13.8%</td>
</tr>
<tr>
<td><strong>Feeding per day</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 meal per day</td>
<td>15</td>
<td>20.8%</td>
</tr>
<tr>
<td>2 meals per day</td>
<td>31</td>
<td>43.0%</td>
</tr>
<tr>
<td>3 meals per day</td>
<td>19</td>
<td>26.3%</td>
</tr>
<tr>
<td>&gt; 3 meals per day</td>
<td>7</td>
<td>9.7%</td>
</tr>
</tbody>
</table>

Majority of study population (54.1%) live in semi permanent houses of (trees, mud and iron sheets), followed by those who live in unfinished permanent houses of bricks, mud and iron sheets (27.7%).
Majority of respondents live 1 person per room (65.2%) while only (13.8%) of respondents live more than 1 person per room, while majority of the study population (43.0%) can afford 2 meals per day, while 20.8% and 26.8% can afford 3 meals and 1 meal per day respectively.

**Figure 3: occupation of the participants.**

Most of the study population (77.7%) is peasant farmers, followed by 5.5%, 5.5% who are businessmen and civil servants respectively, and 11.1% are students.
Table 3: working conditions and earning from work done.

<table>
<thead>
<tr>
<th>number of working hours per day n=72</th>
<th>frequency n=72</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-6</td>
<td>18</td>
<td>25%</td>
</tr>
<tr>
<td>7-12</td>
<td>51</td>
<td>70.8%</td>
</tr>
<tr>
<td>12-18</td>
<td>3</td>
<td>4.1%</td>
</tr>
<tr>
<td>&gt;18</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>earning as pay or income from work done n=72</th>
<th>frequency</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>none monthly</td>
<td>23</td>
<td>31.9%</td>
</tr>
<tr>
<td>01-100,000 monthly</td>
<td>30</td>
<td>41.6%</td>
</tr>
<tr>
<td>100,001-200,000 monthly</td>
<td>13</td>
<td>18.05%</td>
</tr>
<tr>
<td>200,001-300000 monthly</td>
<td>2</td>
<td>2.7%</td>
</tr>
<tr>
<td>300001-400000 monthly</td>
<td>3</td>
<td>4.1%</td>
</tr>
<tr>
<td>400001 and above monthly</td>
<td>1</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

Most of study population (70.8%) work for 7-12 hours, followed by those that work 1-6 hours (25.0%).

Majority of the study population earn between 1-100000 shillings monthly, followed by those who completely don’t earn from their work monthly, while only 1.3% earn 400001 shillings from their work monthly.
Most of the people in the study population (59.7%) did not have at least a group where they belonged, while 40.1% of the study population had.

4.3 mental and other medical conditions associated with relapses.

Table 4: mental disorders and other conditions associated with illnesses

<table>
<thead>
<tr>
<th>Mental disorders associated with relapses</th>
<th>frequency n=72</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>mood disorders</td>
<td>18</td>
<td>25%</td>
</tr>
<tr>
<td>thought disturbances(psychotic disorders)</td>
<td>26</td>
<td>36.1%</td>
</tr>
<tr>
<td>anxiety disorders</td>
<td>5</td>
<td>6.9%</td>
</tr>
<tr>
<td>somatoform disorders</td>
<td>1</td>
<td>1.3%</td>
</tr>
<tr>
<td>bipolar disorders</td>
<td>19</td>
<td>26.3%</td>
</tr>
<tr>
<td>organic psychotic disorders</td>
<td>2</td>
<td>2.7%</td>
</tr>
<tr>
<td>cognitive impairment disturbances</td>
<td>3</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other medical conditions associated with relapses</th>
<th>frequency n=12</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>4</td>
<td>33.3%</td>
</tr>
<tr>
<td>Puperium</td>
<td>1</td>
<td>8.3%</td>
</tr>
<tr>
<td>Malaria</td>
<td>2</td>
<td>16.6%</td>
</tr>
<tr>
<td>Meningitis</td>
<td>1</td>
<td>8.3%</td>
</tr>
<tr>
<td>other chronic illnesses like diabetes, hypertension</td>
<td>2</td>
<td>16.6%</td>
</tr>
</tbody>
</table>
Thought disorders were the most associated with relapses with 36.1% of all relapsed patients, followed by bipolar disorders with 36.3%, while somatoform disorders were least associated with relapses.

HIV was the co-morbidity associated with relapses with 33.3%, followed by malaria and puerperium and other chronic disorders with 16.6% and 16.6% respectively, while puerperium and meningitis had 8.3 percentages.

4.4 Personal and community factors.

Table 5: personal characteristics associated with relapses.

<table>
<thead>
<tr>
<th>personal factors</th>
<th>frequency n=72</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration of illness since first diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 1 year</td>
<td>15</td>
<td>20.8</td>
</tr>
<tr>
<td>1-2 years</td>
<td>20</td>
<td>27.7</td>
</tr>
<tr>
<td>3-4 years</td>
<td>26</td>
<td>36.1</td>
</tr>
<tr>
<td>≥5 years</td>
<td>11</td>
<td>15.2</td>
</tr>
<tr>
<td><strong>Insight of patient towards his previous illness</strong></td>
<td>n=72</td>
<td></td>
</tr>
<tr>
<td>knew that they were mentally ill</td>
<td>31</td>
<td>43.0</td>
</tr>
<tr>
<td>didn’t know that they were mentally ill</td>
<td>41</td>
<td>56.9</td>
</tr>
<tr>
<td><strong>Whether the patient took his/her treatment as was prescribed following discharge?</strong></td>
<td>n=72</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>29</td>
<td>40.2</td>
</tr>
<tr>
<td>no.</td>
<td>43</td>
<td>59.8</td>
</tr>
<tr>
<td><strong>If No from question above, what was reason for not taking the treatment?</strong></td>
<td>frequency n=43</td>
<td></td>
</tr>
<tr>
<td>high costs of drugs</td>
<td>5</td>
<td>11.6</td>
</tr>
<tr>
<td>sometimes forgets</td>
<td>12</td>
<td>27.9</td>
</tr>
<tr>
<td>felt better and stopped</td>
<td>19</td>
<td>44.2</td>
</tr>
<tr>
<td>had serious side effects</td>
<td>7</td>
<td>16.2</td>
</tr>
</tbody>
</table>
Majority (36.1%) of patients that relapsed had been diagnosed mentally ill for 3-4 years, while those > 5 years were the least (15.2%).

Patient who did not knew that they are mentally ill (56.9%). were the majority, while those that knew that they were mentally ill (43%) were few.

Majority of patients (59.8%) that relapsed did not take their treatments as prescribed on discharge, major reason for not taking the treatment (44.2%) being those who felt better and stopped.

**Figure 5: drug use among relapsing patients.**

61.2% of patients abused drugs, and majority (38.8%) abused alcohol, while 11.1% marijuana and 20.3 were cigarette smokers.

**Table 6: community factors associated with relapses.**

<table>
<thead>
<tr>
<th>Community factors associated with relapses.</th>
<th>frequency n=72</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free social involvement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>38</td>
<td>52.2</td>
</tr>
<tr>
<td>No</td>
<td>34</td>
<td>47.8</td>
</tr>
<tr>
<td>Community outreach services to foster mental wellbeing away from hospital?</td>
<td>n=72</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>no</td>
<td>70</td>
<td>97.2</td>
</tr>
</tbody>
</table>
Majority of study population (52.2%) freely socialized with community members within their community, while 47.8% did not freely socialize with their community members.

Majority (97.2%) admitted that they did not have community outreaches to foster mental well being within their community.
CHAPTER FIVE: DISCUSSION OF RESULTS

5.0 Introduction

This chapter discusses the results of the study “Factors contributing to increased relapses among mentally ill patients attending mental health unit at Kampala international university teaching hospital” by comparing and contrasting with studies done by other scholars on relapses of mental illnesses in Uganda and all over the world, conclusions, recommendations and implication to nursing practice.

The findings are arranged following demographic characteristics from the study participants, and objectives of the study topic.

5.1.0 Demographic characteristics of the study population.

Majority of respondents were males with 59.7%, while females were only 40.3. There is no scientific clear cut difference in prevalence of mental illnesses and their relapses basing on patient’s sex.

Age 21-40 formed the majority (52.7%) of the respondents, while those >60 were the least with 1.3% similarly to the research conducted on prevalence and associated factors for relapse among mentally ill inpatients at Emmanuel Mental Specialized Hospital that revealed that the mean age of the respondents who relapsed was 31 years (Yihunbelay Dinku, 2014). This could be because, at this age, as more responsible a man grows, more stresses like how to independently handle daily life, meeting all life’s demands and coping with stresses becomes inevitable. These directly or indirectly affect psycho-social functioning of an individual. If not in hand handled carefully with psycho therapy, end up aggravating mental illness or relapses in formerly mentally ill patients. This is contrary to Kazidi et al (2008) in south Africa who found out that mean age of patients who had mental illness relapse were aged 42.5 years.
Majority of the study participants were Catholics with 41.6%, followed by Protestants who were 36.1%. This could be uniform distribution of the study population in the study area. Religion of respondents may not directly contribute to relapses in mental illnesses, but has a capacity to contribute to mental health and mental well being bases on beliefs towards causes and sources of relapses, positive attitudes towards treatment of mental health will control relapses, where as beliefs that are negative towards mental illness treatment will greatly contribute to relapses.

Majority of participants were Banyankole with 63.8%, followed by Bakiga with 25% of the participants. This could be possibly because of the study area being located in the region of Ankole majorly inhabited by these tribes dominantly. There is no scientific evidence so far on relationship between individual’s ethnicity and mental illness relapses, however, different tribes see mental illness, its causes and methods of management differently. There is no distinct view of Banyankole ethnic group on mental illness relapses, but if there and unpublished, has a major influence on incidence of relapses in this particular study population. However, in areas where culture and beliefs has been studied in relation to relapses, Among South Africans, cultural and social attitudes and belief systems are speculated as common reasons for increased cases of relapse among the mentally ill (Moosa, et al, 2008)

Majority of the respondents (68%) had had primary level of formal education, and only 5.5% of the participants had had tertiary education. there is a significant low level of formal education in this study population. This could be possibly because, these having been mental ill persons, could have encountered mental and cognitive functions disorders in early schooling that could have possibly forced dropping out at these low levels. Relapses are more expected in this community because, with low education, goes with inadequacy in knowledge
regarding mental illness, adherence importance in preventing relapses, among others which may increase relapses. This contrary to findings in South Africa where About 30.6% of patients who relapsed had achieved a primary level of education, and 48.5% a secondary level of education (Kazidi et al 2008)

5.1.2 Social-economic characteristics.

Most of the study population were single (56.9%) followed by divorced (23.6%) while only 1.3% had separated but not divorced with their spouses. This could be possibly because, having been mentally ill, may be suffering from community pressure including rights to marry and rights to be married which may be contributing to their social stressing factors resulting into relapses of previously suffered mental illnesses.

There is an extremely high incidence of divorce among relapsing patient compared to general population. This may indicate family problems among homes of relapsing patients leading to rejection, stress, denial, and violated right which increases chance of relapsing as result of lack for social support and psycho sexual challenges beyond these individuals copying mechanism which catalyzing incidences of mental illness relapses.

Similarly to Moran M (2009) who found out that mental illnesses is a major clinical event and commonly affects the personal and social functioning of the person, Most of participants (51.3%) did not have good relationship with their family members; this could be due to how these relapsing patients behaved in their previous illness period that may deteriorate relationship with their family members. Others still fail to socially recognize previously mentally ill members of family even when they have been discharged from health facility, and still take them as mentally ill. This is embarrassing to cope with, and make these persons
feel out of place, which disorganize their copying mechanisms, increasing stress, resulting into relapsing of mental illnesses.

Majority of study population (54.1%) live in semi permanent houses of (trees, mud and iron sheets), followed by those who live in unfinished permanent houses of bricks, mud and iron sheets (27.7%). while majority of the study population(43.0%) can afford 2 meals per day, while 20.8% and 26.8% can afford 3 meals and 1 meal per day respectively.

There is significant lower social class among these relapsing patients, characterized by poor housing facilities which indicate poor economic bargaining and purchase power, resulting to stresses related to failing to meet daily life requirements, poor and inadequate feeding which hinder sound mental developments and copying mechanism hence may easily result into relapses, and stressing environment. All these have a direct impact on mental health and preventing previously mentally ill patients from relapsing.

Majority of respondents live 1 person per room (65.2%) while only (13.8%) of respondent live more than 1 person per room, this indicate low social interaction with other members of their community. This create a sense of loneliness and rejection, creates a gap in social adaptation by the patients hence increasing chances of relapsing to previously suffered diseases. This is similarly to Lily’s findings on factors leading to relapse included lack of social support, grief following the loss of a close family member, lack of employment, poor procurement processes, and lack of resources, poor planning, stigma and lack of specialized psychotherapies at primary health care level (Lilly 2008).

Most of the study population (77.7%) is peasant farmers, followed by 5.5%, 5.5% who are businessmen and civil servants respectively, and 11.1% are students. this indicate low social economic status among most of the population which could be simply because, individuals
who are sometimes mentally sick in their cannot fully concentrate on sole businesses which whose standing depends on their mental capacity in terms of affect and cognitive functioning.

Uganda is a low-income country with the average per capita income of USD 300, with 31% of the population living below the poverty line. This economic situation has implications for mental health and such as poverty, has a dialectical relation, reinforcing and exacerbating each other and a precipitant to mental illness relapses. (Kigozi, et al., 2010)

This has a negative impact as far as triggering mental illness relapses is concerned. Low social economic status is greatly associated with social economic pressure to meet daily life demands which can trigger relapses of anxiety disorders, mood disorders, and most of other neurotic disorders.

Most of study population (70.8%) work for 7-12 hours, followed by those that work 1-6 hours (25.0%). This is a good working hour length in that it gives enough time for resting. Majority of the study population earn between 1-100000 shillings monthly, followed by those who completely don’t earn from their work monthly, while only 1.3% earn 400001 shillings from their work monthly. This indicate that a low income per capital by most of the study population. Hence meets a lot of economic challenges to meet their daily cost of living. This may be associated with failure to meet their medical bills after discharge from facilities hence dropping out care, failing to meet nutritional demands that aid proper mental functioning, failing to access treatment cost which leaves them exposed to relapsing. Therefore most of the families for patients with mental disorders cannot afford maintaining therapy appointments or the cost of their medications hence increased rates of relapses (Ssebunya, et al., 2012).
The burden posed by these disorders on the mentally ill persons, the care givers (parents, family members) and the health workforce, as well as the requirement for resources, may further worsen the already poor economic conditions of the people and many families. Therefore most of the families for patients with mental disorders cannot afford maintaining therapy appointments or the cost of their medications hence increased rates of relapses (Ssebunya, et al., 2012).

Most of the people in the study population (59.7%) did not have at least a group where they belonged, while 40.1% of the study population had. Social groups act as social therapy to create a sense of belonging into a community, relieving stressful situations and helping mentally recovering patients to cope hence thereby improving on well being, and preventing stress. It’s unfortunate that majority of the study population had no group of social belonging, this leaves them un supported in case of stresses, and copying with normal life following recovery from mental illnesses hence leaving them exposed to relapsing. This finding is similarly to (Magura, et al., 2013), finding that reported that low friends’ support for drug/alcohol abstinence and lack of more recovery-promoting behaviors, contribute to relapses among individuals with substance abuse problems.

5.1.3 Mental disorders and other medical conditions that are associated with relapses.

Thought disorders comprising of schizophrenia, schizophreniform, and delusional disorders were the most associated with relapses with 36.1% of all relapsed patients, followed by bipolar disorders (mood disorders that include the occurrence of depressive episodes and one or more elated mood episodes.) with 36.3%, while somatoform disorders(Somatization disorder, Undifferentiated somatoform disorder, Conversion disorder, Pain disorder, Hypochondriasis, Body dysmorphic disorder and Somatoform disorder not otherwise specified) were least associated with relapses. This is similarly to Weret et al’s finding that concluded that Major
mental disorders associated with relapses include: depression, bipolar affective disorder, schizophrenia, drugs and substance abuse (Weret et al 2014), this is also similarly to Emsley et al 2013, Xiao et al 2015 that (Emsley et al., 2013) in the United Kingdom, patients with First Episode Psychosis (FEP) have a high rate of relapse in their first year after the onset. In China by (Xiao, et al., 2015) relapse is common in schizophrenia, and seriously impacts patients’ quality of life and social functioning.

Relapses in schizophrenic psychotic mental disorder among mentally ill patients may be due to their genetic makeup as there is evidence that An increased risk of schizophrenia is seen in individuals with genetic variation in the catechol-O-methyltransferase gene, which is involved in the manufacture of an enzyme that metabolizes neurotransmitters. Other current candidate genes include GRM3, DISC1, dysbindin, and neuregulin. This implies that even following appropriate treatment, therapy to control influence of such genes need to be maintained. In case of absence of this therapy, relapses are likely to re-occur due to these genes already present in previously mentally ill patient

However, little has been established about the etiology of delusional disorder, there is no demonstrated genetic linkage; it is possible that psychosocial stressors have a role in the etiology of delusional disorder in some persons. This is illustrated in some of the rarer conditions such as shared psychotic disorder.

HIV was the co-morbidity associated with relapses with 33.3%, followed by malaria and puerperium and other chronic disorders with 16.6% and 16.6% respectively, HIV is greatly associated with worries which increase stress and may trigger delusional and illusional behaviors among patients if not under proper counseling, its greatly associated with other infections like meningitis (Fungal and mycobacterial meningitis) or even rapidly causing HIV induced psychosis as a relapse in patients that had previously recovered compared to their
HIV sero negative counterparts that has no this relapse triggering factors. This is similarly to findings by Jeenah et al that cerebral involvement in infectious diseases, like malaria, typhoid fever or human immunodeficiency virus (HIV) infection all of which have relapse tendencies. (Jeenah et al., 2008).

Majority (36.1%) of patients that relapsed had been diagnosed mentally ill for 3-4 years, while those > 5 years were the least (15.2%).

Patient who did not knew that they are mentally ill (56.9%) were the majority, while those that knew that they were mentally ill (43%) were few.

Majority of patients (59.8%) that relapsed did not take their treatments as prescribed on discharge, major reason for not taking the treatment (44.2%) being those who felt better and stopped.

1.4 Personal and community related relapses.

Majority (36.1%) of patients that relapsed had been diagnosed mentally ill for 3-4 years, while those > 5 years were the least (15.2%). This could be because; these having been on anti-psychotics for long develop tolerance to their maintenance doses, hence failing to meet their desired anti-psychotic effects to the patient thereby resulting into relapses similarly to Moosa, et al, (2008) that patients that had been diagnosed and on therapy for long were more likely to relapse than those with shorter periods.

Patient who did not know that they were mentally ill (56.9%). were the majority, while those that knew that they were mentally ill (43%) were few similarly to Kane et al (2013) who found out that Non-adherence is highly influenced by patient knowledge, attitudes towards their illness, that is illness insight play a major role in adherence behaviors (Kane, et al., 2013). This could be because, these not knowing that they were mentally ill, lack knowledge on mental illness, cause and treatment modalities. Lack of insight into ones mental health condition is
associated with poor or non compliancy to therapy, and involvement into risky behaviors that could be resulting into relapses similarly to findings by (Kazadi et al 2008) The factors associated with poor adherence and to treatment and relapses in the diagnostic group under review in Johannesburg Poor insight that contributed to a 5.2-times increase in the risk of relapse (Kazadi et al 2008)

Majority of patients (59.8%) that relapsed did not take their treatments as prescribed on discharge, Not taking treatment among mentally ill patients could be associated with various factors including drug side effects, pill burden among those with others medical conditions, poor social economic status hence failing to meet the coast for long periods of treatment, among others. However, not taking treatment as per health workers advice can be associated can result into necessitating relapsing of mental illness symptoms requiring re-hospitalization

Similarly to findings by zewdu et al (2014) on factors associated with relapses among schizophrenic patients in Emmanuel mental specialized hospital, Addis Ababa, Ethiopia that non-adherence have a significance association with relapse of schizophrenia [AOR (95% C.I, 2.80(1.58, 4.96)]. The prevalence of relapse of schizophrenia is a common and major problem in Ethiopia and factors that are associated with relapse are depression, drug non adherence.

Major reason for not taking the treatment (44.2%) being those who felt better and stopped. Patients feeling betters and stop treatment may be because of inadequate counseling on drug adherence, financial burden related to high cost of atypical antipsychotics, among others. Absence of mental symptoms is not an indicator of complete cure of mental illnesses, hence patients stopping taking their treatment cause re-occurrence of mental illness symptoms resulting into relapses. The finding is contrary to (Kazadi et al 2008) where in Johannesburg, south Africa on factors associated with relapses in schizophrenia, The factors associated with poor adherence were medication side-effects and lack of insight.
61.2% of patients abused drugs, and majority (38.8%) abused alcohol similarly to Kazadi et al (2008) and Weret et al 2014 finding in South Africa that alcohol abuse and cannabis abuse were reported as significant factors that contributed to relapse in all mental illness in acute psychotic states (Kazadi, et al, 2008). Drugs can be influence poor adherence as found by (Magura, et al., 2013). Drugs also may directly or indirectly affect mental functioning of an individual ranging from simple CNS activation or mental impairment. Whatever the immediate effects of any abused drug, peak concentration of the drug into nervous system of an individual alters mental functioning that results into simple disorder to drug induced psychoses and dependency. However, in previously mentally ill individual, these symptoms are even more likely to occur than mentally healthy individuals’ hence precipitating occurrence of relapses. Similarly to Razali et al(2010) that in patients with an established psychotic disorder, Drug abuse is associated with a higher risk of psychotic relapses and with poorer social outcomes. Cannabis use has been reported to increase positive symptoms in schizophrenia (Razali, et al 2010).

Majority of study population (52.2%) freely socialized with community members with in their community, while 47.8% did not freely socialize with their community members. This be could an indicator that the community has no bias on mental illness and have confidence in therapy given to these patients. Hence they do not segregate them after they have been discharged from the facility. Patients feel welcomed into their communities resulting into them actively socializing with other members of the community, this also controls stigma that could result from bias and segregation from community. Community socialization and involvement builds a great sense of trust hence preventing feelings of hatred among previously mentally ill patients, help patients cope with occupational and family hence preventing stress related relapses. The finding is contrary to Razali et al (2010) who concluded that from Asia-pacific, a strong stigma towards mental patients and the influence of traditional leaders aggravates the adherence
problem. It's also contrary to Moosa, et al, (2008) where among South Africans, cultural and social attitudes and belief systems are speculated as common reasons for increased cases of relapse.

Majority (97.2%) admitted that they did not have community outreaches to foster mental well being within their communities. Community outreaches and community based mental health care can be a big deal in promoting mental health and preventing relapses among previously mentally ill patients through health education and counseling, linkage of discharged patient to his/her family and community, employers among others. This could help patients to cope with normal life easier and faster, thereby preventing relapsing. However, without these supportive community based management, patients can be faced with challenges ranging from being rejected by their family members, losing their jobs and positions in the community, and exacerbation of simple symptoms that can result into mental illness relapses and re-hospitalization. Similar to Nosopho (2013) that found out that among factors contributing to relapses mental cases in Nkonkobe Local Service Area at Debe nek and zihlahleni clinics in the eastern cape province was lack of community outreach due to lack of transport to these communities.
5.2 Conclusions

The study titled factors contributing to relapses among mentally ill patients enrolled on mental health care in KIU-TH found out the following:

The study basically consisted of majorly males, mean age of participant 20-40 years. With Banyankole, catholic faith dominating the study population, there was a significant low level of formal education with majority having primary level and less.

Single men were the majority, and majority of the study population were reported to have not had a good relationship with family members which could be one of aggravating factors to relapses. Majority of relapsing patients are of low social economic class, with less social support from family members. The majority work for reasonable length of time and get time to rest, but earn less from their work which leaves their needs unsatisfied.

Thought disorders (schizophrenia, schizophreniform and delusional disorders) and bipolar disorders were the most reported associated with relapses among all other mental disorders, an implication that genetic makeup of patient has a factor it does contribute to relapsing mostly in schizophreniform disorders. HIV and malaria medical conditions greatly associated with relapses.

Patients who adhered to treatment were least likely to relapse, where as those that had for not adhered to chemotherapy were relapsing greatly. Poor adherence to drugs was due to patients who feeling better and ignore taking treatment. Drug abuse especially alcohol was also associated with relapses. Patients freely socialized with other members of their communities following discharge; however, relapses were also associated with scarcity of mental health services within patients’ communities.
5.3 Recommendations

To KIU-TH psychiatry unit management

I recommend that all therapists in mental health unit work hand in hand to educate all caretakers and patient with insight and proper cognitive function on importance of adherence to all forms of therapies as advised by health care provider in preventing relapses, so as patient can adhere to treatment and other forms of therapies to avoid relapses. Emphasizing on continuing treatment even when symptoms subside.

I recommend that adherence counseling be emphasizes in patients that have recovered from most relapsing mental disorders like delusional and schizophreniform (psychilytic) disorders to curb on their rate of relapses, and emphasis on continuing treatment as advised by health care provider be ensured.

I recommend that community outreaches be initiated to areas of patients whom they discharge to help them cope, rule out any other minor complaints and manage them before patient relapses to hospitalization.

To the caretakers of the patients.

I recommend that family bond and social support be accorded to all mentally rehabilitated patients to help them develop a sense of belonging to a family and community, thereby avoiding paranoia and avoidance behaviors and their related relapses.

I recommend that as part of rehabilitation, social support groups be created within the community, where these people can gather, exchange ideas, carry and share life burdens there by reducing worries and stresses related to tackling challenges individually. This will help greatly to reduce stress related factors.
To the community.
I recommend that formal education be empowered to develop minds that can easily cope, handle daily life’s stress and live self supported and positively contribute to community without being broken down by life’s challenges.

I recommend that drugs and drug abuse be closely controlled and restricted from members of community in order to avoid their related challenge that include causing and aggravating mental illnesses and their relapses to patients that had previously recovered from mental illnesses.

To the government through ministry of health Uganda.
I recommend that drugs that directly or indirectly negatively affect the mental functioning of individuals be restricted or legalized within the Ugandan communities in order to avoid their related challenges like mental illness and relapse among users and abusers.

I recommend that planning regarding financing community based mental health care be initiated to control mental illness aggregating factors among members of the community and prevent relapse among those that have recovered from symptoms of mental illnesses.
5.4 Implication to nursing practice.

To nursing practice.

Practicing nurses should put much emphasis on integrating caretakers of mentally ill patients, so that they can learn together how to provide holistic care to mentally ill patient to avoid paranoia related to feeling neglected and lack of sense of community belonging. This will help patient cope with normal life easily, enable them solve stresses, and live productive life for both formerly patient and his/her community.

Co-illnesses that are associated with relapses like HIV and Malaria should be managed holistically taking care of physiological and psychological needs of patient in order to relieve stress related to them, and prevent cerebral impacts of these illnesses like cerebral malaria, creptococcal meningitis, TB meningitides there by reducing their potential to induce relapses of previously mentally ill individuals.

To nursing research.

Nursing researchers should comprehensively study factors affecting therapy adherence among stabilizing mentally ill patient in order to elaborate why there are sudden refraction from taking treatment and other therapies behaviors associated to relapses.

To nursing education.

Nursing education should emphasize on communication at all levels of nursing training and nursing care. this will bridge the gap between nurses, patients and caregivers there by allowing freely sharing needs, fee counseling that will result into adherence to all forms of therapies and caretaker involvement in patient’s care there by allowing continuity of care to patient even long after he/she is discharged from psychiatry unit.
REFERENCES


http://www.nimh.nih.gov/publicat/burden.cfm


Mahamba ND(2010) “Factors influencing relapse of psychiatric outpatients in the rural communities of the Eastern Cape Province” Scholarly article Debe Nek Clinic pg 58 volume 14 no 2 Division of Psychiatry, University of the Witwatersrand, Johannesburg.


APPENDICES

Appendix 1: consent form

I am Muhindo Scovia, a student of Kampala International University western campus.

I am conducting research on Factors contributing to increased relapses among mentally ill patients attending mental health unit at Kampala International University Teaching Hospital Ishaka Bushenyi. Your participation in this study is voluntary and you have a right to withdraw at any time. The interview requires about 20 minutes of your time and I will be available to clarify on any information or questions that will not be clear and if anyone needs further information, it will be provided. Your identity shall not be revealed and all information collected will be treated with ultimate confidentiality. Your participation is voluntary and you can choose to end the session at any time.

This consent form has been read and explained to me and I voluntarily consent to participate in this.

Respondents’ signature…………………………………………….. Date……………………
Appendix II: Questionnaire

A questionnaire to investigate the Factors leading to increased cases of relapse among patients with mental disorders at Kampala International University Teaching Hospital Ishaka-Bushenyi.

SECTION A: SOCIAL DEMOGRAPHIC FACTORS

Please TICK the alternative that represents you where necessary.

1 Social demographics statistics of the respondents.

<table>
<thead>
<tr>
<th>characteristic</th>
<th>Others specify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex of participant.</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>How old are you?</td>
<td></td>
</tr>
<tr>
<td>0-20</td>
<td></td>
</tr>
<tr>
<td>21-40</td>
<td></td>
</tr>
<tr>
<td>41-60</td>
<td></td>
</tr>
<tr>
<td>&gt;60</td>
<td></td>
</tr>
<tr>
<td>Which religion do you belong to?</td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td></td>
</tr>
<tr>
<td>Pentecostals</td>
<td></td>
</tr>
<tr>
<td>African traditional religion.</td>
<td></td>
</tr>
<tr>
<td>Muslims</td>
<td></td>
</tr>
<tr>
<td>Which tribe are you?</td>
<td></td>
</tr>
<tr>
<td>Munyankole.</td>
<td></td>
</tr>
<tr>
<td>Mukiiga.</td>
<td></td>
</tr>
<tr>
<td>Mutooro.</td>
<td></td>
</tr>
<tr>
<td>Muganda.</td>
<td></td>
</tr>
<tr>
<td>Others.</td>
<td></td>
</tr>
<tr>
<td>What is your level of education?</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td></td>
</tr>
<tr>
<td>Tertiary</td>
<td></td>
</tr>
</tbody>
</table>
SECTION B: SOCIAL ECONOMIC FACTORS

2 Social and economic status of the patient. (TICK RIGHT corresponding to the choice of your answer)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your marital status?</td>
<td>single, married, divorced, Separated</td>
</tr>
<tr>
<td>How is your relationship with other family members?</td>
<td>good, fair, bad</td>
</tr>
<tr>
<td>Which type of house do you reside in?</td>
<td>mud, trees and grass, trees, mud and iron sheets, bricks, sand and iron sheets, plastered brick wall, iron sheets and cemented floor</td>
</tr>
<tr>
<td>How many people do you live within your room?</td>
<td>1, 2, &gt;2</td>
</tr>
<tr>
<td>How many meals do you eat per day?</td>
<td>1 meal, 2 meals, 3 meals, &gt;3 meals</td>
</tr>
<tr>
<td>What is your occupation?</td>
<td>peasant, civil servant, businessman/woman, student</td>
</tr>
<tr>
<td>How many hours do you work per day?</td>
<td>1-6, 7-12, 13-18, &gt;18</td>
</tr>
<tr>
<td>What is your monthly earning?</td>
<td>01-100,000/=, 100,001-200000/=, 200,001-300000, 300,001-400,000, 400,001 and above</td>
</tr>
<tr>
<td>Do you have any social group where you belong?</td>
<td>with a social group where he belongs, without a social group where he belong</td>
</tr>
</tbody>
</table>
SECTION C: Mental illnesses and co-morbidities associated with relapses. (TICK RIGHT; seek clear clarity from care taker)

<table>
<thead>
<tr>
<th>How was the patient presenting during previous illness?</th>
</tr>
</thead>
<tbody>
<tr>
<td>sometimes happy, other times sad</td>
</tr>
<tr>
<td>Behaviors not related to situations at hand.</td>
</tr>
<tr>
<td>worries, anxiety and fearful</td>
</tr>
<tr>
<td>always had a complaint of sickness/pain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Which other health related challenge did the patient have that you think precipitated this re-occurrence?</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
</tr>
<tr>
<td>Puperium</td>
</tr>
<tr>
<td>Malaria</td>
</tr>
<tr>
<td>Meningitis</td>
</tr>
<tr>
<td>other chronic illnesses like diabetes, hypertension</td>
</tr>
</tbody>
</table>
SECTION D. Personal and community factors associated with relapses.(TICK RIGHT as corresponding to answer given)

<table>
<thead>
<tr>
<th>personal factors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For how long has the patient been diagnosed mentally sick?</td>
<td></td>
</tr>
<tr>
<td>&lt; 1 year</td>
<td></td>
</tr>
<tr>
<td>1-2 years</td>
<td></td>
</tr>
<tr>
<td>3-4 years</td>
<td></td>
</tr>
<tr>
<td>≥5 years</td>
<td></td>
</tr>
<tr>
<td>Does the patient know and admit that he was mentally ill?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Did the patient take his/her treatment as was prescribed following discharge?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If No from question above, what was reason for not taking the treatment?</td>
<td></td>
</tr>
<tr>
<td>High costs of drugs</td>
<td></td>
</tr>
<tr>
<td>Sometimes forgets</td>
<td></td>
</tr>
<tr>
<td>Felt better and stopped</td>
<td></td>
</tr>
<tr>
<td>Had serious side effects</td>
<td></td>
</tr>
<tr>
<td>Does the patient use any of the following drugs apart from prescribed treatment from a health worker?</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
</tr>
<tr>
<td>Cigarettes smoking</td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
</tr>
<tr>
<td>Cart chewing</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
</tr>
<tr>
<td>Do people in your community freely interact with him/her?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Are there community outreach services to foster mental well being away from hospital?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

THANK YOU FOR YOUR TIME.
Appendix IV: SCANNED AUTHORISATION LETTER TO CARRY OUT THE RESEARCH STUDY

TO WHOM IT MAY CONCERN

Dear Sir/Madam

RE: MUHINDO SCOVIA - ENS/E/6104/162/DU

The above mentioned is a student of Kampala International University – School of Nursing Sciences undertaking Diploma in Nursing Science and she is in her final academic year.

She is recommended to carry out her data collection as a partial fulfillment for the award of the Diploma in Nursing Science.

Her topic is FACTORS CONTRIBUTING TO INCREASED RELAPSES AMONG MENTALLY ILL PATIENTS ATTENDING MENTAL HEALTH UNIT AT KAMPALA INTERNATIONAL UNIVERSITY TEACHING HOSPITAL.

Any assistance rendered to her will be highly appreciated.

Thank you in advance for the positive response.

17 AUG 2017

Namahisa Sarah

RESEARCH COORDINATOR
APPENDIX V: The Map of Uganda showing location of Bushenyi where KIU-TH the hospital with study population is located.
APPENDIX VI: MAP OF BUSHENYI DISTRICT SHOWING LOCATION OF KIUTH

Showing location of KIU-TH
Appendix V1I: The Map of Ishaka Town
Appendix VIII: The Psychiatry Department of Kampala International University Teaching Hospital Ishaka Bushenyi.