EXPLORING THE PERCEIVED VALUE OF WORK AS PART OF PSYCHOSOCIAL REHABILITATION OF THE STATE PATIENT: KOMANI HOSPITAL, QUEENSTOWN

A thesis submitted in partial fulfilment of the requirements

for the degree of

MASTERS IN SOCIAL SCIENCE

IN THE DEPARTMENT OF SOCIAL DEVELOPMENT

RHODES UNIVERSITY

Anna Petro Crocker

January 2002

ABSTRACT

During the research an attempt was made to gain an understanding of the perceived value of work in psychosocial rehabilitation with the Sate patient at Komani Hospital. The respondents' motivation to work and what they gain from working, was investigated, as well as the experience of the non-working respondents and their motivation not to work.

To achieve this, ten respondents who were working and ten respondents who were not working, were interviewed. This study involves only a limited number of State patients at Komani Hospital and therefore findings cannot be generalised and also because the study was done at one Hospital only.

A literature study was undertaken during which it was evident that work as part of vocational rehabilitation contributed to the well being of the mentally disabled person. It was also stated in the literature that the disabled person must be actively involved in his/her own rehabilitation planning and that the person must make conscious decisions to move away from the "sick" role and participate in his/her rehabilitation process.

Interview schedules were developed. Response received from the twenty participants was analysed. The overall findings of the study showed that the majority of respondents who were working, were motivated by money. The fact that the respondents work from Hospital and therefore disrupt the Hospital routine, work with abled co-workers and feeling needed by the factory where they are employed, also emphasised the respondents' motivation to keep on working.

The findings of the study with the non-working group showed that some respondents want to work, but there are not enough work opportunities available in and from Hospital. The non-working respondents are not interested in working at the occupational therapy department because the pay patients get for work done at the department is too little, and therefore they reject the work there. Some respondents do not want to work, whether work is available or not. The non-working group is largely dependent on staff and co-patients for an income, or tobacco. The predominant activity of the non-working group of respondents during the day, as well as that of the majority of the working group respondents during weekends was sleeping, talking to friends, and smoking.

The research findings, conclusions and recommendations could contribute to a better understanding of patients and the value of work for the patient in a Psychiatric Hospital.

ACKNOWLEDGEMENT

I would like to express my sincere appreciation to the following people who supported and encouraged me throughout this research process;

My study leader, Dr Felicity Coughlan, Rhodes University, thank you for all the invaluable and unstinting guidance, knowledge, support and encouragement.

The Superintendent of Komani Hospital for allowing me to undertake this study at the Hospital.

To all the participants, for so willingly sharing their experiences in assisting me in this study.

To my friend Carol van der Mescht, thank you for the linguistic editing of this study, your support and always being available.

To all the staff members of the Social Work Department, thank you for your assistance and encouragement. To the Library staff at Rhodes University, East London, thank you for your kindness and assistance. To Mrs. J. Richter, for the editing of my thesis.

Aan my pa, dankie vir al die jare se opoffering, motivering en ondersteuning aan my. Aan my familie en vriende dankie vir jul ondersteuning.

Aan my vriendin en mede-student Tyzie, dankie vir alles, ons het "memories" gemaak.

Aan Harry en Anje, dankie vir al julle ondersteuning, geduld en opoffering. Dankie Anje dat jy jou rekenaarvaardighede met my gedeel het.

Aan God al die eer!

LIST OF TABLES

TABLE OF CONTENTS

CHAPTER 1

1.1 INTRODUCTION

The psychiatric rehabilitation process for the State patient usually consists of the diagnostic, planning and intervention phase of which vocational rehabilitation is a part. The patient forms part of his own rehabilitation plan, which is usually formulated by the multi-disciplinary team. The different skills of the patients, which include working skills and habits, are usually developed. In some instances work is available as part of the process and in this instance, patients are able to choose whether or not to work.

I wanted to explore with the State patients that chose to work, what is it that motivates them to work and what do they get from working and, on the other hand, explore with the non-working patients why they are not working. Through this exploration of the patients' view, the value of work in psychosocial rehabilitation would be reviewed. Any knowledge generated by this research could be used to benefit patients in hospital by promoting the motivation of patients to work and to gain insight into how they benefit from working. Patient's motivations not to work will be investigated and presented. This information may benefit the multi-disciplinary teams by gaining insight into the motivation of patients.

1.2 REASON FOR THE CHOICE OF THE RESEARCH SUBJECT

My interest in the subject of the perceived value of work in psychosocial rehabilitation with the State patients originated when I was employed as a social worker, rendering services to some State patients at Komani Hospital, Queenstown.

The State patients have stimulated my interest in exploring the motivation and attitudes on work of working- and non-working State patients and how this falls into the psychosocial rehabilitation programme of the patients.

1.3 OBJECTIVES OF THE STUDY

The objectives of this research are:

- To gain a deeper understanding of what motivates the State patient to work.
- To explore what the State patient gets from working, and why do they keep on working?
- How, if at all, did work change their lives?
- To gain understanding of why some State patients do not work and what they think will motivate them to work.
- To make recommendations regarding the value of work for the State patient.
- To make recommendations for further empirical research studies.

1.4 RESEARCH METHODOLOGY

I decided upon an exploratory research design because this study focuses on a relatively under-studied topic. Oppenheim indicates that exploratory research is concerned with trying to understand how people think and feel about the research topic (1997: 67).

I made use of a qualitative research method, which embarks on a voyage of exploration, and how the experience of others can best be represented. I gathered and presented data in such a way that the respondents used in the study speak for themselves (De Vos 1998: 243-245). The subjective and unobtrusive approach to information gathering in qualitative methods is close to traditional social work, and this was also a motivation to use this method as the researcher is familiar with these methods (Grinnell 1988: 193).

I used a purposive non-probability sample procedure to choose ten voluntary State patient respondents, who were working for a period of six months and more, and ten State patient respondents who were not working. Using purposive sampling one can make sure that the sample meets the criteria needed for the research (De Vos 1998: 198).

A semi-structured interview schedule was developed on the basis of the literature reviewed. The interview schedule was used as a method of gathering data for the study using mostly open-ended questions to enable the respondents to reflect their understanding of the questions asked (Marlow 1998: 160).

The semi-structured interview schedule consisting of open-ended questions was chosen by me in order to have a certain amount of control over the interview and to cover the topics in the

interview (Rubin and Babbie 1997: 192).

I held preliminary interviews with two members of each group, two working respondents, and two non-working respondents, to ascertain whether the items on the interview schedule were of significance to them. The two respondents of the non-working group both indicated that they did not work, because there was no work available. I then decided to change the question from why they choose not to work to why they are not working. Ten other non-working respondents were then interviewed.

The interviews of the working respondents were held at their workplace at the factory in an administration office where control of the environment was possible. This venue was chosen because the factory manager agreed that the respondents could do the interviews during working hours without losing any pay, otherwise they would be absent from work. The non-working respondents' interviews were held in a vacant office in the occupational therapy department.

Only male Xhosa-speaking State patients do industrial therapy from hospital, therefore the choice of respondents. No Afrikaans or English-speaking State patients are interested in doing industrial therapy. No industrial or occupational therapy is available for female State patients at Komani Hospital. The ten working respondents were Xhosa-speaking, with one English-speaking non-working respondent. I decided to make use of an interpreter to make sure that the respondents understood the questions and that I understood their response. I had worked with the interpreter before which made the planning and working relationship easier. Pedersen et al (1996: 248) states that translators must not only be carefully trained but must have a well-defined partnership with the mental health professional. They add that in the communicative processes, two sub processes are involved: (i) probing for insight, the focus on probing should be on self-experience, motivations, strengths, coping patterns, and identity goals. The pieces of information are put together and feedback is received from the client about the accuracy of the information. (ii) conveying accurate understanding, the counsellor conveys his understanding of what the client meant, back to the client. In the planning of the interview schedule and in the choice of an interpreter, I was alert to what Scott and Borodovsky as cited in Pedersen et al) stated:
"Language differences become barriers when (a) the participants misconstrue the statements of one another, (b) negative pre-judgements by participants of one another are based on these differences, and (c) such differences are not experienced or appreciated as expressions of the client's cultural heritage and/or identity" (Pedersen et al 1996: 40). One Xhosa-speaking respondent from the working group and one Xhosa speaking respondent from the non-

working group preferred to answer in English. Ultimately, three of the twenty respondents answered in English.

Qualitative data produces a mass of detailed information in the form of words and this data must be subjected to forms of analysis that will make sense out of these words (Marlow 1998: 265). The information gathered from the respondents was divided into categories, similarities and dissimilarities and common themes and general norms. The data was then presented by utilising different presentation methods. Findings and recommendations were made from the data.

1.5 VALUE OF THE RESEARCH

With this study the researcher hopes to contribute to the literature on psychosocial rehabilitation of the State patient, and especially on the value of vocational rehabilitation to the State patient.

It is also hoped that this research will show possible areas of intervention for the management of Komani Hospital in the vocational rehabilitation programme planning. I feel that this research could show the State patients' areas of need in vocational rehabilitation.

The care of the State patient is expensive, as patients are usually cared for over a long period of time. If this research could contribute to the development of a constructive rehabilitation programme, it could lesson the time spent in hospital for the State patient, and save costs of caring for the patient.

1.6 PROBLEMS EXPERIENCED WITH THE RESEARCH

I made use of an interpreter to ensure that the respondents understood the interview questions and that they could respond in their own language. This meant that I was dependent on the interpreter and the times he was available to do the interviews. The interpreter is partly self-employed and the researcher had to pay for each interview.

1.7 LIMITATIONS OF STUDY

The findings of this research study cannot be generalised because of the relatively small number of respondents used. According to Creswell (1994: 162), qualitative research pays attention to particulars of a case rather than generalisations.

This study was done in only one hospital. It would have been beneficial to have interviewed respondents from other hospitals as well, as this study produces a limited picture of the experience of the working- and non-working State patients' work motivation and experience of being unemployed.

CHAPTER 2

LITERATURE STUDY

2.1 INTRODUCTION

Employment is believed essential to the recovery process for persons with mental illness. Little is known about what makes work meaningful for these patients. It is however certain that the value of work will vary in groups and individuals, and between patients and professionals (Strong 1998: 31).

Vocational rehabilitation as part of psychosocial rehabilitation is seen as a means of preparing the patient to return to everyday life. Work is an avenue of creating equally challenging conditions which patients have to face in the community. Work increases social status, reinforces notions of self-importance and competence. Work can also be seen as a ticket to social participation and acceptance. Work therapy done by the patient contributes to changing attitudes of staff and the community concerning the roles of persons with mental illness. Thus work is identified as one aspect that can promote the community re-integration of persons with mental illness, which is the ultimate goal of the State patients' rehabilitation (Modiba 2000: 11-13).

Literature on motivation to work and the motivation not to work will be reviewed. Psychosocial rehabilitation will be discussed as well as literature concerning the social worker's role in psychosocial rehabilitation with the State patient. During this literature study I hope to broaden the understanding of the research topic.

2.2 PSYCHOSOCIAL REHABILITATION

The World Health Organisation defines psychosocial rehabilitation as a process which aims to facilitate the optimum functioning of ill and disabled people. It implies both improving individual's competencies and introducing environmental changes in order to create a life of the best quality possible for people who have experienced a mental disorder, or have an impairment of their mental capacity which produces a certain level of disability (Reynolds in Foster, Freeman and Pillay 1997: 76).

Bachrach summarised different definitions of psychosocial rehabilitation as follows: "psychosocial rehabilitation is a therapeutic approach to the care of mentally ill individuals that encourages each patient to develop his or her fullest capacities through learning procedures and environmental supports" (Bachrach 1992: 1456).

From a South African point of view, Uys describes psychosocial rehabilitation "as the functional and social rehabilitation of people living with a psychiatric condition. Since psychiatric illness affects thoughts, feelings and perceptions, rehabilitation is the process of gaining skills lost or never learnt to be able to normalise relationships with the environment, people and situations, or to adapting to permanent loss of sections of a person's ability" (Uys 2000: 14).

The State patients at Komani Hospital qualify for psychosocial rehabilitation because of their illness or disability according to the above definitions. A combination of the above definitions of psychosocial rehabilitation is being used at Komani Hospital. The focuses are on utilisation of the individual's strengths and the active participation of the patient in the programme, so that the patient can develop to his/her full capacity. Skills development is provided. Participation in recreational and working programmes is encouraged. Environmental support is given as far as the limited budget can provide.

According to Uys the mission of psychiatric rehabilitation is, "To increase the functioning of persons with psychiatric disabilities so they can be successful and satisfied in their environments of choice with the least amount of professional intervention" (Uys 1997: 3-4).

Together with psychosocial rehabilitation I think it is appropriate to look into definitions of mental health because service delivery is aimed at improving the mental health of patients. The World Mental Health Organisation states that "The concept of Mental Health encompasses the notion of the optimum development and functioning of the individual allowing the realisation of aspirations and satisfaction of needs as well as the ability to change or cope with the environment within the context of family, cultural, social and community parameters" (Eastern Cape Mental Health Services 1999: 9).

The South African Federation for Mental Health states that, "Mental Health is a feeling of well-being and happiness that humanity strives to achieve throughout life, a feeling of satisfaction, contentment and generally feeling good about the things done. People who are mentally healthy trust others and accept them for who they are. They enjoy being part of the group but are also happy being alone occasionally. Mentally healthy people believe in

themselves (Eastern Cape Mental Health Services 1999: 9). It is interesting to note that there are some similarities with the definitions of psychosocial rehabilitation.

2.2.1 PSYCHOSOCIAL REHABILITATION AS PROCESS

Psychosocial rehabilitation is a process that evolves from the medical model of diagnosis/treatment to a counsellor/practitioner facilitation of the individual patient's recovery process. The individual's responsibility is the key and unless the individual makes a conscious choice to move forward and recover, it will not happen. There is still a need for medication and medical treatment and together with this, in the psychosocial model, the individual takes responsibility for the healing process with the guidance of the rehabilitation counsellor. The patient decides the next step from a list of options presented and through that the counsellor empowers and encourages the individual to make conscious choices. The individual must have a clear understanding of probable consequences of those choices (Crate 1999: 1-2).

Sullivan (1997: 184) says that it must be remembered that individual and cultural forces influence the understanding and response to disease and illness by the patient. This will force the professional to uncover patient's relevant personal and cultural variables that affect long-term prognosis. In rendering mental health services to the State patient, the multi-professional team at Komani Hospital is aware of the cultural differences of patients.

Together with the process of rehabilitation there are some concepts of rehabilitation that should be looked at. Bachrach (1992: 1456-1458) notes that psychosocial rehabilitation consists of the following fundamental and interrelated concepts:

(1) To enable an individual who suffers from long-term mental illness to develop to the fullest extent of his capacities.
(2) Psychosocial rehabilitation stresses the importance of environmental factors in the care of persons with long-term mental illnesses.
(3) The rehabilitation is oriented towards the exploitation of the person's strengths.
(4) To restore hope to the individuals whom because of their psychiatric illnesses suffered setbacks in functional capacity and self-esteem.
(5) The optimism about the vocational potential of the mentally ill individuals.
(6) To reach beyond work activities and to gain a full social and recreational life.
(7) Patients must be actively involved in their own rehabilitation.
(8) It is a process that is ongoing and must continue over time and must be conducted in the various settings in which the patients find themselves. The basic orientation of

rehabilitation is towards the individual patient and to realistically assessing the person's strengths, disabilities and working from there to maximise his potential. The needs of a mentally ill person and not the needs of a mentally ill population, must be the focus when planning a service.

Taking the process and concepts into consideration one may ask how this psychosocial rehabilitation can be achieved? Psychosocial rehabilitation should be achieved by some of the following:

- Improving social competence
- family support
- social support, including covering basic needs to housing
- social network
- leisure and employment
- reducing symptomatology through appropriate biopsychosocial treatment
- reducing iatrogeny, by diminishing the adverse consequences of treatment, including institutionalisation.

It is thus important to note that patient participation in the process of rehabilitation should be promoted, and their individual needs for personal development in everyday life, recreation and work should be met (Rankin 1991: 77 & Foster, Freeman and Pillay 1997: 77).

At Komani Hospital the above-named concepts are taken into consideration when developing rehabilitation programmes for State patients, sub-acute and long-term patients. Emphasis is placed on family support, because without family support the patient feels isolated, easily loses hope for discharge, feels unwanted, and has few goals to work for. Attention is also given to employment. Through these aspects the patient learns to socialise, develop a feeling of self-worth, develop a feeling of achievement and learns to focus on other things and not only on his illness. The programme includes appropriate biopsychosocial treatment, which reduces symptoms. The ultimate aim of the programme is to discharge the patient if possible and to prevent institutionalisation where possible.

The care of the State patient (forensic care) is extremely costly to a mental health service, as the State patients usually require hospitalisation for long periods with a relatively high level of staff support. The Eastern Cape Provincial Mental Health Service is of the opinion that State patient (forensic) care needs to be viewed as a specialist service and it should develop a range of community forensic services in line with the overall move towards providing more care in the community. Komani Hospital renders services mostly to the previous Transkei and

Ciskei areas, which are remote, where community services are limited, and where poverty is rife. These factors, together with transport problems and the lack of trained psychiatric nursing staff in the community clinics, make ideal services delivery difficult. Family members have to travel long distances to the hospital to visit patients. Family members sometimes live in poverty and cannot provide for the patients over long periods of time without financial assistance. State patients cannot receive a Disability grant before they are discharged and these places a further financial burden on the family while the patient is on leave for periods of one to three months. The Komani Hospital provides transport for State patients to their family for visits when transport is available (Eastern Cape Mental Health Services 1999: 13).

2.2.2 PSYCHOSOCIAL AND PHARMACOTHERAPY

Psychosocial rehabilitation programmes must make the most effective use of pharmacotherapies. It is the competent and judicious prescription and monitoring of drugs that may start the reversal of primary symptoms and allow intervention at other levels. Unless the primary symptoms are under control, rehabilitation intervention will have little success (Bachrach 1992: 1460). Kaplan & Sadock (1998: 925) are also of the opinion that it is important to combine drug and psychosocial treatments for most patients. If this is done, there is greater protection against a relapse and higher levels of social adjustment than to drugs or psychosocial treatment alone. Wing and Morris (1981: 84) add that it is important to ensure that the patients are not suffering from the side effects of drugs which may effect their ability to work.

The State patient, like other patients, must be helped to understand, accept, and come to terms with his/her illness. The mental health professionals must assist the person to develop insight into his/her illness and this is not always easy. It can be a long, painful process. The person must have a variety of interventions available which will help him/her respond more realistically to his/her illness, that may include counselling, psycho-education as well as skills training, and behavioural change (Bachrach 1992: 1460). This includes educating the patient about medication and side effects and the reality that in many cases medication should be taken for the rest of their lives. At Komani Hospital the multi-professional team does the orientation of the State patient to his/her mental health condition, and the patient then benefits from a wide spectrum of disciplines, such as psychiatrist, social workers and psychiatric nurses.

2.3 GOALS OF PSYCHOSOCIAL REHABILITATION

Psychosocial rehabilitation is aimed at recovery. It is an ongoing process that must start where the individual is at present, and then moves towards healthy behaviour and activity. The goal must come from the individual, and professionals can make suggestions, encourage, or even demand certain goals, but the final choices must be left up to the individual. The professional intervenes when choices are harmful to the patient or others (Crate 1999: 2).

The goal of psychiatric rehabilitation is to teach skills and provide community supports so that the functioning of individuals with mental disabilities can improve socially, vocationally, and educationally with the least amount of supervision from the helping professions. In addition the goal of psychiatric rehabilitation is to enable the disabled person and his family to be involved in the treatment decisions and to achieve a good quality of life in the community after discharge. The social worker in the hospital setting usually involves the family of the patient in the discharge process, which is essential for successful placement in the community.

2.3.1 CREATING HOPE

Psychosocial rehabilitation fosters wholeness in the individual and it enables the patient to develop a sense of hope. It supports the goals that psychiatry holds for the patient, namely to, "live, love, and work meaningfully and productively in the world". Psychosocial rehabilitation assists the patient in finding their place in the community and provides the individuals with learning and skills that are necessary for societal integration. These skills should be constantly updated in continuity of care. Psychosocial rehabilitation offers a tangible point for consensus and co-operation among medical groups and provides a focus for the interdisciplinary care of people with long-term mental illnesses (Bachrach 1992: 1461).

2.3.2 INDEPENDENCE

Psychosocial rehabilitation is complex and ambitious because it encompasses many different sectors, from mental hospitals, home to work settings. Reynolds mentions that some of the goals for rehabilitation are to give people with disabilities the greatest possible measure of social and economic participation and independence. Independence for the person with a disability means acquiring as great a degree of self-reliance as possible and this can be

achieved through the measures contained in the rehabilitation process. The present-day concept of rehabilitation entails greater involvement of individuals in determining and choosing their rehabilitation process. This includes the assessment of the results of their various phases of rehabilitation, and in any adaptations of the process (Foster et al 1997: 77 & Liberman, Kopelowicz and Smith in Sadock & Sadock 2000: 3218).

Lloyd et al states (1998: 216) that the key requirement of rehabilitation is the reduction of functional impairments that limit independence. Mental health workers should focus on assisting consumers to achieve maximal independent functioning. The emphasis in rehabilitation is on providing a normalising experience as far as possible. The rehabilitation process enables the person to experience real life situations and encourages the skills and confidence necessary to lead satisfying and productive lives.

I agree with Liberman et al (in Sadock and Sadock 2000: 3225) who say that it is not always easy to make a patient a full and equal partner in the treatment and rehabilitation process. Negative symptoms, disabilities, institutionalisation and cognitive dysfunction may impede the patient's ability to participate actively.

2.3.3 EMPLOYMENT AND IDENTITY

Employment, the position you hold at work, your salary, and your achievement of the work you do, has an influence on a person's identity. Similarly for the employed psychiatric patient, work has an influence on their identity. Christiansen (1999: 547) is of the opinion that occupation is the key not just to being a person, but to being a *particular* person, and so creating and maintaining an identity. Occupations come together within the context of our relationship with others and provide us with a sense of purpose and structure in day-to-day activities. When one builds one's identities through occupations, one provides oneself with the contexts necessary for creating a meaningful life, and life meaning helps us to be well. The contribution of work to one's identity is reflected in achieving values such as a sense of accomplishment and independence or the attainment of a valued lifestyle. Occupations have the potential to influence identity and develop a sense of competence and mastery (Spencer, Daybell, Eschenfelder, Khalaf, Pike and Woods-Petitti 1998: 481).

2.4 VOCATIONAL REHABILITATION.

The following section focuses on vocational rehabilitation as part of psychosocial rehabilitation.

Vocational rehabilitation is a centrepiece of mental health treatment. Anthony and Blanch (in Sullivan 1997: 195) assert that "all people-regardless of the severity of their disability can do meaningful, productive work, in normal settings, if that is what they choose to do, and if they are given the necessary support".

An important part of psychosocial rehabilitation is enabling people to work. Job placements are usually at an entry level and may require minimal training or skills. Employment may be competitive or sheltered. These jobs can be temporarily en route to full-time employment elsewhere or to longer-term employment in an entry-level position. The key is that work is inextricably tied to the concept of rehabilitation. Schneider and Ferritor (in McKinlay 1993) stress that "to be rehabilitated is to be employed" (Kaplan & Sadock 1998: 9225 & McKinlay 1993: 67-70). Wing and Morris (1981: 83) mention some requirements for work: it should be plentiful, attractive, varied and fairly paid to meet motivational and vocational needs. They say that these requirements are not easily met, but they should remain the goal. Whatever jobs the patients' perform, it provides the opportunity for "work habituation" that can prepare him/her for work after discharge.

A State patient is admitted to a hospital in terms of Section 28(3) of the Mental Health Act, 1973 (Act 18 of 1973) for treatment of his mental condition. Because of their mental condition and need for admission in a psychiatric hospital, I see the State patient as a disabled person.

Work for the disabled should be with non-disabled co-workers, and should provide room for advancement in settings that produce valued goods and service. Employment should be integrated and competitive where the person works for at least minimum wages or better. Employment should be supported rather than sheltered. Pre-vocational training should be available as well as transitional employment (Foster et al 1997: 78 & Sullivan 1997: 78). Wing and Morris (1981: 82) refer to a study that was done by Miles, who studied two matched groups of patients working respectively in the industrial unit and the occupational therapy department of the same hospital. She found that the type of organisation and supervision prevailing in the industrial unit was more conducive to patients forming relationships and incipient friendships, than were those prevailing in the occupational therapy

department. They add that the work in the industrial unit frequently necessitated patients handing materials and components to one another, or in a flow line where co-operation and speech were necessary.

Komani Hospital obtained the support of a local factory that was prepared to provide industrial therapy to State patients. The vocational rehabilitation setting provides what Foster and Sullivan suggest. Patients are placed in work where they can make valued goods, work with non-disabled co-workers, and get minimum wages or more depending on their work performance. Transitional employment is not guaranteed, as employment in the catchment area of Komani Hospital is limited. The factory has in the past given some State patients permanent employment after their discharge, if the patient was interested in permanent employment.

Bachrach refers to Shephard who has written that work gives the individual patient "a sense of personal achievement and mastery" and that "no other single activity is so rich and complex in its psychological, social and material significance" (Bachrach 1992: 1456-1458). Bachrach further refer to Van Weeghel & Zeelen who summarised five advantages of pursuing vocational goals in rehabilitation. They are as follows:

- work provides an income, which allows the person autonomy in gaining goods and services,
- work provides the person a time and space structure,
- work broadens the social contacts of the mentally ill person,
- work provides the person with a recognisable societal role,
- work forces persons to be active and involved (Bachrach 1992: 1456-1458).

Harding, Strauss, Hafezand and Liebermann (1987: 317) mention Galen who pronounced, "Employment is nature's best physician and is essential to human happiness". The view that work is crucial to mental health and to the treatment of mental illness has persisted over years and despite this basic understanding of human functioning, the integration of work into systems that treat severe mental illness is limited, sporadic and inadequately addressed. Taking the above into consideration, I agree with Bachrach (1992: 1460) who says that rehabilitates and everyone involved in the care of long-term mentally ill individuals must be prepared to pressure the service system, from within and without, to alter its practices and become responsive to the social disablement of mentally ill individuals.

It is known that work can cause stress to many people and this should also be taken into account in dealing with job placements and monitoring of the psychiatric patients. To minimise stress-induced relapses that can defeat vocational rehabilitation, practitioners and

service systems must ensure that:

(1) occupational goals must be realistically linked to the patient's assets,

(2) the patient's progress must be promoted and supported,

(3) social skills training must be made available to help the worker develop social support inside and outside the workplace,

(4) The pharmacotherapy and crisis intervention services must be kept accessible (Liebermann et al 2000: 3238-3239). The above-named precautions are being taken at Komani Hospital to minimise relapses. Hospital staff and factory supervisors are monitoring the State patients.

2.4.1 GOALS OF VOCATIONAL REHABILITATION

There are some implicit and explicit goals of work rehabilitation and Mitchell (1998: 345) mentions the following:

- Keeping health problems in proportion could help people move away from an illness-focused perspective,
- Promoting group cohesion will improve the completion of tasks and develop group skills required for adequate functioning in the community,
- Providing a sense of intimacy and friendliness, is more likely to engender conscious experiences of contentment,
- Promoting insight and broadening of thoughts may lead to more positive self-evaluation,
- Promoting the expression of emotions is a goal of psychosocial rehabilitation,
- Increasing the subjective value of an activity may make it more meaningful and worthwhile.

Lloyd (1988: 187) describes the objectives of work performance as follows: (1) to increase work tolerance (2) learn strategies for coping with job stress, (3) learn to carry out task requirements, (4) Learn how to relate to fellow workers, (5) learn to follow instructions, and (6) to develop good work habits.

Work usually involves some level of physical exercise and exercise has long been associated with the reduction of anxiety and depression. Variety in work has been identified as a characteristic of motivation to work and is an example of an intrinsic reward and Mitchell (1998: 345-346) indicates that studies have found work variety to be influential in producing worker satisfaction. This underlines the need to understand and consider the factors that make work a rewarding or not a rewarding experience when work rehabilitation is developed.

The value of work in psychosocial rehabilitation lies in the concept that work is a normal activity, which can be associated with status, reward, satisfaction, and acceptability. To be effective, work should be realistic and be of some recognisable value to society. An apparently pointless task is unlikely to contribute towards an environment which promotes self-respect and constructive behaviour. Patients should be given a variety of work and an opportunity to perform at their highest possible level of ability (Willson 1983: 134).

2.4.2 WHAT IS SUCCESSFUL EMPLOYMENT?

Crist and Stoffel (in Mitchell 1998: 347–348) suggests that to be successfully employed one must view oneself as employable and employability is a match between work-related skill, your judgements regarding work, your work abilities and the work itself. People who are ill sometimes evaluate themselves in a negative way. This process occurs when the persons see themselves totally in terms of their illness, and is often seen in institutions. Only if the person can move away from the sick role, can it help him to develop and maintain a non-illness self-concept. In a recent study by Dixon, Goldberg, Lehman and McNary (2001: 22-23) at the University of Maryland on the impact of health status on work, symptoms and functional outcome in severe mental illness, it was found that the patient's self-perceived overall health assessment was greatly related to work motivation, chronic unemployment, self-esteem, and almost all of the quality of life variables. The study suggests that it should be important for the service systems and families to appreciate that the quality of life and the functioning of persons with mental illness can be improved by a more holistic approach to the individual's overall health.

Social groups have certain expectations of people who are sick and disabled. A person who is sick usually gets exempted from regular performance expectations and usually receives special treatment, support, and concern. Sometimes people with a disability or severe or chronic illness get so accustomed to the role of being sick that they have difficulty in returning to normal functioning.

There have been changes in health care delivery over time and expectations, from the traditional patient role where the individual was viewed as dependant and less able to actively be in involved in the job of getting well, to a role where an individual is expected to collaborate actively in goal-setting and goal-achievement. However the way in which health care professionals view the individual, the expectations of him/her and the labels attached to him/her, can influence the patient's recovery or adjustment back into society (Davidson in

Christianen & Baum 1991: 149). Wing and Morris (1981: 83) state that the mental health workers' attitudes are all-important and that the conventional over-protection can be disastrous. These mental health workers should regard themselves as teachers of self-help and other skills. They add that high expectations can be influential. The aim should be to make it possible for a patient to achieve a mini-success in work in the hope that this taste for the experience will encourage him to further effort.

Wallace, Tauber and Wilde (1999: 1147-1149) say that it is essential to teach workplace skills to persons with mental illness. It is the clinical staff member's task to assist the workers to adapt the skills to their specific workplaces. Timely and comprehensive communication among stakeholders is critical to the success of the mentally ill person's work adaptation and work performance. These skills will help the mentally ill workers to keep their job. The workers with mental illness generally have difficulties with interacting with supervisors and co-workers as well as performing their job tasks and maintaining satisfactory work. Some have difficulties in managing symptoms and medication. It is suggested that workers would be more likely to keep their jobs if the specific details of the workplace are identified such as: timing of work and breaks, specific job tasks, pay, prospective stressors, peers and supervisors are known before beginning their employment at a workplace.

Wallace et al (1999: 1148) mention that literature indicates that workers with mental illness generally had difficulties interacting with their co-workers and supervisors, performing their specific job tasks and maintaining satisfactory work. This indicates that work can have a negative influence on people too, as I mentioned before, and that the helping professionals must assist where possible. This can be overcome with detailed preparation of the patient and the employer and co-workers.

2.4.3 IMPACT OF WORK ON THE MENTALLY ILL PATIENT

Juhasz (in Mitchell 1998: 347) has identified the work role as one of three major role dimensions, in addition to family and the individual role. He believes the search for self-esteem can motivate the individual to strive for confidence in these roles. He sees the development of self-esteem as crucial for people with mental health problems. The work role will help them to develop a more positive self-concept and to move away from the patient role. Project workers participating in Mitchell's (1998) study saw the development of new skills and the acquisition of new knowledge as an important aspect of their involvement in the project. The development of such skills can be seen as a key factor in the confidence-building

process of the worker. The worker must, however, believe that he has the ability to carry out the task and that the skills may not be the most important factor. These findings concur with a previous study done by Calvin who found that the majority of volunteers on an equivalent work scheme felt that they learned new skills, that they progressed, were more independent and self-reliant, personally were happier and their self-respect grew (1998: 347-348). Dickerson (in Mckinlay 1993: 70) adds that it can be assumed that the individual once had a skill but because of trauma or some other reason, no longer possesses it. The ideal is that the individual will learn a new skill and this will ensure that the individual's chance to obtain employment after discharge will be better.

Sullivan (1997: 184), in his study to find out the key elements of the recovery process, used current and former consumers of mental health services. Respondents faced severe and persistent mental illness and had extensive hospitalisation histories. All respondents were engaged in some form of vocational activity. Respondents were asked to identify those activities, attitudes, and behaviours, initiated by themselves or others, which they experienced as essential to their successful recovery. The following factors were associated with success:

- medication. The use of medication is the most universally noted factor of success.
- community support services, the strength of the relationships and caring atmosphere and protection the programmes and persons in the community offered.
- self-will, self-monitoring, learning to take proactive steps to cope and manage.
- spirituality and participation in formal religious activities is a central aspect of daily life for many individuals.
- mutual aid groups, supportive friends, the ability to learn and share with others in similar situations, offering help and participating in a formal support group.
- significant others, the power of personal relationships, romantic involvement.
- vocational activity, including items such as volunteer work, school, and maintaining a home.

Nearly half of the respondents mentioned one of these activities as central to their recovery. The work provided structure, and by remaining occupied, kept attention off personal difficulties. The respondents expressed their desire to make a contribution to others. Sullivan's (1997: 187) study displayed a desire by individuals to accomplish individual goals and that recovery is a vigorous experience, and the insights gained from the study can point to attitudes, behaviour and services that can support recovery.

According to Waters (in Sullivan, 1997: 188), from a consumer perspective, work puts people in a unique relationship with other human beings so that the opportunity to form meaningful

relationships is readily available to them. Work allows the person to feel a common bond with the larger community and gives a person a better picture of what their lives will be in future.

2.4.4 MEANINGFUL EMPLOYMENT

Meaningful employment is believed to be essential to the recovery process for persons with mental illness. Strong (1998: 36) undertook a research study in Italy with persons with psychiatric disabilities. This study examined the relationship between the meaningfulness of work and persistent mental illness, and how work impacted on the recovery process. The major themes framing participants' meaning of work were:

(a) **Living with a label.** Work was described as acting as a bolster against their battle with illness and as a buffer for their dealings with society's negative attitudes. Patients reported experiences in society that characterised persons with mental illness as "lazy," incompetent and lacking intelligence. These disempowering experiences usually affect people's self-confidence and their willingness to try new things and their ability to make future plans. Lewis & Lewis (in McKinlay 1993: 49) add that when an individual suffers some disability or impairment, whether physically or mentally, he is labelled accordingly. Unfortunately, such labels carry with them an assumption of dependence and limited worth by the individual.

(b) **Becoming a capable person with a future**. Work took on the meaning of providing the concrete evidence for the participants to believe that they were more than an illness. By persistent efforts at work, workers were redefining themselves in that they were capable of being more than just a patient, but a person and thereby transcended society's labels. They were proud of their successes at work, taking initiatives and added responsibilities at work. Workers viewed themselves as active participants in making thing happen for themselves and future possibilities were being realised.

(c) **Getting on with life.** Work became the medium through which their self-concept-illness relationship was challenged by incremental successful experiences with work's daily challenges. Work inspired hope as they began to be aware of future possibilities. Work became the modality to practice and develops the interests, skills, and habits necessary for the roles of worker and friend. Their activities and roles were not illness-focused. They developed a life closer to the mainstream society.

(d) **Finding a place in the world.** Work was a way to feel valued through making contributions to a common purpose, and work was attributed as the meaning of a place to belong and feel accepted and useful. The meaning of work was linked to the emerging self in the recovery process.

It is known that persons with severe mental illness often have a diminished self-concept and a distorted sense of self-efficacy. The study of Strong (1998: 36-37) illustrates how powerful the act of work can be on creating or facilitating change in a person's self-concept and self-efficacy. Persons linked their changed thoughts and feelings with their work experiences. Work provided the structure for renegotiating a new sense of self. Work provided the opportunity through which respondents experienced connection with others, contributing to others and where challenges and successes can be obtained. Some participants experienced a sense of pleasure and rhythm in their work. Some participants experienced a sense of competence. Others were engaged in meaningful activities while working. When the participants connect with the organisation, they reported feeling a sense of belonging and being valued through their contributions. People are presented with challenges and new experiences while working, and with each successful experience that they credit to their own efforts, their self-efficacy improves.

By creating job opportunities for State patients, Komani Hospital has started the process of trying to empower patients by giving them an opportunity to work or not to work, but at this stage there are less job opportunities for patients wanting to work. The value of meaningful work for psychiatric and physically disabled persons is known. It is also known that work opportunities for disabled persons are very limited. The South African government has attempted, through the Employment Equity Act of 1998, to achieve equity in the open labour market by ensuring that previously marginalised groups, which included mentally and physically disabled persons, are represented. The extent to which this Act will achieve its purpose is yet to be seen and will depend on job creation for the disabled.

The multi-professional team should focus on the individual's strengths rather than on exploring his/her pathology, or weaknesses. Attention must be given to areas of competence and honouring fears and occasional bouts of hopelessness that are caused by the unknown of a new lifestyle. The supportive and non-threatening environment allows the patient to formulate his plans and goals to himself and then to communicate them to others. The patient is encouraged to develop a voice that can express and define his own needs. Often the psychiatrically disabled person is an object of care rather than an individual who may choose support or not. Having a voice according to Kruger (2000: 429-431), is a central aspect of empowerment.

Strong's (1998: 36-37) study has suggested that an occupation is meaningful when it fits the person's values, beliefs, interests, goals, sense of self, and relationship with illness. She found that meaningful tasks and activities not only engage a person's time and energy, but also

engage the person by forming a connecting bond. Participants reported listening to other's ideas, and thinking of doing what others were doing and feeling healthier, experiencing pleasure, and seeing new possibilities and opportunities, and beginning to make future plans. The process of change has shown to be dynamic and multifaceted. Participants began to reinitiate themselves in a new sense of self that influenced their actions, thoughts, and feelings. They were listening to other's ideas, and thinking that they could try doing what others were doing. They felt healthier, experienced pleasure, saw new possibilities and opportunities and started to make future plans. When workers connect with the organisation, they report feeling a sense of belonging and being valued through their contribution.

The benefits of occupation include the maintenance of general physical health, a positive psychological affect, e.g. mood, and satisfactory adaptations. Engagement in a daily occupation is a mechanism for meeting intrinsic needs and when met, improves happiness, life satisfaction, or perceived well being. In a study done by Christiansen, Backman, Little and Nguyen (1999: 92-99) it was found that:

- occupation with meaning to the performer, contributes to well-being,
- occupation provides a means for expression of self and therefore, contributes to the formation and maintenance of a personal identity,
- environmental characteristics, including competing demands and relationships with others, create contexts that facilitate or hinder the attainment of goal-directed pursuits,
- perceiving the self as efficacious is instrumental to engaging new challenges and gaining the success necessary for well being.

The activity of work satisfies many of a person's needs. The degree of happiness and fulfilment experienced through work will be largely determined by the extent to which the needs and wants of the individual are being met by the particular job he is doing.
Pilling's (in Landman 1994: 125) on the other hand, makes reference to the relationship between work and mental well-being and says that:

- work gives a person a place in the community,
- work gives status and identity,
- work links the individual to the social world,
- work provides time structure to an individual's life.

Strauss and Sayles (in Rankin 1991: 51) divide the needs that are satisfied by work into physical, social, egoistic and security needs. They state that needs are satisfied away from the job (physical needs are met of the job), around the job (needs are satisfied through personal contacts around the job), through the job (egoistic needs are satisfied through the job). These

needs seem to be important and shall be looked into.

1). **Personal needs satisfied through work:**

Work secures income and gives the individual purchasing power. Money provides security, status, and the physical necessities of life.

Work satisfies important self-esteem needs by being a provider, having autonomy, and establishing self-worth and self-respect. Rankin (1991: 51) refers to the Report on Work in America, which claims that work contributes to the individual's self-esteem in two ways. Firstly, a person acquires a sense of mastery over himself and his environment through the awareness of one's efficacy and competence in dealing with work. The second method derives from the view that an individual is working when he is engaging in activities that are useful to other people.

Work creates order and structure in the life of the individual and work is seen as a source of certainty and predictability. Work offers the individual a set of meaningful experiences. Work gives purpose in life, it provides new experiences to employees, and it is a service to others. People engage in work for the enjoyment of the activity. Work contributes to aspects of one's identity, e.g. social recognition, accomplishment, independence, and attaining a valued lifestyle.

2) **Social needs satisfied through work:**

The work situation provides for the satisfaction of certain social needs of the individual. Through work the individual is integrated into society. In the workplace, people are met and friendships are conversed and formed. The individual is provided with friendship relationships, peer relationships and subordinate relationships. The group situation at work satisfies the individual's need for belonging and support (Rankin 1991: 51).

Turner and Graffam in their work with clients of a sheltered workshop, have emphasised the value of peer support in various aspects of the personal adjustment process. The workshop provides individuals with a network of valuable social relationships as well as work experience. The lives of the clients outside the sheltered workshop setting are marked by heightened dependency and restricted social mobility and this is often expressed in terms of boredom and loneliness. In the workshop there are opportunities of social stimulation otherwise lacking from the clients' lives. Two of the effects of peer involvement in this process are, that it allows a level of adjustment

more or less equal to that of the non-disabled population, and it inspires or allows individuals to perform at a level of competency greater than that displayed in interactions with non-disabled persons (Dovey & Graffam 1987: 39-40).

3) **Societal needs satisfied by work:**
Usually the production system, of which a job is part, orientates and controls the behaviour of those individuals who participate in it. Goals are set for the worker, the manner in which they can be attained, and the rewards offered for its achievement (Rankin 1991: 51-52 & Hall 1994: 121-122).

2.4.5 PAID EMPLOYMENT

Most people have an expectation of reward for work carried out in their participation in employment. This usually means they earn money and can buy things that give them pleasure and satisfaction. Ransome (in Mitchell 1998: 346-347) suggests that one of the actions in the contemporary concept of work is that it is a deliberate undertaking to satisfy certain recognised needs. He adds that the related work expectation is for income and security and that the criteria of work is that it is performed in return for a salary. It is often said that people with mental health problems are not different in this respect and demand real wages for real work. Other payments-in-kind made instead of direct financial payment are also greatly appreciated by workers. The sharing in the profit of product produced also stimulates interest from workers. Mitchel (1998: 347) refers to a study done by Galvin who found that workers felt adequately rewarded by outings, social gatherings and annual gifts. These findings can not be generalised to work rehabilitation as representing workers, and staff advocate payment of real wages as not only desirable, but also a necessary part of psychosocial rehabilitation.

Willson (1983: 134-135) states that payment is one of the strongest motivators, not only for industrialists, therapists, and their medical colleagues but for their patients as well. If work is to provide status, personal satisfaction, and a link to a normal lifestyle, payment should have some correlation with money earned in outside industry. For many patients inadequate rewards will amount to reduction of motivation. Society places a monetary value on people and if one is paid an inadequate reward, the individual has a low valuation of his ability or existence.

An important fact regarding the value of work undertaken as a means to rehabilitation, is that it is paid, providing uniquely powerful motivation for patients whose own natural drives have

drained away as a result of their illness (Wing and Morris 1981: 81).

Robbins (1996: 239-240) points out that many behavioural scientists downgrade money as a motivator. They prefer to highlight the value of a challenging job, participation in decision-making, goals, and cohesive work groups as stimulants to the employee's motivation. Robbins states that money is a crucial incentive to work motivation. As a medium of exchange it is the way by which employees can purchase need-satisfying things they desire. People may not work for money alone, but Robbins asks the question, if one takes money away, how many people will still be working? In a recent study of 2,500 employees, it was found that the workers could not agree on what was their number one motivator, but they unanimously ranked money as number two. This study reaffirms that for the majority of employees, a regular pay cheque is necessary to meet their basic physiological and safety needs. It can be said that money motivates some people under some conditions. For money to motivate an individual's performance, there are certain conditions that must be met: (i) money must be important to the individual, (ii) money must be perceived by the individual as being a direct reward for performance, (iii) the amount of money offered for the work must be perceived by the individual as significant. It can be said that money is not the only motivator, but it is difficult to argue that it does not motivate workers.

The question can be asked whether payment increases affect motivation? For Maslow's theory payment would be a motivator only for people functioning at the lower levels of the hierarchy of needs. In the expectancy theory, payment will be an effective motivator to the extent that the person desires it. If he can identify behaviour that will lead to higher pay, the person must be capable of performing the behaviour. Money will motivate to the extent that it is seen as being able to satisfy the individual's personal goals. (Arnold, Cooper and Robertson 1998: 164-265 & Robbins 1996: 239).

Tully (1986: 154-155) is of the opinion that mentally ill and disabled adults have a basic right to paid employment because paid employment is:

- a normal feature of life,
- used as a measure for evaluating the worth of an individual,
- provides an earned income,
- provides meaning and purpose, and offers the opportunities for attaining personal satisfaction and a sense of achievement and advancement,
- involves obligations and responsibilities,
- provides opportunities for interacting with able people and becoming more integrated into mainstream society,

- helps to improve the perceptions of others, like family and employers, have of disabled people.

Those that are not in paid employment can feel, and often experience themselves as, diminished and stigmatised and can become fringe members of society. Appropriate efforts should be made to integrate disabled people into a workplace.

On the other hand many ill and disabled people live in congregated residences like after-care homes and hospitals. They are usually involved in work, which is related to the maintenance of the residential facilities, like work in the kitchen, laundry, and gardens. Much of this work has been of a menial kind and offered very few possibilities for attaining any real job satisfaction or recognition and these jobs are usually unpaid. Where patients choose to work in this way, and is consistent with their individual plans, and does not exploit them, payment should always be made and patients should also be encouraged by mental health workers to explore alternative rewarding lifestyles (Tully 1986: 155).

From the above it is clear that work plays an important role in people's lives. Work-related issues have implications for the individuals, their families, but also for social groups and communities.

Komai Hospital has an agreement with a factory that provides industrial therapy to State patients with payment for patients. Patients are paid the same as casual workers at the factory.

2.4.6 OCCUPATIONAL DEPRIVATION

Surveys done by Roger as mentioned by Mueser, Becker, Torrey, Xie, Bond, Drake and Dain (1997: 419) on competitive employment for persons with a psychiatric disorder, have indicated that psychiatric patients are dissatisfied about not working, and they expressed desires for competitive, integrated employment. Relatives of patients indicated that engagement in structured daily activity, such as work, is an unmet need of persons with severe mental illness. Work has become an increased focus of rehabilitation efforts for persons with mental illness because it is believed to have positive effects on different areas: finances, self-esteem, satisfaction with life, mental health service utilisation, and symptomatology. It was also noted that work played a crucial role in the integration of persons with mental illness into the broader social milieu.
Whiteford (2000: 200-202) talks about occupational deprivation which is a state in which a

person or group of people are unable to do what is meaningful and necessary in their lives due to external restrictions. This state makes it difficult, if not impossible, to perform those occupations that have social, cultural and personal relevance, mostly due to factors beyond their control. According to Whiteford, occupational deprivation implies that "someone or something external to the individual is doing the depriving." This state of deprivation occurs not as a result of limitations inherent within the individual, but due to forces outside his control. Wilcock (in Whiteford 2000: 200-202) includes prison inmates, prisoners of war, minority groups and women in the list of people that are most vulnerable to occupational deprivation. This list reflects a collection of those individuals and groups who have traditionally had little or no legitimate say in mainstream society. I want to add patients in hospital where there are no real occupational, rehabilitation or pre-discharge programmes. These patients are deprived, as Yerxa (in Whiteford 2000: 202) stated, "Occupation is not just something nice to do, rather, it is wired into human" and that "Individuals are most true to their humanity when engaged in occupation". I hope that with the new Mental Health Care Bill and Patients Rights Charter patients will have a "voice" to negotiate for their needs.

At Komani Hospital occupational therapy activities, work variety and payment of patients for work done, is limited, and this can be seen as occupational deprivation. These circumstances at Komani Hospital are caused by staff shortages, limited funding for occupational therapy and very little community involvement in the hospital activities.

Whiteford (2000: 203) in her study of occupational deprivation, pointed to the positive relationship between time spent engaging in meaningful occupation and perceived well-being, against lack of time spent engaged in meaningful occupation in a prison setting that appeared detrimental to health and well being. Inmates, who were deprived of occupation, experienced repeated psychotic breakdowns due to gross disturbances in orientation. The inmates had few occupations (except eating) to provide structure and punctuate the day, and little variation between days, weeks and months. The inmates reported sleep as a predominant response to occupational deprivation. The prisoners described time by saying, "Time is long and it passes slowly" and, "Time is nothingness". In addition they commented that increased occupational opportunities had the potential to, "Keep my mind occupied and diverted from thoughts that make me crazy", "Give me a chance to change my behaviour" and, "To let out anger and frustration".

2.5 THE MEANING OF WORK

As a social worker I was particularly interested in social work literature on the significance of work in peoples lives. I found that social work literature provides few examples of discussion of the significance of work in peoples' lives or the practice involved in helping secure employment for those who are customarily excluded from participation in the workplace like many mentally ill persons. As a social work profession, we have paid little attention to the work of our clients or their potential to work, except those social workers doing occupational social work. Akabas and Gates (2000: 164-165) are of the opinion that ignoring work as part of the social workers clinical agenda, has important implications for persons with serious and persistent mental illness like:

(1) Not talking about work can carry a message to patients/clients that we do not think they are capable of work. This may hamper the promotion of self-determination by the patient.

(2) Not discussing work deprives us of important insight into the patient/client. By discussing work, the patients are helped to talk about themselves.

(3) The return to functional performance is the main intent of a therapeutic service and work as a measure of functional performance is vital for the encouragement of self-esteem and a sense of self-worth.

(4) For patients that were working just prior to their hospitalisation, ignoring issues of returning to work, can relegate them to a reduced quality of life.

(5) For all patients a treatment programme that seeks work provides a functional outlook and this can help to avoid creating the disability mentality that can result from a focus on benefits (grants) as the preferred outcome.

Research has shown that work is important in contributing to quality of life, in personal satisfaction, health and wellbeing and that it is therapeutic and reduces symptoms. The social worker must, on the other hand, realise that in serving people with mental illness, work is only a partial answer and only for some people at some stage in their lives. However, people with mental illness have a right to employment as an option, even if in the end it is not attainable (Akabas & Gates 2000: 165-188). Hudson (1982: 126) on the other hand, says that work has potential benefits and potential risks. There is an increased possibility of a relapse at times of important life-changes, like the return to work. People who take a lower-status job than they held previously, may experience a lasting sense of humiliation and failure. Hudson adds that conditions at work can take many forms, such as overstimulation, or understimulation. A person may suffer from isolation if he/she works alone too much, or if there is too much close contact with other people. Taking the above into consideration, it is

important that social workers see the employment of patients/clients as part of their service delivery. In a hospital setting, the social workers as part of the multi-disciplinary team, are in some ways forced to give attention to work as vocational rehabilitation, which is one of the goals of psychosocial rehabilitation.

Akabas and Gates (2000: 181-182) have recommended that social workers must return to an active advocacy role for their patients/clients and social workers as a profession, need to believe that work is important in people's lives and that entitlement to an emotionally and financially fulfilling job is an outcome worthy of constant attention.

McKinlay (1993: 174-175) adds to the above by saying that social workers must adjust their thinking to be creative and innovative in creating work for their clients. In a study done by Mckinlay (1993) on work creation as part of the social worker's duty in the rehabilitation of the disabled, she found that social workers had little insight on the impact that unemployment had on their patients/clients. This opinion was confirmed by the high percentage of social workers that stated that work creation formed no part of their task with the disabled. She recommended that the social workers, in their service delivery to the disabled patient/client, should learn and develop new roles and tasks, which will focus on the need of their patients/clients to form part of the open labour market, which will fit their skills and abilities.

I think the social worker can do much to change the community's negative attitude and stigma attached to mentally ill persons. Stigma is viewed as a major impediment in the work adjustment of people with mental illness. The education of the community and the employer is essential in dealing with stigma, and social workers are one of the professions that can assist with this education.

2.6 MOTIVATION TO WORK

What motivates people to work? What motivates the disabled person to work? From the literature it is clear that motivation is a complex phenomenon, and there is no single answer to the question of what motivates people to work.

What is motivation? Robbins (1996: 212-213) sees motivation as the result of the interaction of the individual and the situation he is in. He says many people view motivation as a personal trait, something some people have, and something others do not have. He claims it is the situation a person is in, and that the level of motivation varies between, and within

individuals at different times. Robbins defines motivation, "as the willingness to exert high levels of effort towards organisational goals, conditioned by the effort's ability to satisfy some individual need". Motivation is seen as a need-satisfying process. A need means some internal state that makes certain outcomes appear attractive.

In a summary of motivational theories and definitions by Katzell and Thompson (in Lowenberg and Conrad 1998: 334), they state that there are two categories of theories:

(i) endogenous theories, which deal with a person's internal variables such as feelings of fairness, beliefs, values, and expectations, and

(ii) exogenous theories, which emphasise variables that are introduced and can be changed through external agents, such as praise from others, feedback, and money.

Motivation is not directly observable and can only be inferred from observing behaviour. We know a person is motivated if they tell us or behave in an indicative manner.

Rankin (1991: 53) is of the opinion that a person is motivated by the anticipated satisfaction of his needs through the job. A person's motivation, job satisfaction, and work performance will be determined by the strength of his needs and expectations, and the extent to which they are fulfilled.

Motivation concerns the factors that push us or pull us to behave in certain ways. Arnold et al (1998: 245) notes that motivation is made up of three components;

- direction: what a person is trying to do
- effort: how hard a person is trying
- persistence: how long a person will continue to try.

Many motives influence people, and the different theories of motivation provide a framework to understand motivation. In this review brief attention will be given to two motivation theories for the sake of a broad overview.

HIERARCHY OF NEEDS THEORY: Schultz & Schultz (1998: 239 – 240) refer to Abraham Maslow (1943) who hypothesised that within every human being, a hierarchy of five needs exists, namely:

(1) Physiological needs: Hunger, thirst, shelter, and other bodily needs are at the base of the hierarchy.

(2) Safety needs: Security and protection from physical and emotional harm.

(3) Social needs: Affection, belongings, and friendships.

(4) Esteem: Internal esteem factors such as self-respect, autonomy, achievement, and

external esteem factors such as status, recognition, and attention.

(5) Self-actualisation: The need to feel that one has reached his/her potential.

Maslow acknowledges that the hierarchy of needs may vary from one individual to another. He believes that the lower level, physical and physiological needs must be fulfilled before an individual develops motivation to fulfil higher order needs (Robbins 1996: 213-214 & Auster 1996: 200). Maslow said that self-actualisation, the need to realise one's potential in life, can never be fulfilled, and sees it as a lifelong growth process (Dipboye, Smith and Howell 1994: 88). Luthans (in Rankin 1991: 54) is of the opinion that Maslow's need hierarchy theory can be applied to work motivation and Arnold et al (1998: 247) and Dipboye et al (1994: 89) mention that the need hierarchy has been broadly applied in many organisations and worksettings.

EXPECTANCY THEORY: Schultz & Schultz (1998: 245 – 246) refer to Vroom's (1964) work motivation which served as the basis of many expectancy theories. The expectancy theory asserts that people make choices that are based on their perceived expectancy that a certain reward will follow if they behave or work in a particular way. The worker will be motivated to work hard if he expects his effort to lead to positive outcomes such as higher pay or promotion and those successful outcomes will be instrumental in leading to other desired outcomes. One's work behaviour is therefore shaped by the expectancy that your actions will accomplish what you believe they can. Schultz & Schultz (1998: 245-246) notes that the expectancy theory agrees with personal experience and common sense; the greater a person's expectation of receiving a reward, assuming it is of sufficient value, the harder he will work for the reward.

There are other models of motivation, but they fall beyond the scope of this study. It is, however, clear that a variety of explanations for motivations exist, and it is important to realise that it constitutes a valuable determinant of work behaviour. Rankin (1998: 245-246) refers to Pelman who regards motivation as one of the dimensions to be considered when the situation of a client is explored.

2.7 WORK VALUES

People learn about work values, and how to feel or how to think about work. Usually work values are transmitted from parent to child, especially when there are close and empathetic

relationships between parent and child.

A person's colleagues have influence on work values. Workers are in continual interaction with colleagues, supervisors, and clients. The development of work values is not some neutral and placid activity, they are made from interaction with real people in real organisations and throughout a person's working life (Hall 1994: 92-93).

2.8 UNEMPLOYMENT

In this section I studied the literature on unemployment to get an idea whether unemployment has any effect on the psychiatric patient.

The mentally ill suffer as a result of being unemployed, in the same way as all people do. The effects of unemployment will be felt even more by the disabled, as it is already stigmatised in the society. The mentally ill may value the opportunity to work more highly, because it can demonstrate to the world that they are no longer mentally disabled. The study of Wing and Brown of work in institutions has demonstrated the value of activity for chronic schizophrenic patients in reducing the degree of apathy, withdrawal and poverty of speech. Other studies have shown that engaging in activity can lessen antisocial behaviour. One should not underestimate the power of the wage packet, as the lack of financial incentive, rather than of ability, may be the reason for low levels of productivity among the chronic psychiatric patients (Hudson 1982: 124-126).

Some patients, who are reluctant to return to work, may suffer from the loss of confidence in their ability. This is a common consequence of "being a mental patient," rather than of mental illness in itself. The social worker, with other multi-professional team members, should be able to help the patient by analysing the sources of this anxiety and devising a plan to help to overcome it. In hospital the patient can be helped by a step-by-step approach, with gradually increasing demands, active supervision and immediate and consistent reinforcement (Hudson 1982: 126-127).

The patient's family and their attitude towards the patient are often very influential in the person's work performance. Poor work performance by patients can be related to low expectations the parents may have for the patient. The social worker can share the process of assessing the patient's abilities with the relatives, which might help to modify their expectations of the patient's abilities (Hudson 1982: 127)

Unemployment has an impact on the psychological wellbeing of an individual and the following impacts are mentioned:

(1) **Financial effect**. This includes interrupted or reduced income that eliminates spending on clothing and entertainment. It also reduces daily variety in experience.

(2) **The ending of relationships.** Social relationships, are affected with former co-workers, as the ending of social activities that require spending of money.

(3) **A loss of personal pride that results from the frustration and humiliation of job hunting and being dismissed affect self-esteem.** The unemployed person develops an inability to structure both leisure and daytime activity.

(4) **Physical and mental health**, suffers from the effects of fear, boredom, and sleep problems. Unemployment also reduces the opportunity to make decisions because there is little to decide. There are fewer goals to guide day-to-day activities. Unemployment increases apathy in the patient (Hall 1994: 30-32, Landman 1994: 125 & Landy 1989: 487).

It is thus clear that the cost of unemployment can sometimes be high. A study by Mueser et al (1997: 423) on work and non-vocational domains indicated that formerly unemployed psychiatric patients who obtained competitive employment while participating in a vocational programme had fewer symptoms, better overall functioning, higher self-esteem and higher satisfaction with vocational services and finances. This study also indicated that psychiatric patients are dissatisfied about not working. In response to these needs of patients, mental health providers are increasingly focusing on improving programmes designed to improve employment outcomes.

It is sad to say that despite the changes in approaches of caring for persons with mental illness, there are still negative attitudes and stigma towards the mentally ill population in the work place and community. It is known that persons with mental illness have higher levels of unemployment, lower income, and fewer social networks. Barriers preventing people with mental illness from participating in the open labour market include: social stigma, consumers, family members, employers, economic incentives of social grants, professional attitudes and the lack of follow-up support (Modiba 2000: 11-12).

The experience of unemployment varies substantially for different individuals. In some cases work is available, but is rejected by individuals. Potential reasons for rejecting employment includes:

- various types of adverse working conditions,
- low wages,

- unsatisfactory job content.

These reasons for rejecting job offers reflect areas of dissatisfaction with work rewards. In a study done by Kulik (2000: 161-164) reasons why an unemployed person would turn down a job offer were examined. The following reasons were given: (i) health (ii) low wages (iii) unsatisfactory job content (iv) family considerations (v) adverse job conditions. It was also found that men put more emphasis on instrumental aspects such as financial rewards and various material benefits. Older people who become unemployed may face more difficulty than younger workers may, in finding work. Usually industries are likely to hire young and more recently trained people. On the other hand, the job involvement of the younger worker (age 16-24) is volatile in the initial stages of the work career, but increases as the worker grows older.

2.9 THE STATE PATIENT

I am including this section in the literature review to give an insight into the legal implications of State patients. I chose to research the State patients specifically because they have little autonomy or control over their own lives. The State patient, in his community lifestyle, criminal activity, and subsequent institutionalisation, has lost skills and a sense of responsibility for his actions. However, the choice to work or not to work is one of the options at Komani Hospital. Whether they work or not, will have little impact on their discharge. Knowing this, I wanted to research why then the State patients still chose to work.

Authorisation for the detention of an accused as a State patient is given in terms of the Criminal Procedures Act, 1977 (Act 51 of 1977), namely:
in terms of Section 77(6) where a person is not capable of understanding the proceeding so as to make proper defences: and/or
in terms of Section 78(6) where the person committed the act in question but that he/she at the time of commission of such an act was, by reason of mental illness or mental defect, not criminally responsible for such an act, and thus found not guilty.

A State patient is admitted to a hospital in terms of Section 28(3) of the Mental Health Act, 1973 (Act 18 of 1973) for treatment of his mental condition.

On admission to hospital the State patient is admitted to a closed ward for evaluation and treatment. The patient's movements are controlled and supervised, and there is strict security at the ward. When the patient's mental condition and behaviour allows it, he/she is transferred

to an open ward where the patient has more freedom and spends more time outdoors. The open ward is utilised as a final step in the rehabilitation programme where the aim is to reintroduce the patient to the community. The patient at Komani Hospital then starts with short leaves to family or friends, can choose to do industrial therapy from hospital on a daily basis, or choose to work at the hospital occupational therapy department (Zabow 1981: 451).

A person who is declared a State patient is not convicted of a crime, nor is he/she acquitted. A declaration as a State patient is not a punishment; it is a measure to protect the public and to provide for treatment of the accused. Because a State patient is not found guilty he/she is not given a fixed sentence. He/she can be detained (theoretically) for the rest of his life. It is therefore not strange that the defence of non-responsibility is usually only raised in cases where murder or other very serious crimes are involved (Kruger 1980: 208-211).

The State patients have to be treated for their psychiatric condition within a legal framework. Treatment in the criminal justice sense, means helping the patient to avoid future law breaking. A significant proportion of these patients suffer from manifest personal or social deficiencies, or are diagnosed as psychotic, alcohol/drug dependent, sexually deviant, or have anti-social personality disorders and are therefore suitable candidates for psychiatric intervention. The emphasis is on rehabilitative aspects of care rather than on the punitive approach of the correctional/justice system. It has been determined that the State patient has three major problem areas, which need to be worked at:

(1) psychopathology,
(2) dysfunction in the performance of their daily occupation, and
(3) criminal or anti-social behaviour (Lloyd 1988: 182).

Most State patients view their involuntary commitment/hospital orders as a punishment, as a sentence to be served. The purpose of hospitalisation is secondary prevention, to treat a disorder and keep it under control, greater autonomy, and a better self-understanding. The rehabilitation should deal with the patient's preparations and perceptions of post-discharge life with the ultimate goal of forming a realistic, productive and hopeful future. There is always one part of a patient that wants to live a decent social life in peace with fellow human beings (Lindqvist & Skipworth 2000: 322).

Work with State patients is a multi-disciplinary specialist field involving psychiatry, psychology, social work, nursing, occupational therapy and physiotherapy. The social worker's task is to gather information with special reference to diagnosis and prognosis and the compiling of a full psychosocial report. This report is a valuable tool that enables the

social worker to structure an in-depth rehabilitation or treatment programme together with the patient. Information in the report is later used when leave and/or discharge is considered with a suitable custodian who will be able to support the patient after conditional discharge (Mamasel & Landman 1991: 20-22). Specific functions of the medical/psychiatric social worker are:

a) Social evaluation of a patient and his family to help identify and diagnose psycho-social pathology,
b) Psychotherapeutic treatment through the use of special social work techniques to improve the social stability of the patient and his family and to provide both a therapeutic and preventive service for patients and their families,
c) interpret the social work findings to the multi-disciplinary team members in order to make a diagnosis and to compile a treatment programme (Eastern Cape Dept of Welfare: 1998).

The multi-professional team is usually faced with a dual challenge of rendering a comprehensive therapeutic service to the patient as well as conforming to all legal requirements involving the patient's detention, care, treatment, and discharge.

Browne (in McKinlay 1993: 72) and Serfontein (1993: 1) state that interactions, interdependencies, and interrelationships between and among many disciplines, patients, resources, families, communities, and government, is the essence of rehabilitation. In a clinical situation, all members of the team accept that each has a professional contribution to make in his own right and that it is equally the responsibility of each member of the team to make that contribution if the patient needs it. This responsibility derives from the right of the patient to have the benefit of all the team's skills, as he needs them. As part of the multi-disciplinary team the social worker is often involved in the placement and monitoring of patients who are working and in other aspects of the rehabilitation programme that include work. This is particularly true in rural hospitals such as Komani Hospital, where occupational therapists do not always form part of the multi-disciplinary team. (Zabow 1981: 452).

The social worker can assist other disciplines in the hospital setting and being familiar with the field of occupational social work, it will be a bonus in service delivery. Googins and Godfrey (in Bargal 2000: 140-141) defined occupational social work as a "field of practice in which social workers attend to human needs and the needs of the work community by designing and executing appropriate interventions to insure healthier individuals and environments." The social workers' interventions are also aimed at the organisations and

workplaces of their employees where they are expected to consult with management and the formation of policies which respond to the physical and mental health as well as the social needs of employees. The social workers' role includes counselling to individuals, the provision of information and mediation between employee and employer. The patients are assisted with maintaining their jobs and the employers are assisted in accommodating the patients. Therefore the social workers are in an excellent position to effect change because of their proximity to both management and workers (Mudrick 1991: 494-495). This is one of the tasks that are being done by the social workers at Komani Hospital. Adams & Soifer (in Mc Kinlay 1993: 78) note that "social workers are valued by every discipline for their ability to help people cope with instrumental problems such as finding jobs or managing finances".

2.10 HUMAN AND PATIENT'S RIGHTS

South Africa has come a long way in addressing some of the imbalances of the past. The human rights of persons with mental illness are now safeguarded by the new South African Constitution. To ensure the realisation of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa (Act no. 108 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and therefore proclaimed the **Patients Rights Charter** as a common standard for achieving the realisation of this right.

2.10.1 NEW MENTAL HEALTH CARE BILL

The process toward a new Mental Health Act began in 1997. The Bill is currently in parliament for debate. Most of the proposed major changes from the current Mental Health Act are:

(1) The new legislation will be called the "Mental Health Care Act." The main reason for this is that the proposed legislation does not claim to cover all aspects of Mental Health, but more specifically the care aspects.

(2) A chapter dealing with patients' rights has been included and the law will protect these rights. The new law will spell out the rights and responsibilities of mental health care users and proposes that mental health care services be provided at all levels of care, i.e. at primary, secondary and tertiary level health facilities. What will be an important change for the benefit of the State patients, is the shortening of the period or review for involuntary, assisted, State patients and prisoners who are mentally ill. An initial

review will be done after 6 months and then yearly thereafter.

(3) Introduction of a "Mental Health Care Practitioner" category.

(4) Addition of "Mental Health Review Boards."

(5) Introduction of a 72 hour assessment period prior to involuntary admission at a psychiatric hospital (Directorate: Mental Health and Substance Abuse: 2001 & National PPHC Network: 2000).

In the Past State patients in some cases have been detained in psychiatric hospitals for unduly long periods of time without an adequate rehabilitation programme. Reynolds is of the opinion that these programmes should be stipulated as part of their conditions of detention and there should be safeguards against unnecessarily long detentions (Reynolds 1997: 91-92). The Mental Health Care Act will hopefully prevent these unduly long periods of detention of the State patient in hospitals.

2.10.2 EMPLOYMENT EQUITY ACT 1998

It is a known fact that persons with disabilities are discriminated against in obtaining competitive employment. The government also realised this fact, and is trying to improve employment opportunities for the mentally and physically disabled persons.

The **Employment Equity Act, (55 of 1998)** is a new development and attempts to protect the rights of people with disabilities and makes provision for the employment of persons with disabilities, including physical and mental disability.

The Act specifies that people with disabilities have a right to be protected against unfair discrimination and to expect employers to make reasonable accommodations. These "accommodations" refer to:

(A) Job Supports: People with psychiatric disability can benefit from assistance, by:

- Sharing posts where workers cannot work a full day.
- Using co-workers for peer support.

(B) Changes in Workplace Policies: Flexibility in workplace policies can create relatively inexpensive accommodations, such as:

- Providing a quiet location within the workplace where the employee may go to for short breaks when feeling stressed.

- Sub-contracting work to organisations specialising in income generating projects for people with disabilities.

(C) Flexible Scheduling: In view of the changing nature of psychiatric disabilities, flexible scheduling can be important for individuals with psychiatric disabilities. These include:

- Permitting a self-paced workload.
- Allowing flexitime to cater for medical appointments.

(D) Supervision: For someone with a psychiatric disability, positive supervision is important to keeping a job. These include:

- Instructing supervisors to give detailed explanations of job duties, responsibilities, and expectations.
- Assisting the employee to prioritise his work and, if necessary, break down tasks into more manageable steps.

(E) Shaping Co-workers' Attitudes: It is important to consider the attitudes of co-workers and to help educate them so that the workplace becomes more "emotionally accessible." This may include:

- Educating co-workers on the reasons why people with disabilities need accommodations.
- Providing employee education and training on mental illness and the ways symptoms interfere with working (The Employment Equity Act 1998).

From the above it is clear that patients that are doing industrial therapy while in hospital will also benefit from the Employment Equity Act and that hopefully more firms will open their doors to people with disabilities. It will be the hospital management and multi-disciplinary team's task to propagate to the business community that a person with a psychiatric disability, depending on the severity of the disability/illness, can be gainfully employed and is an asset to their employers. The emphasis should be placed on the person's strengths and abilities and not only on their disabilities (SA Federation for Mental Health: 2001).

A draft Code on Disability has been issued under this Act. It outlines the rights that people with disabilities enjoy to ensure equal opportunities in employment, and provides employers with good practice guidelines for promoting them. The code aims to:

- Guide employers and employees on key aspects of promoting equal opportunities and fair treatment for people with disabilities as required by the Act;
- Help employers and employees understand their rights and obligations, promote certainty and reduce disputes to ensure that people with disabilities can enjoy and exercise their

rights at work (S A Federation of Mental Health: 2001).

Social work principles place a special responsibility on the social work profession to advance the cause of human rights. Social workers work to prevent or alleviate groups, community, and individual problems, and to improve the quality of life of people. The social worker in the hospital setting aims to uphold the rights of the patients with whom they are working. The White Paper on Social Welfare (1997) reflects the social policy in South Africa which sets the framework for policies and programmes to be in line with the following principles: **people-centred policies, investment in human capital, improved quality of life, non-discrimination and human rights**. Social workers are in line with policies and together with the organisation they work for, are contributing to the enhancement of a human culture (Lombard 2000: 133-138).

2.11 CONCLUSION

Working with State patients is not an easy task and all professionals should be involved in planning with the patient and rendering the needed service. Work in psychosocial rehabilitation can be seen as an important focus of rehabilitation of the patient. The social workers in Hospital have a task to use their skills to the benefit of the patient and not just to stick to traditional social work roles. This will promote the circumstances of the patient as well as promoting the social work profession in the opinion of colleagues and service users.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

Basic research was utilised by the researcher to gain some understanding of what motivates the State patient to work and what do they gain from working, and why other patients do not work.

I am a social worker at Komani Hospital. In my work milieu I wondered why some patients are keen to work and keep themselves busy and other patients are content to sit around or sleep during the day, doing nothing constructive. I had conversations with some of the nursing staff in the wards and their opinion was that the patients that are not working do not want to work, others are lazy and some said the patients were spoiled because everything is done for them in hospital. I then decided to investigate from the patients themselves.

I approached the Superintendent of Komani Hospital about the proposed research. Permission was given to do the research with State patients in hospital who volunteer to participate in the research.

3.2 PILOT STUDY

A pilot study was done with two patients from each group; two patients that are working and two patients who choose not to work. During the interviews with the latter patients it become clear that the patients do not "choose" not to work. They indicated that they wanted to work but that work is limited and there is very little variety to choose from. It was decided to change the question from; why did you choose not to work at the factory or occupational therapy? to, Why are you not working at the factory or occupational therapy? The respondents who were not working, and participated in the pilot study were not included in the final study. According to Grinnell (1988: 320), three groups of people are particularly suitable for the pre-testing of an instrument to be used; (i) colleagues, (ii) potential users of the data, and (iii) individuals drawn from the population to be surveyed, as used in this study. Feedback is needed from those who might be the focus of the study to determine whether they have

understood the questions.

The pilot study was also done to evaluate whether the participants understood questions or whether the interview schedule needed to be refined before continuing with further interviews. Grinnell (1988: 319) states that "before a research instrument is submitted to the sample population, it should be pre-tested to be sure that other individuals who are asked to answer the questions, understand them and have a favourable impression of the appearance and utility of the instrument. The questions were understood during the pilot study and the interviews were included in the research study.

The pilot study was also used to see whether the interpreter understood the object of the research and the interview schedule and that the interpreter and researcher could work hand in hand.

3.3 SAMPLING PROCEDURE

According to Kerlinger (in De Vos 1998: 189-191) sampling means taking a portion of a population as representative of that population, and the population is considered to be representative. The sample is being studied in an effort to understand the population from which it is drawn. The sample helps us to explain some facet of the population. A "sample" is only a small set of the total that is referred to as the "population". The reason for sampling is feasibility (Grinell 1988: 240).

Purposive non-probability sample procedure is suited to exploratory studies, where the goal is to gain as much unique data on a research question as possible. The sampling units are usually in the position to observe or experience the phenomenon being investigated. Purposive sampling is based on the judgement of the researcher, the sample used composed of elements which are of interest to the researcher, and the most characteristic representation of the population under study. Using purposive sampling one can make sure that the sample includes elements that are directly relevant to the question under study. This means that the participants were not randomly selected, but were purposefully selected because they met the criteria needed for the research (De Vos 1998: 198, Grinell 1988: 251-253, Royse 1991: 116 & Rubin and Babbie 1997: 383).

Participants in this study were sought on the basis of the following criteria:

- Participants who were working had to work for a period more than six months from

hospital so as to have work experience from hospital and a clear picture of what it is like to work as a patient.

- Participants must be physically and mentally proven fit to work by the psychiatrist.
- Participants must be State patients.
- Participation in this study must be voluntary.

Dr Jeeves, Senior Psychiatrist of Komani Hospital, identified some State patients as mentally and physically fit to work. Purposive sampling made it possible to use my own judgement to select ten State patients from the group of patients that chose to work and ten patients from a group who did not work. All patients had the choice to participate voluntarily in the research study.

A limitation of purposive sampling is that it lacks the ability to generalise from the samples. In this research study the sample is small and not representative of all working and Non-working State patients. I do not wish to generalise from the data, but rather to produce data that focuses on the experiences of the patients themselves. This study, however, provided valuable information regarding the motivation to work and how it influences the patients' lives, and why other patients are not working, and their motivation behind their choice (Marlow 1993: 114, Rubbin & Babbie 1997: 268).

3.4 RESEARCH DESIGN

Exploratory research design is usually used where little is known about the field of study. The exploratory design is specifically useful in this study, as the focus of the study is on exploring a relatively under-studied topic. The purpose is to explore and to gather facts. The idea is to build a foundation of general ideas, which can be explored later with more complex research (Grinnell 1988: 220- 225). Oppenheim (1997: 67) adds that exploratory research is concerned with trying to understand how people think and feel about the topic concerned in the research.

Exploratory research design is often useful in social work research because it adds depth and richness to the investigation. Usually the findings in the research cannot be generalised and further research is necessary, involving the experience of other groups (Marlow 1993: 24).

The research is explorative, as I explored the patient's motivations to work and why others do not work. To add to this the meaning of work for the patient can provide new insight into the topic. Rubin and Babbie (1997: 108) state that the exploration can always yield new insight

into a topic.

3.5 RESEARCH METHODOLOGY

I made use of a qualitative research method. Qualitative researchers embark on a voyage of discovery, of exploration, and of how the experience of others can best be represented. The researcher gathers and presents data in such a way that the respondents used in the study, speak for themselves (De Vos 1998: 243-245).

De Vos (1998: 240) defines qualitative research as "a multi-perspective approach to social interaction, aimed at describing, making sense of, interpreting or reconstructing this interaction in terms of the meanings that the subjects attach to it".

Qualitative research is mostly employed to describe social reality from the point of view of the participants, who are in the system that is being studied, assuming that the individual in the social situation can describe best what they are doing, and why. This is also why it can be said that in qualitative research the participants' natural language is employed. Rubin & Babbie (1997: 382) are more concerned with the subjective tapping of the deeper meanings of human experience. This is why the qualitative method was used, to attempt to understand the subjectiveness of the State patient's experience, their own definitions and concept of their motivation to work or not to work and the influence on their lives.

The inductive, subjective, descriptive and unobtrusive approach to information gathering in qualitative methods is close to traditional social work, and this was also a motivation to use this method, as I am familiar with these methods (Grinnell 1988: 193).

3.6 METHODS OF GATHERING RESEARCH INFORMATION

3.6.1 THE RESPONDENTS

My male social work colleague, who is rendering service to State patients at Komani Hospital was asked to inform the potential respondents (who were identified by the senior psychiatrist) about the anticipated research and the goals of the research. The respondents were informed that their participation was important because I wanted to find out their personal opinion and

motivations. The respondents were informed that it was "safe" to participate, and their response would be confidential.

3.6.2 INTERVIEW SCHEDULE

The method of data-gathering used in this study was a semi-structured interview schedule with each patient, using mostly open-ended questions to enable the patients to reflect their understanding of the questions asked. Open-ended questions gave the respondents freedom to let their thoughts roam freely (Grinell 1988: 274-275, Marlow 1998: 160 & Oppenheim 1997: 112-113). Behr (1983: 145) is of the opinion that using interviews as a data collection method can be beneficial in obtaining information about matters of a personal nature. Grinell (1988: 281) is of the opinion that open-ended questions allow for a wide range of answers, but that the answers may be difficult to code and categorise. The researcher, however, by using open-ended questions may gain a great range of responses of which many may not have been anticipated. Marlow (1998: 166) adds that open-ended questions are particularly useful when one does not have a great deal of knowledge about the subject under investigation.

A semi-structured interview schedule was chosen by the researcher in order to have a certain amount of control over the interview and to cover the topics in the interview. Semi-structured interviews makes it possible for the interviewer to stimulate through probing for more information as needed on the subject, or in the case of vague answers, probe for further particulars. The respondent gets the opportunity to answer the question in his own words. These probes should be as non-directive as possible and in a reassuring and non-threatening way (De Vos 1998: 310, Oppenheim 1997: 113 & Rubin & Babbie 1997: 192). Semi-structured interviews are used for respondents who have shared a common experience, such as the patients in this study (Grinell 1988: 275). Fielding (in Gilbert 1993: 136) describes this type of interview as an interview where "the interviewer asks certain, major questions the same way", but is free to alter the sequence and to probe for more information. This means that the researcher has the freedom to explore in her own way, matters that may pertain to the research study. Hall and Hall (1996: 158) state that open-ended questions are usually used in exploratory research.

The interview schedule was self-developed in English. A Xhosa-speaking colleague translated the schedule into Xhosa. My supervisor checked both English and Xhosa interview schedules in order to test for consistency of meaning of the questions.

This method of interviewing was chosen because all but one of the respondents were Xhosa-speaking male respondents and the researcher had to make use of an interpreter. By making use of a semi-structured interview schedule, it was believed that it was the most reliable way to capture the correct data given by the respondents.

I can understand and speak some Xhosa, but preferred to make use of an interpreter to make sure that the respondents understood the questions and could answer in their own language. Fontana and Frey (2000: 654) say that there are different ways of saying things and, certain things should not be said at all, linking language and cultural manifestations. I could probe into some answers, as I understood the answers of the respondents. The interpreter that was used was a former Nursing Manager at Komani Hospital, who retired six years ago. The interpreter and I am familiar with each other, we worked together before, which made the planning and work relationship easier. The interpreter was familiar with psychiatric patients and could relate to, and understand them. I used a male interpreter as all the respondents were males, and it was thought that the patients would relate better to a male interpreter. The interpreter was briefed beforehand about the research motivation and research tools. The interpreter had done his own research previously and had some background on research.

Male patients were chosen because there are very few Female State patients in Komani Hospital and none of them are working from hospital.

Two participants that were working preferred to answer their questions in English, and one respondent who was not working, answered his questions in English.

Reformulated questions were carefully arranged and put to all respondents in a similar sequence. This had the advantage that the data is obtained relatively systematically, which facilitates the comparison of the data (De Vos 1998: 299).

3.7 LOCATION

The interviews with respondents who were working took place at the factory where they work, in one of the administrator's offices that was not in use. A relaxed and private setting was available, as well as control of the environment (Grinell 1988: 287-288 & Oppenheim 1997: 69). This venue was chosen because the factory manager was informed about the research and permission was granted for the interviews to be conducted in working hours, so that the participants should not lose pay because of absenteeism from work, to be involved in

the research. The respondents that were not working were interviewed in an empty office in the occupational therapy department, which was private, and there was control over the environment. According to Merriam (1988: 20), the qualitative researcher is the primary instrument for data collection, which is mediated through this human instrument. The researcher physically approached the people to record behaviour in its natural setting. The interviews took place from 27 June until 2 August 2001. The first few interviews took about 50 to 60 minutes, but as the interpreter understood the process better, the length of interviews ranged between 35 and 45 minutes.

3.8 DATA RECORDING

The responses obtained were tape-recorded in the respondent's own words as interpreted by the interpreter for reliability and analysing (Grinell 1988: 297 & Marlow 1993: 71). Rubin & Babbie (1997: 392) add that tape recording is an essential tool in qualitative research. It allows the interviewer to keep her focus on the respondents and to probe into answers when necessary. The data recording was done with the respondents' permission as suggested by Marshall & Rossman (1999: 148).

3.9 ANALYSIS OF DATA

Qualitative data produces a mass of detailed information in the form of words and this data must be subjected to forms of analysis that will make sense out of these words (Marlow 1998: 265). Tesch (1990: 97) sees the analysis of data both as a process of taking data apart and of putting it together into a larger and consolidated picture.

By condensing the bulk of the data into analysable units, one creates categories with and from the data. This process is referred to as coding. Coding enables us to rigorously review what the data is saying. Coding links different segments or instances in the data. Codes, data categories, and concepts are related to one another. The importance of analytical work lies in the establishing and thinking about such linkages, not in the mundane processes of coding. It is important how we use the coding and concepts. Coding can be thought of as a range of approaches that aid the organisation, retrieval, and interpretation of data. Coding can also be thought of in terms of data simplification or reduction. According to Seidel and Kelle (in Coffey and Atkinson (1996: 26-29) the role of coding is (i) noticing relevant phenomena, (ii) collecting examples of those phenomena, and (iii) analysing those phenomena in order to find

commonalties, patterns, structures, and differences. Coding can be used to expand, transform, and reconceptualise data, and opens up more diverse analytical possibilities.

Tesch (1990: 142-145) furthermore describes eight steps to be considered by the researcher in analysing data, which was used by the researcher. At first, one gets a sense of the completed interview, by reading through it carefully. One may then look for the underlying meaning in the text. A list of topics is made and similar topics can then be grouped together. The topics are abbreviated as codes, which are written next to the appropriate segments of the text. Descriptive data is then turned into categories and lines are drawn between categories to show their inter-relationships. If necessary, the recording of existing data can be done.

The information received from the respondents was divided into categories, similarities and dissimilarities and common themes and general norms. I was alert for differences and deviations from the general norms. Data presentation also included selected quotations of responses of patients and discussions thereof (Rubin & Babbie 1997: 397 & Vithal & Jansen 1997: 27-28).

3.10 TESTS FOR VALIDITY AND RELIABILITY

Miles and Huberman (in De Vos 1998: 351) address the importance of verification of data analysis results. This involves the checking for the most common biases when drawing conclusions. Guba (in De Vos 1998: 351) proposes four strategies to ensure trustworthiness, namely: credibility, transferability, dependability and confirmability.

Validation of qualitative data includes the consideration of rival or alternative hypotheses, consideration of negative cases and the preservation of the context of the data (Marlow 1998: 218).

Miles and Huberman (1994: 277) question verifying data in relation to how one would know whether the findings are valid and reliable. It must be borne in mind that the responses were from real life experiences and have had real consequences in the lives of these respondents. What they have stated must thus be taken and accepted at face value. In this study a number of responses agreed with the available literature. Douglas (in Miles and Huberman 1994: 168) stated that irrespective of trust being established, people have a reason for omitting, selecting or distorting data, and may even have a reason for deceiving the researcher and themselves at times.

Some ethical issues in qualitative data analysis are that some personal and professional biases are more likely to interfere than in quantitative data analysis. Sometimes it can be tempting for the researcher to ignore negative cases, implying that there is more agreement than actually exists among findings in the data and to make arguments appear stronger. Marlow (1998: 221-222) suggests that researchers conducting qualitative analysis should constantly use self-examination to determine whether they are perpetuating stereotypical or negative images of the respondents in their study.

I was aware of the threats to validity of the study because of the racial and cultural differences between the participants and the researcher. The researcher checked for possible bias. While working on the questionnaire I consulted a Xhosa-speaking colleague on the trend of the questions and how it could be translated into Xhosa so that the respondents could understand the questions. The questions were translated into Xhosa so that the interpreter knew exactly what was asked. In the first two interviews of each group, another Xhosa-speaking person, to make sure that the interpretation was done correctly, checked the interpretation. This procedure was followed to avoid what Fontana and Frey (2000: 655) say when some researchers rely on interpreters and thus become vulnerable to added biases, added layers of meaning and interpretations which may lead to misunderstandings.

A classmate checked the coding of two interviews of the data, one of each group to make sure that analysing of the data was correct.

3.11 ETHICAL CONSIDERATIONS

The university guidelines on ethical considerations were adhered to. The proposed research was explained to the respondents and it was emphasised that participation in the research was voluntary. I explained that the interviews would be conducted individually, in private, to protect confidentiality. I explained to each respondent the reason for tape recording the interview, and they consented to tape the interview. I stressed that the names of participants would not be divulged in the feedback of data.

3.12 LIMITATIONS OF THE RESEARCH

The small number of participants is not representative of All State patients in Komani Hospital, however, this study provided valuable information on work motivation as viewed by

the patients.

The fact that I had to make use of an interpreter could be a limitation, as well as the fact that I am a white woman, doing research with black male respondents, with a different cultural view on their motivation to work.

3.13 CONCLUSION

This chapter dealt with the manner in which the research was conducted. The data is based on responses from the respondents. Data analysis was done and the findings will be discussed in the next chapter.

CHAPTER 4

ANALYSIS OF DATA

4.1 INTRODUCTION

This chapter documents the biographical details of the respondents followed by the data collected during interviews conducted with the twenty respondents, the first ten respondents from the working group, and respondents eleven to twenty from the non-working group. An analysis and discussion of the data and the relation to the literature was done. The findings explore the perspectives on the perceived value of work in psychosocial rehabilitation with the State patient.

As this study is at least partly aimed at comparing the needs and interests of those patients who are working and those who are not, the groups will be considered jointly, with extra detail given about one or other of the groups, as and when needed.

4.2 SECTION A

4.2.1 BIOGRAPHICAL DETAILS

Most of the respondents grew up in rural areas with only three of the working and two of the non-working group growing up in urban areas. In this way the groups are similar.

This similarity is reinforced when considering their age range. While the average age of the working group is 34.9 and that of the non-workers is 33.9, there is not a very wide range of ages. The working group range in age from 27 to 48 years, with three in the category 30 years and younger, four in the category 31- 40 years and the remaining three between 41 and 48 years. The non-working group range in age from 21-43 years with three in the category 30 years and younger, six in the category 31-40 years and the remaining one between 41-48 years.

TABLE 1

Age of respondents

	-30 Yrs	31-40Yrs	41-48Yrs
Respondents working:	3	4	3
Respondents not working:	3	6	1

The education levels of the working group are three in the category Std 2 and less, three in the category Std 3-5 and four in the category Std 6-10. The non-working group has one in the category Std 2 and less, three in the category Std 3-5, and six in the category Std 6-10.

TABLE 2

Education level of respondents

	Std –2	Std 3-5	Std 6-10
Respondents working:	3	3	4
Respondents not working:	1	3	6

The education levels of the non-working respondents are higher than those respondents who are working.

Both the groups report that their fathers are working or were working. Most of the respondents' siblings are working. None of the working groups' mothers are working. Two of the non-working groups' mothers are working. The majority of the respondents' fathers worked for a mining company, others hold jobs like farm labourer, driver, dockworker and carpenter. All the parents are unskilled workers. Some of the siblings are skilled and hold jobs like accountants and clerks. In this way the groups are similar.

It is interesting that Hall (1994: 92-93) says that people learn about work values and how to think and feel about work. He claims that work values are transmitted from parents to children. He adds that work values are not some neutral and placid activity, but are made from interaction with real people in real organisations and throughout a person's work life.

Eight respondents of the working group worked before their admission to hospital and two never worked. Two respondents worked for five years and less and six worked for five years

and more. Seven of the non-working group worked before their admission and three never worked. Three worked for less than three years, two worked between three and five years and two worked for five years and more. The working group has more years working experience than the non-working group.

Two respondents from the working group have never worked. Three respondents from the non-working group have never worked before.

TABLE 3
How long did you work before your admission to hospital?

	-3 yrs	3-5yrs	5+yrs
Respondents working:	2	0	6
Respondents not working:	3	2	2

All the respondents who worked before their admission, report that they stopped work because of their illness and admission in Komani Hospital.

Two respondents from the working group, Respondent Four and Respondent Eight, received Disability grants before their admission. Both these respondents worked full-time before they become ill and received grants, they thus have some working experience. Two of the non-working group received a Disability grant before their admission to hospital. Respondent Thirteen worked before he got ill and than qualified for the grant. Respondent Twelve never worked and received a grant before his admission.

4.3 SECTION B MOTIVATION TO WORK/NOT TO WORK

4.3.1 REASONS GIVEN FOR WORKING OR NOT WORKING

Respondents One to Ten are the working group respondents and respondents Eleven to Twenty are the respondents not working.

The reasons given for working are centred on the following motivations. The staff in the ward suggested to Respondents One and Two that work was available at the factory. They chose to

work. Respondent One started work because there was nothing to do in the hospital and he felt bored and lonesome. In a study with clients/patients of a shelter workshop, the value of peer support in various aspects of the personal adjustment process is emphasised. The lives of the clients outside the workshop setting are marked by heightened dependency and restricted social mobility and this is often expressed in terms of boredom and loneliness (Dovey & Graffam 1987: 39-40). Respondent One experienced what was found in the study on patients of sheltered workshops, that the hospital setting could be compared with life outside the workshop.

In the psychosocial rehabilitation process, it is important that the staff show optimism about the vocational potential of the individual and it is important that the individual be actively involved in his own rehabilitation. Teaching the patient skills, improving vocational and social skills will assist the patient to achieve a good quality of life in the community after discharge (Bachrach 1992: 1456-1458 & Lieberman et al 2000: 3218). The recovery of the patient must be understood as an interactive phenomenon, taking into consideration the efforts of the individual, (patient decides to choose to work) the actions of the professional (to create work opportunities and encourage patient to work) and the use of community opportunities (the factory which provide work opportunities to patients) (Sullivan 1997: 185-187). It is encouraging to get feedback that the staff is optimistic about the vocational potential of patients, as was shown in the response of Respondent One and Two. Crate (1999:1) sees psychosocial rehabilitation as a process that is evolving from the medical model of diagnosis/treatment to a counsellor/practitioner facilitation of the individual patient's recovery process. The individual's responsibility is the key and unless the individual makes a conscious choice to move forward and recover, it will not happen. It could be said that Respondent One and Two had made a decision to recover.

Respondent Three chose to work because, "one thinks of a lot of things when you are not busy, one can come into trouble if you are not busy". He says that if you are bored you may think of absconding from hospital. He decided to stay out of trouble and rather chose to work. It is interested to note that work creates order and structure in the life of the individual and it is seen as a source of certainty and predictability. Christiansen (1999: 547) adds that work provides us with a sense of purpose and structure in day-to-day activities. Work offers the individual meaningful experiences and gives purpose in life. The productive system of which a job is part, orientates and controls the behaviour of those individuals that participate in it. Work provides the person with a time and space structure and work forces the person to be active and involved. (Bachrach 1992: 1456-1458 and Rankin 1991: 51-52). Respondents One and Three have worked before their admission to Komani Hospital and it can be assumed that

they knew from their previous experience of working, what work could offer them and that work can bring order and structure in one's life.

Respondent Two started to work because his health had improved and his epileptic fits were under control, since he received treatment in hospital. This is in line with what Kaplan & Sadock (1998: 925) and Bachrach (1992: 1460) suggest, that programmes must make the most effective use of pharmaoctherapies. They state that it is important to combine drug and psychosocial treatment and to ensure that the patient does not suffer from side effects of drugs that may affect his ability to work. Unless the primary symptoms are under control, rehabilitation interventions will have little success (Wing & Morris 1981: 84). Bachrach (1992: 1456-1458) also adds that the patient must understand and accept his illness and be helped to respond realistically to his illness through counseling and skills training. Suggesting to the patient that he may be able to work because of his recovery on treatment, is a sign of hope to the patient. Respondent Two seems to have insight into his illness and treatment.

Seven of the respondents mention money as their reason to choose to work. Respondent Four says that while he was sick, he burnt down his family home and he wanted to earn money to help re-build the house. Respondent Five says that he is old (33 years old) and cannot be supported by his family and he must work to be self-supportive. Respondents Six and Seven are working because they receive no financial support from their family. They must work to provide for their needs. Respondent Eight is working to support himself, as well as to take presents home on leave to his family. Respondent Nine saw his friends that were working had money, so he started working too, to earn money for himself. Respondent Ten started to work because he had no money, and he wanted to be self-supportive, and not be a beggar.

In this study money was found to be the most prominent reason why the respondents chose to work. Work secures income and gives the individual purchasing power. Work provides an income, which allows the worker autonomy in gaining goods and service. Money provides security, status and the physical necessities of life (Bachrach 1992: 1456-1458 & Rankin 1991: 51-52). Rankin (1991: 53) adds that a person is motivated by the anticipated satisfaction of his needs through the job. Having a job with an income will satisfy the respondents' needs for money and to be financially independent.

People may not work for money alone, but Robbins (1996: 239-240) asks the question, if one takes money away, how many people will still be working? He mentions that in a recent study of 2,500 employees, it was found that the workers could not agree on what their number one motivator was, but they unanimously ranked money as number two. This study reaffirms that

for the majority of employees, a regular pay cheque is necessary to meet their basic physiological needs. It can be said that money is not the only motivator, but it is difficult to argue that it does not motivate workers. It is thus not surprising that seven of the respondents were motivated by money to work. Through earning money they could provide for their basic needs.

Reasons given for not working by the non-working respondents included the following: Respondent Eleven said he is afraid to go and work at the factory or in therapy as he thinks he might get tired. He feels weak and does not know whether he would be able to work. He says the doctor talked to the ward nurse about his condition, as he only answers the doctor's questions. He realises that he should work and be independent of his family. He sometimes thinks of going to work, but then again, thinks it is better to sit in the ward. It seems as if the concept of psychosocial rehabilitation was not emphasised enough in the rehabilitation process with Respondent Eleven. Bachrach (1992: 1456-1458) suggests that the individual who suffers from long-term mental illness must be assisted to develop to the fullest extent of his capacities. It is essential that psychosocial rehabilitation must emphasise the need for individually tailored intervention and not a predetermined, stereotyped and non-individual care for a patient, and to restore hope to the individuals who, because of their psychiatric illnesses, have suffered setbacks in functional capacity and self-esteem.

Respondent Twelve has indicated that he is not interested in working at the occupational therapy department because the payment for work done there is too little, as he cannot work for R6.00 a week. He worked at the factory for a few weeks, but suffered from headaches and left the job. He says the work at the factory is difficult. Although the money at the factory is much better than that of the therapy, he is not interested in going back to work.

In a study done by Kulik (2000: 161-164) reasons why an unemployed person would turn down a job offer was examined and one of the reasons given was health reasons. Psychosocial rehabilitation programmes must make the most effective use of pharmacotherapies. It is the competent and judicious prescription and monitoring of drugs that may start the reversal of primary symptoms and allow intervention at other levels. Unless primary symptoms are under control, rehabilitation intervention at other levels will have little success (Bachrach 1992: 1460). Kaplan and Sadock (1998: 925) are also of the opinion that it is important to combine drugs and psychosocial treatments because if this is done there is greater protection against relapse and higher levels of social adjustments than to drugs or psychosocial treatments alone. It can be said that Respondent Twelve's health had effected his ability to work at the factory. Although the respondent knows that the salary at the factory

is good, he is not prepared to work at this stage. It can be said that in Respondent Twelve's case, money is not a motivator for work if one suffers from illness.

Respondent Thirteen does not work at the factory or therapy. He had the opportunity to work in a staff member's garden on the hospital grounds. He works 3 days a week in the garden and earns R50.00 per month. He also washes the staff cars for R5.00 per car. This work is sufficient for him and he is satisfied with his income.

In a study done by Mueser et al (1997: 423) on work and non-vocational domains, psychiatric patients indicated that they were dissatisfied about not working as in the case of Respondent Fourteen. Respondent Fourteen says he will never work at the therapy department because the pay there is R6.00 a week. He states that they are mental patients, but they deserve more money for work done. He wants to work at the factory, but the staff keep saying that there are no vacancies, and his name is on a waiting list. Pay at the factory is good enough and he suggests that the hospital must get more firms where patients can work. He says it is not nice to sit around in Hospital, as he wants to work.

Respondent Fifteen says that although he gets very few fits, as he is on treatment, he does not know whether he will be able to work a full day. He cannot work for the money they pay at occupational therapy. He does not know whether he will work again, but he needs money because now he cannot buy things for himself. He must look to others to give or buy him things. He thinks the government should give them a grant because he is sick in hospital. He will send some of the grant money to his mother at home as he used to from the mines where he worked before. Hudson (1982: 127) mentions that some patients who are reluctant to return to work may suffer from the loss of confidence in their ability. This is a common consequence of "being a mental patient" rather than of mental illness in itself. In hospital the patient should be helped by a step-by-step approach, with gradually increasing demands, active supervision and immediate and consistent reinforcement. Respondent Fifteen could be helped if what Hudson (1982) suggests can be implemented in Komani Hospital.

Kulik (2000: 161-164) says a potential reason for rejecting employment includes low wages that reflects dissatisfaction with job rewards. In a study done by Kulik (2000), reasons why an unemployed person would turn down a job offer were examined, and the following reasons were given: (i) health reasons (ii) low wages (iii) unsatisfactory job content (iv) family considerations (v) adverse job conditions. In this study Respondent Fifteen turned down employment at the occupational department because of low wages and turned down employment at the factory because of health reasons. Kulik's findings can be related to the

participant's decisions to turn down job offers.

Respondent Sixteen works for the manager of the tuck shop, doing the deliveries and earning R24.00 per week, which is enough for him. Respondent Seventeen says that nobody has offered him a job at the factory, but if offered a job, he will work. Respondents Eighteen and Nineteen would like to work at the factory, but the staff select other patients and their names are on a waiting list. Respondent Nineteen worked at the factory in 1997 and went on leave. When he returned, nobody approached him to work in the factory again. He would like to work if work is available.

Most of the respondents do not want to work at the occupational therapy department because the money patients earn, is too little. Tully (1986: 154-155) is of the opinion that mentally ill and disabled adults have a basic right to paid employment because paid employment is:

1) a normal feature of life,
2) used as a measure for evaluating the worth of an individual,
3) provides an earned income,
4) provides meaning and purpose,
5) offers the opportunities for attaining personal,
6) satisfaction and a sense of achievement and advancement,
7) involves obligations and responsibilities,
8) provides opportunities for the interacting with able people and becoming more integrated into mainstream society,
9) helps to improve the perceptions others, like family and employers have, of disabled people.

Robbins (1996: 239-240) states that money is a crucial incentive to work motivation. People may not work for money alone, but Robbins asks the question, if one takes money away, how many people will still be working? Robbins mentions that for money to motivate an individual's performance, there are certain conditions that must be met:

- money must be important to the individual.
- the individual as being a direct reward for performance must perceive money.
- the individual as significant must perceive the amount of money offered for the work.

It can be said that money is not the only motivator, but it is difficult to argue that it does not motivate workers. Taking Robbin's (1996: 240) opinion into consideration, it is clear that

money is a motivator for work. Most of the patients mentioned that the money for work at occupational therapy is too little and that they are not interested in working for such little money. Three of the respondents did not want to work, whether they could work or not and whether or not work was available.

GENERAL FINDINGS

The majority of respondents work for money to be self-supportive. Money can be seen as the main motivator to work.

Some respondents' health improved, which made it possible for them to work. These respondents seems to have insight in their health condition, as they mention being on medication, thus accepting that the medication is important for their recovery. There are some respondents that are uncertain of their work abilities, and it seems as if they have not yet gained confidence in their abilities.

Respondents turn down work at the occupational therapy department because the salary is too little, in their opinion. A sizeable proportion of the non-working respondents would like to work at the factory, but there are no vacancies and they must wait their turn.

4.3.2 WHAT RESPONDENTS SAY THEY GET FROM WORKING

Respondent One stated that he is familiar with the type of work he does at the factory and is now used to working. He would rather be at work than to be bored in hospital. Strong (1998: 37) found in his study on what meaningful work was, that the participants mention that work helped them to get on with life. Work becomes the medium through which their self-concept-illness relationship was challenged by incremental successful experience with work's daily challenges. Work inspired hope as they began to be aware of future possibilities. Work becomes the modality to practice and develop the interests, skills and habits necessary for the roles of worker and friend. Strong (1998: 34) adds that some participants experienced pleasure and rhythm in their work. It was found that meaningful tasks and activities not only engage a person's time and energy, but also engage the person by forming a connecting bond.

In this study, money is the reason why Respondent Five started working, but also adds that he has made lots of friends at the factory and that these friends can advise him about life. He says that he is a patient on medication, but since he started working, he always feels good and

feels like a normal working person. Strong's (1998: 37) study on the meaning of work found that the participants reported listening to other's ideas, and thinking of doing what others were doing and feeling healthier, experiencing pleasure, and seeing new possibilities and opportunities and beginning to make future plans. Work provides for the satisfaction of certain social needs of the individual. Through work the person is integrated into the society. In the workplace itself, the individual meets people, and friendships are formed (Rankin 1991: 51). Christiansen (1999: 92-99) found that the benefits of occupation include the maintenance of general physical health and satisfactory adaptations. Occupation, which is meaningful for the performer, contributes to a person's well being.

The main reason why Respondent Six is working, is money. He states that he also appreciates the chance to get out of hospital and to see and speak to other people. There are not only patients around him every day, as in the hospital. He likes being with the other workers from town. Dovey and Graffam (1987: 39-40) in their work with patients in a sheltered workshop, emphasised the value of peer support in the personal adjustment process. The effect of peer involvement in the recovery process is that it allows a level of adjustment more or less equal to those of the non-disabled population, and it inspires or allows individuals to perform at a level of competency greater than that displayed in interactions with non-disabled persons.

Respondent Nine says when he is working at the factory he always feel healthy and well. At the factory he forgets he is a patient. The response of Respondent Nine underlines the findings that psychiatric patients who are employed tend to have fewer psychiatric symptoms, better overall functioning, higher self-esteem and satisfaction with vocational services and finances (Sullivan 1997: 423). The person's work role will help him to develop a more positive self-concept and help him to move away from the patient role (Mitchell 1998: 347-348).

Eight respondents said that they get money from working. As mentioned before, money gives purchasing power and a certain amount of independence. It is interesting that the respondents mentioned that their contact with other workers is important to them and that they enjoy the other workers' stories. It underlines that patients in an institution need contact with the community. The literature states that occupation contributes to well being and it is quite surprising to hear four respondents report that they feel healthy when/since working at the factory (Christiansen 1999: 92-99). They bring their improved health status in line with their employment.

The majority of the respondents enjoy working with co-workers and they appreciate that the workers treat them as normal people.

There must be an incentive like money for patients to keep on working. Money is the main motivator to keep on working.

4.3.3 DO THE WORKING GROUP GET ANYTHING SPECIAL BECAUSE THEY ARE WORKING?

It was noted that the majority of the working respondents stated that they do not get anything extra or special because they are working. Nine of the non-working group stated that the working group gets nothing extra or special for working. Three of the working group mention that they think they might get something special and one respondent of the non- working group mentioned that the working respondents get something special. Three respondents (Six, Eight and Ten) mention that they do not expect special treatment because it is already a privilege to work from hospital.

Respondent Four says he does not get special treatment, but if he is short of tobacco the staff will buy tobacco for him, because they know he will repay them when he gets his pay. Respondents Two and Four say they have asked the staff to recommend them for permanent employment at the factory after their discharge. Respondent Nine thinks he sometimes gets special treatment, because when he comes back from work, the staff do not ask him to clean the ward, as the other patients do the cleaning.

Christiansen (1999: 92-99) is of the opinion that occupation provides a means of expression of the self and therefore contributes to the formation and maintenance of a personal identity. He adds that perceiving the self as efficacious is instrumental to engaging new challenges and gaining the success necessary for well being. Respondent Five says he does not get any special treatment, but it does not feel the same as before he was working. Since he is working, he gets leave to go home, and he now approaches the doctor for leave. He says he feels he is being listened to since he is working. It is clear that what Christiansen is saying, are what Respondent Five encounters. He expressed himself to the doctor, his identity has improved and he has engaged in new challenges by requesting leave from the doctor.

To underline the above, Respondent Eighteen of the non-working group says that he does not see any special treatment that the working patients are getting, but he has noticed that they go on regular leave to their families. It is interesting that Respondent Eighteen has noticed and associated those patients who are taking leave to their families, with their work.

From the information obtained from the respondents it is certain that they do not get anything special from the hospital. There are no material or significant privileges that they receive. This finding is also according to the majority of the non- working group's observation.

GENERAL FINDINGS

The opportunity to work is seen as a privilege by some respondents. This could be because respondents know that employment for mentally ill persons is limited, and that they have the opportunity to work while ill in hospital and earn some income.

4.3.4 WHAT IS THE STATUS OF THE WORKING GROUP?

The findings on the question of what the other patients are saying about the respondents that are working, suggest that the working group has in some way become providers for the non-working group. All the respondents from the working group reported that the patients that are not working ask for tobacco and/or money from them, and if they have, they give to the non-working group.

Respondent One claims that the patients in hospital are bored. They ask him for money and tobacco, but they do not want to work. He says he thinks they are jealous of him working. Respondent Two agrees that the other patients are jealous of them working. He can understand that some patients are sick and cannot work. He says those that are working are privileged to be able to work. It is interesting to note that two respondents have mentioned that the other patients are jealous of them. It means that these respondents do (work) or gain something (money) from working, that those patients that are not working, have not. Respondent Seven indicates that he feels sorry for some patients that want to work, but there is no work available and they must wait their turn.

Respondent Nine says that some patients show respect for him because he is working and has some status, and some look up to him, although he is young. They ask him for things that they need because he is working, and has money. Respondent Nine indicates that he has some

status, that the non-workers look up to him and Respondent Ten adds that the non-working patients treat him with respect and those patients need him to provide them with tobacco/money. Pilling's in Landman (1994: 25) says that work gives status and identity and that is what Respondent Nine and Ten have gained through working.

In accordance with the above, Rankin (1991: 51) states that work secures income and it gives the individual purchasing power. Money provides security, status and the physical necessities of life. It is clear from the findings that the working respondents have purchasing power and that the non-working patients know it and ask them for money. Work satisfies important self-esteem needs of a person by being a provider, having autonomy and establishing self-worth and self-respect. Rankin (1991: 51) refers to the Report on Work in America, which claims that work contributes to the individual's self-esteem in two ways. Firstly, a person acquires a sense of mastery over himself and his environment through the awareness of his efficacy and competence in dealing with work. The second factor derives from the view that an individual is working when he engages in activities that are useful to other people. The respondents in a way have become providers for the non-working patients as they now provide tobacco and money to them. The respondents have some form of autonomy and independence as they are self-supportive in some ways and it contributes to their self-worth and self-respect. Work also contributes to aspects of one's identity, e.g. social recognition, independence, accomplishment and attaining a valued lifestyle. The respondents and non-workers know that the respondents are competent in dealing with work.

Respondents that are not working gave the following responses on what they think of those patients that are working. Respondent Eleven says that those patients get money for working and that they give them, the non-workers, tobacco and they are their friends. Respondent Twelve says those patients are lucky to get money. He gets tobacco from the workers and says that those patients that are not employed, work for those that are employed in the ward.

Respondent Thirteen says that the patients that are working are enriching themselves. They get everything they need from the government and the factory pays them.

Respondent Fourteen says that those patients that are working are lucky to have a job and get good pay and they can save money to take home when they go on leave. He says they get out of hospital and get to see other people and hear these people's stories. The non-workers stay in the ward all the time and get visitors once a year. He says that some of the patients that are working are making money out of the non-workers and staff by lending them money, with interest.

Respondent Fifteen says that those patients that are working, have money, and that they are healthy enough to work, as many other patients cannot work. He says that if they as non-workers, work for the patients who are working in the ward, they get paid with tobacco. He says that some of the workers like it if the non-workers ask them for tobacco and that some think they are better than those not working, especially younger workers are.

The literature makes reference to the relationship between work and mental illness and Pilling's (in Landman (1994: 125) in this regard state that: (i) work gives a person a place in the community (ii) work gives status and identity (iii) work links the individual to the social world.

Five of the respondents (Sixteen - Nineteen), have mentioned that those patients that are working are lucky to earn an income and that they get tobacco from them.

In this study all the respondents mentioned that the patients who are working, earn money, and they associate money with work. Three patients mentioned that those patients that are working are "lucky" to work. They envy those working and would also like to work. The working group provides the non-workers with tobacco and money.

GENERAL FINDINGS

The respondents have gained some status in hospital. They provide tobacco to non-working patients. The general feeling is that the patients need the respondents and are treating them with respect. Two of the working group is convinced that the other non-working patients are jealous of them because they are working and earning an income. Three of the non-working group said that those patients that are working are "lucky" to have a job and earn money.

It is clear that the respondents gain much more from working than the money they receive. The way the patients in hospital treat them is conducive to the recovery of self-confidence, identity, and self-respect. They have a certain amount of status, they have proven to the other patients and staff that they can keep a job, and that the salary is enough to be self-supportive and that they are successful in what they are doing.

4.3.5 FAMILY RESPONSE TO RESPONDENTS' EMPLOYMENT STATUS

Dixon et al (2001: 22-23), in their study on the impact of health status on work, suggests that it should be important for the service systems and families to appreciate that the quality of life and the functioning of persons with mental illness can be improved by a more holistic approach to the individual's overall health. The traditional patient role where the individual was viewed as a dependant and less able to be actively involved in his well-being has changed to a role were the individual is expected to collaborate actively in goal-setting and goal-achievement (Davidson 1991: 149).

In this study, Respondent One's family does not know he is working. He says he has not told them because they would want his money, and while he did not work, they never gave him any money. Respondent Four and Eight's families do not know that they are working because they have never had a visit from the family while they were working.

The majority (7) of the respondent's families know that they are working and the families approve of them working.

The literature on psychosocial rehabilitation emphasises family support to the disabled person. Rankin (1991: 77) is of the opinion that psychosocial rehabilitation should be achieved by some of the following: family support, social support and leisure and employment. Most of the respondent's families know that they are employed and have expressed their support to the respondents. It is interesting to note that only one respondent did not inform or try to inform his family about his employment. It can thus be assumed that the fact that they had the opportunity to work, is important to the respondents, and that is why they informed their family about their work. Respondent One seems to have negative feelings towards his family because they did not provide him with money while he was home and unemployed.

GENERAL FINDINGS

Respondents are proud of their achievement of being employed and want to share this experience with their family. The Xhosa culture of the son/father providing for his family is being continued from hospital by some patients who provide for their families. Maybe the fact that the respondents are keen that their family must know that they are employed, can be to prove to the family that they are recovering from their illness and that they can be self-

supportive in some ways. The feedback from family members about the respondents working is positive, which may contribute to the respondents' motivation to keep on working.

4.3.6 WHO ENCOURAGES RESPONDENTS TO WORK?

The literature indicates there has been a change in health care delivery over time and exchange from the traditional patient's role, where the individual was viewed as dependant and less able to actively be involved in the hope of getting well, to a role where an individual is expected to collaborate actively in goal-setting and goal-achievement. However, the way in which health care professionals view the individual, the expectations of him/her and the labels attached to him/her, can influence the patient's recovery or adjustment back into society (Davidson 1991: 149). Kruger (2000: 428) states that all social sciences, including social work, psychiatric nursing, and psychiatry should see empowerment of the individuals as the ultimate goal for the psychiatrically disabled. Empowerment seeks to help the patient in making changes that will lead to greater life satisfaction and adjustment, and to increase a sense of control over their own lives.

The mental health professional has an important role to encourage and motivate the patient to participate in work as part of rehabilitation. Davidson (1991: 149) mentions that the way in which a health care professional views the individual, the expectations from the person and the labels attached to him, can influence the patient's recovery. This is also why the multi-professional team members should focus on the individual's strengths rather than on exploring his/her pathology, or weaknesses. Kruger (2000: 429-431) says that attention must be given to areas of competence and honouring fears and occasional bouts of hopelessness that are caused by the unknown of a new lifestyle. The supportive and non-threatening environment allows the patient to formulate his plans and goals to himself and then to communicate them to other people.

In this study five respondents (One, Two, Four, Seven and Nine) of the working group were encouraged by the nursing staff in the wards, to work. Four (Eleven, Twelve, Sixteen and Seventeen) of the non-working group were encouraged by nursing staff to work and Respondent Seventeen added that the staff said that employment opportunities are limited in hospital and that their names are placed on a waiting list.

Respondent Six says the staff in the ward encouraged him to start working, as well as his friends in the ward. Respondent Three says the ward doctor encouraged him to work. His

father was always a busy man working, and everything had to be neat and clean at home. It was his father that used to encourage him to work.

Three respondents, (Five, Eight and Ten) said nobody encouraged them to work, but they wanted to work, and they are self-motivated to work. Respondent Twelve does not want to work now because of the headaches he gets. By working in the staff member's garden, encourages respondent Thirteen.
Respondent Fourteen says he knows that one must work for a living and that you must work for money. His father taught him that, and his father was a hard worker. He will work if there is work at the factory, but he cannot work for the money they offer at therapy. He is not lazy, but an adult man cannot work for under R10.00 a day. Respondent Fourteen's opinion of a wage packet is underlined by Hudson's (1982:126-127) statement that one should not under-estimate the power of a wage packet, lack of financial incentive, rather that of ability, which may be the reason for low levels of productivity among the chronic psychiatric patients. Mitchell (1998: 346) indicates that the criteria of work is that it is performed in return for a salary and that people with mental health problems are not different in this respect and demand real wages for real work. The reason for Respondent Fourteen's rejection of a job offer at the therapy department is because of the low wage packet.

Respondent Fifteen says that when he feels ready, he will work, but he does not feel ready now. Two respondents (Eighteen and Nineteen) say that the staff in the ward encourage them to work. Respondent Eighteen says the staff praise him for the work he does in the ward. Respondent Nineteen says that the staff member who used to encourage them to work, has now moved to another ward. They used to work in the ward garden and plant vegetables and they would share in the profit, but now there is no garden, they have no income and nothing to do.

The staff at Komani Hospital seem to have a positive outlook on the patients' vocational ability, and encourage patients to work. On the other hand, the hospital has only a few resources that make it difficult for the staff to actively plan with the patient for vocational rehabilitation, as the staff indicated to Respondent Seventeen.

GENERAL FINDINGS

It is important that the hospital staff encourage patients to work as part of vocational rehabilitation. I think that it must be a positive contribution to a patient's self-confidence if a staff member thinks one could be employed. It is also interesting to know that some

respondents have motivated themselves to work, which shows they are on the way to recovery.

4.3.7 WHAT MOTIVATES RESPONDENTS TO KEEP ON WORKING?

Respondent One reports that he feels free and is relaxed at work. He feels physically well if he knows he has to get up and go to work. On working days he gets up in the early hours of the morning to gets ready for work. On weekends he does not feel well because he knows there is nothing to do, except to sit in the ward and relax. He feels bored and tired over weekends. He likes to work, because it keeps him healthy and busy.

All the other nine respondents say that they keep on working for the money they earn. Respondent Four says that there is nobody that can support him financially and that he must work for money to buy tobacco and to save money to rebuild his family home. Respondent Five says he saves money for his leave at home so that he can buy things for his family. He works for himself so that he does not rely on his family to buy him clothes. Respondent Six says that since he is working he has no financial worries and he is very happy to have the opportunity to work. Respondent Seven says he can buy himself the things he needs and take money home on leave. Respondent Eight adds that he needs the money from working because he saves money for when he goes on leave. Respondent Ten says he works for the ability to be self-supportive.

Respondent Two says that he is interested in the type of work he is doing and it is the work that keeps him going. It is his work that is bearing him up in hospital. He enjoys his job and that is why he keeps on working. In a study done by Strong (1998: 36-37) on how powerful the act of work can be on creating or facilitating change in a person's self-concept, some participants mentioned that they experienced a sense of pleasure and rhythm in their work. Participants reported feeling healthier, experiencing pleasure, seeing new possibilities and making future plans. Respondent Two adds that he feels good and has no physical complaints and since he has been in hospital on treatment, he has had no fits. He gets treatment in hospital and since he is well on the treatment, he got a job. Respondent Eight also reported that his health has improved since he had being working. He still sometimes has fits at work, but after he has recovered, he goes back to work. Bachrach (1992: 1460) suggests that psychosocial rehabilitation programmes must make the most effective use of pharmacotherapies, and Wing and Morris (1981: 84) add that it is important to ensure that the patient is not suffering from the side-effects of drugs which may affect their ability to work.

In a study done by Sullivan (1997: 184) to identify what the key elements of the recovery process are, as used by current consumers of mental health services, medication was noted as the most universal factor of success. It can be concluded that this patient has developed insight into his illness and he accepts medication for his illness. The mental health professionals must assist the patient in developing insight and educating the patient about his illness, which may include skills training, counselling and psycho-education as suggested by Bachrach (1992: 1460). Mitchell (1998: 347-348) says that only if the person can move away from the sick role, can it help him to develop and maintain a non-illness self-concept. Respondent Two and Respondent Eight have moved away from the ill perspective, they feel good, they see their treatment as successful, since they have been on treatment, they had no fits, and they see their job as a result of successful treatment in hospital.

One enjoys working, if one is treated well by one's employer and that is why Respondent Two keeps on working. He says that if you get joy from working, your work will improve like his has improved and then you work even harder, like he does. Strong's (1998: 36-37) study suggested that an occupation is meaningful when workers connect with the organisation, they then report a feeling and sense of belonging and being valued through their contribution at work. Engagement in daily occupation is a mechanism for meeting intrinsic needs and when met, it improves happiness, life satisfaction or perceived well being (Christiansen et al 1999: 92-99).

Respondent Three has gained some knowledge and experience from working at the factory. He adds that it is not always easy to work because it is sometimes difficult to learn new tasks, but once one has learnt, it is easy and then you feel good and happy for achieving it. He says that you know at work that there will be hard times and be happy times. The experience Respondent Three gained from working underlines what Strong (1998: 36-37) found in his study on how powerful the act of work can be. She found that work can create or facilitate change in a person's self-concept and self-efficacy. Persons can link their changed thoughts and feelings with their work experiences. Work provides the opportunity through which challenges and successes can be obtained. People are presented with challenges and new experiences while working, and with each successful experience that they credit to their own efforts, their self-efficacy improves.

Being "entertained" by other workers at work is one of the reasons Respondent Six is working. He likes talking to the other workers and has made many friends. He can also have women friends in hospital and entertain them with the money he earns, and he can buy them small things. Respondent Eight mentions that he keeps on working, because he can get out of

hospital and meet other people. Respondent Nine adds that he likes getting out of hospital and likes working with "normal" people. Respondent Ten also adds that he keeps on working because of the people he meets at work and that he can talk to them. Waters (in Sullivan 1997: 188) says that work puts people in a unique relationship with other human beings so that the opportunity to form meaningful relationships is readily available to them. Working at the factory thus puts the working State patient in a relationship with other workers with whom they can form relationships, and it is these relationships that add to reasons that make them to carry on working. To be treated as "normal" people is greatly appreciated by the respondents, and this is an important issue to them.

Respondent Ten says that when he is working at the factory he does not think he is working, it is like playing, but work is being done. He says it is because there is a happy atmosphere at work. At the factory they are not called patients, but are treated like normal people, like all the other workers. Foster et al (1997: 78) and Sullivan (1997: 178) suggest that work for the disabled should be with non-disabled co-workers. Timely and comprehensive communication among stakeholders is critical to the success of the mentally ill person's work adaptation and work performance. Workplace skills should be taught to mentally ill persons as these skills could help the person to keep his/her job. The helping professional must assist the mentally ill worker where needed. The patient, the employer and the co-worker must be informed about their tasks and different roles (Wallace et al 1999: 1147-1148). From the above response of Respondent Nine it can be assumed that the patient, co-workers and employer were trained and informed what the tasks of each one should be.

GENERAL FINDINGS

The need for money is the most important motivator that makes respondents keep on working. Other reasons mentioned were the types of work an individual is doing, the way the co-workers treat them and the opportunity to get out of hospital and feeling "free" was also mentioned.

Work is a break in everyday routine in hospital. Workers get out of hospital, do interesting work, are treated well, gain experience of work and interpersonal relationships, and with all of this, they are paid for what they do.

4.3.8 WHAT DO THE WORKERS DO WITH THEIR PAY AND HAVE THE RESPONDENTS ANY WAY OF EARNING MONEY?

Tulley (1986: 154-155) says that mentally ill adults have a basic right to paid employment and Willson (1983: 135) adds that the patient's salary should have some correlation with money earned in outside industry .
In this study the respondents are being paid for their work. Eight of the respondents save some of the money they earn. They take pocket money to buy cigarettes, tobacco and clothes. Respondents Two and Three buy tobacco and clothing and give some money to their families at home. Most respondents say they save some money for when they go on leave to their family, then take money home to give to their families or buy something for the family.

Respondents Two and Three are in-patients in hospital, but provide financially for their families. This can be seen as a cultural issue where the man must provide for his family or the son for his parents. Both Respondents Two and Three worked before their admission to hospital, and it seems that now that they are employed, they go on with the role of financial provider.

Respondents who are working, have purchasing power. They are self-supportive and financially independent. They can save and buy what they need, and assist their families.

Four respondents (One, Two, Five and Eight) have no other way of earning money. Respondent Three has a lending scheme business. He lends out money at 20% interest. Respondent Four tried to buy and sell oranges, but says there are so many patients selling oranges that he battled to sell his oranges, and stopped his business. Respondent Six buys and sells oranges. Respondent Seven buys oranges and sweets and sells to staff and patients on the hospital grounds.

Respondent Nine sometimes works for the staff and they pay him a money for pocket money. Respondent Ten gambles, sometimes he wins and sometimes he loses.

Six of the ten respondents who are working, have means of earning extra income, apart from their jobs at the factory. Money makes money, maybe that is why some of the respondents are earning an extra income, because one has to have the means to buy oranges and sweets to resell, one has to have money to lend out to get interest and one has to have money to gamble with. It can also be that the respondents have gained the confidence to try something new as they feel they are more competent and have achieved something through their work

experience.

On the question of whether the non-working group has a way of earning income in hospital, the response was as follows. Respondents Thirteen and Sixteen have jobs on the hospital grounds and receive a salary. The other patients get tobacco from the staff for work done in the wards. Two of the respondents gamble and sometimes win money.

On the question of where the non-working group gets an income from to buy things they need, three respondents (Eleven, Twelve and Nineteen) have no income and do not receive money from their families. Respondent Eleven and Fifteen ask other patients for tobacco, and also from the patients that are working at the factory. The majority of the non-working group work in the ward and get money from the staff to buy tobacco, and they sometimes make requests to the patients who are working from hospital.

Tully (1986: 155) mentions that many disabled people live in hospitals or after-care homes. They are usually involved in work, which is related to the maintenance of the residential facilities, like work in the kitchen, laundries and gardens. Much of this work has been of a menial kind and offers very few possibilities for attaining any real job satisfaction or recognition and these jobs are usually unpaid. Tully suggests that where patients choose to work in this way, and it is consistent with their individual plans and does not exploit them, payment should always be made and patients should be helped to explore alternative rewarding lifestyles.

Respondent Thirteen uses the pay he receives from working in the garden and washing of cars, to buy things he needs. Respondent Sixteen uses the pay he receives from working at the Tuckshop, to buy what be needs. Respondent Eighteen washes cars and uses his income to buy things he needs.

GENERAL FINDINGS

It is interesting to note that only three of the non-working group has an income that does not come from the ward staff or other patients. It shows that working facilities are limited. It is also interesting to note that the patients would rather work in the wards for very little money or tobacco they get from the staff, than to work at the therapy, also for little money.

The working respondents were offered the opportunity of gaining appropriate payment for work and consequent satisfaction. The chance to save some money is appreciated by the

respondents, as they know that when they go on leave to their families, they will need money, as well as on their discharge. Most of the respondents buy tobacco and clothing. Tobacco is very prominent in their lives.

4.3.9 HOW DO THE WORKERS EXPERIENCE WORKING WITH CO-WORKERS FROM TOWN?

Rankin (1991: 51) says that the work situation provides for the satisfaction of certain social needs of the individual, and through work the individual is integrated into society. In the workplace people are met, friendships are initiated and formed. The individual is provided with friendship relationships, peer relationships and subordinate relationships. The group situation at work satisfies the individual's need of belonging, and support. Rankin's observations are experienced by most of the respondents.

Seven of the respondents reported that the workers from town treat them well and they talk to them in a proper and friendly manner. They also mentioned that the workers from town do not differentiate between them as patients and the other workers. Waters (in Sullivan 1997: 188) mentions that work puts people in a unique relationship with other human beings so that the opportunity to form meaningful relationships is readily available to them. Work allows the person to feel a common bond with the larger community and gives a person a better picture of what their lives will be in future.

Respondent Two says that he has work experience and that he has worked in different workplaces and has met many different people. He says he has made good friends with the other factory workers from town. Respondent Six also mentioned that the workers and patients talk to each other and that they are friends. Respondent Seven says he likes to get out of hospital to meet other people. He, as well as Respondent Eight, finds it interesting to see that they are not treated like patients by the other workers, but like "normal" people. He likes to socialise and mix with the other workers from town, because he enjoys their stories. He says he does not feel like a patient in their presence and that he feels happy in their presence. Two other respondents, Four and Nine also mentioned that the employer and the workers from town like the patients. It is interesting to note that in their work with clients of a sheltered workshop, Dovey and Graffam (1987: 39-40) emphasised the value of peer support in various aspects of the personal adjustment process. In the workshop there are opportunities of social stimulation otherwise lacking from the clients' lives. Two of the effects of peer involvement in this process are that it allows a level of adjustment more or less equal to that

of the non-disabled population, and it inspires or allows individuals to perform at a level of competency rather than that displayed in interactions with disabled persons.

In Strong's (1998: 36) study, she examined the relationship between the meaningfulness of work and persistent mental illness and how work impacted on the patient's recovery process. It was found that work was described as acting as a bolster against their battle with illness and as a buffer for their dealing with society's negative attitudes. By persistent efforts at work, workers were redefining themselves so that they were capable of more than just a patient, but a person and thereby transcended society's labels. In the responses of the participants it is clearly seen that it is important to them that the other workers from town and their employer do not treat them as "patients", but as "normal" people. One can say that work has become the modality to the respondents to practice and develop interests, skills, and habits necessary for the roles of worker and friend. Their activities and roles were not illness-focused, and they developed life closer to the mainstream of society, the workers from town.

In this study it was found that all the respondents enjoyed working with their co-workers from town. The main reason seems to be because they feel they are treated like normal people, and that they feel accepted by the workers and the management. The workers talk politely to them and share their stories with them. Some respondents have said that they know that other workers and the management at the factory like them, as they joke with one another and get on well together. Respondent Three also says that the workers from town taught him about the work and they encourage the patients to work. He mentioned that he learnt a lot from the workers about the work in the factory.

The respondents were taught their specific jobs in the factory by co-workers and supervisors. Wallace et al (1999: 1147) say that mentally ill persons generally have difficulties interacting with supervisors and co-workers. There was no indication by the respondents that they have difficulties interacting with supervisors and co-workers. It is essential to teach workplace skills to persons with mental illness. Timely and comprehensive communication among stakeholders is critical to the success of the mentally ill person's work adaptation and work performance. It is suggested by Wallace (1999: 1147-1149) that workers would be more likely to keep their jobs if the specific details of the workplaces are identified such as timing of work and breaks, specific job tasks, pay, prospective stressors, peers and supervisors are known before beginning their employment at a workplace. At Komani Hospital workers are informed about most of the aspects mentioned by Wallace. With detailed preparation of the employer, co-workers and patients, the difficulty of interacting with co-workers and supervisors can be avoided.

GENERAL FINDINGS

The general relationships with supervisors and co-workers are very good. No negative relationship was evident. It is clear that the respondents feel accepted by the co-workers.

The success of the good relationships can be attributed to the training and information the respondents receive before they start working, the preparation of co-workers about the goals of vocational rehabilitation, and the role of employment in the lives of the patients. The responses from the respondents do not agree with what Wallaco et al (1999: 147) found, that disabled workers do not usually interact successfully with their supervisors, as all the respondents indicated that they have learnt from their supervisors and that they enjoy working with the co-workers from town.

4.3.10 WHAT KIND OF JOB ARE YOU DOING AT THE FACTORY AND WHAT HAVE YOU LEARNT?

The literature indicates that an important part of psychosocial rehabilitation is to enable people to work. Job placements are usually at an entry level and may require minimal training or skills. Employment may be competitive or sheltered. The key is that work is inextricably tied to the concept of rehabilitation (Kaplan & Sadock 1998: 9225). The work should be with non-disabled co-workers, and a job, which provides room for advancement in settings that produce valued goods and services. Employment should be integrated and competitive where the person works for at least minimum wages or better. Pre-vocational training should be available as well as transitional employment (Foster et al 1997: 78 & Sullivan 1997: 78).

In this study all the respondents do different work in the factory, and most of them assist their co-workers with tasks. The types of work mentioned were sandpaper work, spraying, staple-gun, assembling of handles, assembling of coffins, cutting of wood, filling holes with filler, working with the machine that extracts the dust, loading and off loading, and sorting of paints.

All the respondents, except Respondent Two, who has done garden work before, learnt new skills since working at the factory. The majority mentioned that they now understand the operating of a factory. From a rehabilitation sense, it is important that patients learn new skills so that they have skills when they leave the hospital. I think they will have a better chance to be employed with new skills and work experience. It is good that respondents work according to their ability and that there are a variety of jobs available at the factory for the patients.

Anthony and Blanch (in Sullivan 1997: 195) assert that "all people regardless of the severity of their disability, can do meaningful, productive work, in normal settings, if that is what they chose to do, and if they are given the necessary support". The respondents have shown that what Anthony and Blanch have said can be achieved. The two respondents that received disability grants before their admission are employed at the factory. The respondents have shown that disabled people can do meaningful, productive work in normal settings, if that is what they chose to do, and if they are given the necessary support. The respondents chose to work and support came from the employer, co-workers and multi-professional team at the hospital. State patients suffer from manifest personal or social deficiency, or are diagnosed as psychotic, alcohol/drug dependent, sexually deviant, or have anti-social personality disorders and therefore are suitable candidates for psychiatric intervention (Lloyd 1988: 182). The respondents are State patients suffering from the above-named diagnoses, and despite that, they are successfully employed. This study revealed that it is clear that the majority of the respondents' (Nine) have learnt new working skills while working at the factory.

GENERAL FINDINGS

Most of the respondents are doing unskilled work. Co-workers and supervisors taught them. The majority of respondents learnt new skills and gained work experience.

4.3.11 WHAT DO WORKERS LIKE ABOUT WORKING?

It is interesting to hear that Respondent One says he does not want to see the day wasted with doing nothing, and as long as he can go to work, he will be happy. He gets bored if not at work. He likes everything about his work, the type of work and the employer.

Respondent Two says he feels good because there are no complaints about his work. He also knows that if he was absent from work, the factory people will enquire where he was and say that they are glad when he is back at work. He says that sometimes they get incentives like braais at work, which adds to the good spirit at work.

Four of the respondents (Three, Four, Five and Eight) have gained a great deal of knowledge about working and learnt new skills at work. They enjoy the kind of work they are doing and they are self-supportive. Three respondents (Four, Five and Eight) add that they like to work with the co-workers, and like to communicate and smoke with them. Respondent Eight says he likes the way they are treated like "normal' people at the factory. Respondent Nine

mentions that he likes the type of job he is doing and the way that the factory people understand them as patients. He adds that the factory management will always listen to them and help where possible and the supervisors have no complaints about the respondents' work. He enjoys the braais and bonus they get at work. Respondent Ten enjoys the kind of work he is doing, he sees the end product and enjoys talking to and being with other workers at the factory.

All the respondents mention that they like the type of work they do at the factory and they enjoy working with their co-workers. They also mention the salary they are paid, and the new skills and knowledge they gained from working, as things they like most about their work. Some respondents have mentioned the way they are treated, as "normal" people who are listened to and who are treated well at the factory. It is clear that a variety of the respondents' life experiences have been effected.

Most people have an expectation of reward for work carried out. One of the actions in the 'contemporary concept of work is that it is a deliberate undertaking to satisfy certain recognised needs. The related work expectation is for income and the criterion of work is that it is performed in return for a salary. It is often said that people with mental health problems are not different in this respect and demand real wages for real work. Other payments-in-kind made instead of direct financial payment are also greatly appreciated by workers (Mitchell 1998: 346-347). Respondents mention their salary, and two respondents mentioned the bonus they receive, as well as braais at the factory.

GENERAL FINDINGS

The prominent aspect that respondents like about work, is the opportunity to work with supervisors and co-workers who treat the respondents like normal people. It must be gratifying to be accepted as a normal person if you are usually treated like a patient with little say, very few things to decide about, always one of a group with little being expected from one. It can be a compliment to the factory management and staff that the respondents feel so positive about their treatment by co-workers. The type of jobs and the experience they are gaining is also mentioned, as well as the salary and other incentives.

4.3.12 DO YOU THINK YOU ARE REALLY NEEDED BY THE FACTORY?

Strong (1998: 36-37) undertook a study examining the relationship between the meaningfulness of work and persistent mental illness, and how work impacted on the recovery process. The major themes framing the participants' meaning of work were: (1) Becoming a capable person with a future; work took on the meaning of providing the concrete evidence for the participants to believe that they were more than an illness. By persistent efforts at work, workers were redefining themselves as capable of being more than just a patient, but a person and thereby transcended society's labels. They were proud of their successes at work, taking initiatives and added responsibilities. Workers viewed themselves as active participants in making things happen for themselves and future possibilities were beginning to be realised. (2) Finding a place in the world; work was a way to feel valued through making contributions to a common purpose, and work was attributed as the meaning of a place to belong, feel accepted and useful.

Employment, the position you hold at work, your salary and your achievement of the work you do, has an influence on a person's identity. For the employed psychiatric patient, work has an influence on their identity. Christiansen (1999: 547) is of the opinion that occupation is the key, not just to being a person, but to being a particular person, and so creating and maintaining an identity. The contribution of work to one's identity is reflected in achieving values such as a sense of accomplishment and independence or attainment of a valued lifestyle (Spencer et al 1998: 481).

In this study all the respondents reported that they are of the opinion that the factory really needs them, and motivate their responses as follows: The respondents feel needed because their supervisors always enquire where they were if they were ill or on leave. As each worker has his own specific job to do, if one is absent, there is no-one to take his place. The respondents also mentioned that they know they are needed because their supervisors praise them for good work and they know the manager is pleased with their work.

It is clear that all respondent's felt accepted and needed by the factory. They have built an identity through their achievements at work, a feeling of accomplishment and capability.

GENERAL FINDINGS

Respondents feel needed by the factory. Again it can be said that the way the co-workers and

supervisors treat the respondents, is good. Not one respondent complains about treatment and bad interpersonal relationships. This finding is in contrast with the literature, which states that the mentally or physically disabled person usually has problems with supervisors. The positive relations the respondents have with supervisors can be attributed to good training of supervisors in understanding the respondents and moving according to their pace.

4.3.13 IF YOU ARE DISCHARGED, DO YOU THINK YOU WILL LOOK FOR A JOB?

Five respondents (One, Two, Three, Four and Six) of the working group will look for a job after their discharge. Three Respondents (Two, Four and Six) want a permanent job at the factory. If that is not possible, they will seek employment at a mining company.

Two respondents of the non-working group will seek employment. The other eight respondents of the non-working group mentioned the possibility of disability grants. Some of the respondents of the non-working group want the grant as financial security to start them off until they have other income, and some want the grant as permanent income.

Respondent Five wants to do a computer course after his discharge. If his family cannot afford to pay for his course, he will try to get a job in a wood factory. Respondent Seven wants to finish his Matriculation certificate. If his family cannot afford to pay for him, he will try and get work at the Forestry Department. Respondent Nine says that he will have to get a job because his family is educated, and he also wants a job where he gets a good salary. Respondent Ten says that after his discharge he will again start a hawker's business as he had before his admission, and make money for himself.

Strong (1998: 36) undertook a study, examining how work impacted on the recovery process of the mentally ill. Participants were proud of their successes at work. They viewed themselves as active participants in making things happen for themselves and future possibilities began to be realised. Work inspired hope as they became aware of future possibilities and they developed a life closer to the emerging self in the recovery process. Strong (1998: 36) found that work facilitates change in a person's self-concept and self-efficacy and that active engagement in work facilitates the empowerment process of the participants. Kruger (2000: 428) adds that by empowering the individual through providing work, empowerment seeks to help the patient in making changes that will lead to greater life satisfaction and adjustment, and to increase a sense of more control over their own lives.

It can be said that the respondents, through their work experience, have hope for the future. They now know what they can achieve, that they can be employed, can learn new skills, and they can work and communicate with co-workers. This working experience could be a motivation for employment after their discharge.

To add to the empowering of individuals Akabas and Gates (2000: 181-182) state that social workers as a profession need to believe that work is important in people's lives and that entitlement to an emotionally and financially fulfilling job, is an outcome worthy of constant attention.

Respondent Eight says he wants a disability grant. He will not be able to work because of fits. He says other firms will not understand his illness as his present employer. He will do odd jobs but not a permanent job. Respondent Eight worked at a mining company, but due to fits, received a disability grant before his admission at Komani hospital. Lewis (in McKinlay 1993: 49) says that when an individual suffers some disability or impairment, whether physical or mental, he is labelled accordingly. Unfortunately, such labels carry with them an assumption of dependence and limited worth by the individual. It can be said that Respondent Eight has experience of living with a label, because he knows that other firms will not employ him because of the fits.

The Employment Equity Act of 1998 attempts to protect the rights of people with disabilities and makes provision for the employment of persons with disabilities. The Act specifies that people with disabilities have a right to be protected against unfair discrimination and to expect employers to make reasonable accommodations (Employment Equity Act 1998). These "accommodations" refer to: **Job supports**: people with psychiatric disability can benefit from assistance, by: sharing posts where workers cannot work a full day. **Changes in workplace policies**: such as providing a quiet location within the workplace where the employee may go for short breaks when feeling stressed. **Flexible scheduling**: permitting a self-paced workload. The "accommodations" in a work place will make employment possible for Respondent Eight.

Foster et al (1997: 77) emphasises that the person's need for personal development in everyday life, recreation and work, should be met. The respondents have made the choice to work from the hospital and they chose to move forward and recover. They gained skills and confidence in their ability to work and that is why all but one, will look for employment after their discharge. One can say that Respondent Eight is realistic about his chances to get employment with his illness (fits), as employment for disabled persons is very limited.

Respondent Eleven does not think he will work after his discharge. He will go home to his family and take what they give him. He says he does not feel sick, he just cannot work, as he does not like it. Respondent Twelve will not look for a job as he knows there are no jobs in his home town. He will apply for a disability grant. At home he will assist his brothers in looking after their herd of cattle. Respondent Thirteen will apply for a disability grant, because he has no parents to look after him.

Respondent Fourteen will look for a job. He says he is not too lazy to work but the salary must be good. Respondent Fifteen says it will depend on his health and what the doctor says, whether he will apply for a grant, as he knows it is not easy to get work. Respondent Eighteen wants to apply for a disability grant. He will do casual jobs while receiving the grant, as he will not be able to keep a full day job because of his health problem.

Respondent Sixteen says he will work for his brother, who has his own sub-contracting company, after his discharge. Respondent Seventeen's family has a shop, and he will assist his family in the shop.

Respondent Nineteen wishes he could complete his schooling. He will apply for a grant to pay for his schooling and give some of the grant money to his mother at home. He says he wants a grant because he knows if people know that you have been in a mental hospital, they will never employ you. He says it is difficult when one is ill like him, and he will not get employment. The experience of Respondent Nineteen about employment for sick people was also experienced by participants in a study done by Strong (1998: 36) on how work impacted on the recovery process of persons with mental illness. Patients reported experiences in society that characterised persons with mental illness as "lazy", incompetent and lacking intelligence. These disempowering experiences usually affect people's self-confidence and their willingness to try new things, and their ability to make future plans. Lewis (in McKinlay 1993: 49) adds that when an individual suffers some disability or impairment, whether physical or mental, he is labelled accordingly.

Modiba (2000: 11-12) adds to the above findings in the literature that some barriers preventing people with mental illness from participating in the open labour market include: social stigma, consumers, family members, employers, economic incentives of social grants, professional attitudes and the lack of follow-up support. Unfortunately, such labels carry with them an assumption of dependence and limited worth by the individual, as can be seen with most of the respondents. It is interesting that Modiba adds social grants to her list of barriers, which prevent people from participating in the open labour market. If one looks at the

responses of the respondents, eight of them mentioned the possibility of a disability grant. I am not sure whether they really qualify for the grants, or whether the grant is an easy way to get an income. It is also true that the unemployment rate of disabled people is high, and that employment opportunities in rural areas are very limited. The respondents also know these factors, as they mention it as a reason why they will apply for a grant.

Respondent Twenty will start working until he has enough money to start his hawking business again. He says he has been in hospital for a long time, and he should get a grant to start him off after his discharge. His mother is unemployed and she cannot help him and he must help her.

GENERAL FINDINGS

Most respondents want to work after their discharge, which can prove that they have gained confidence in their abilities. It can also be that they have become used to work and having money, and they know they will not get money without working. It is interesting to note that only one respondent of the working group mentioned a disability grant. One would think that they would use the opportunity to receive a grant as they are ill, but this is not the case with the majority of the working group, but a reality in the non-working group.

Most of the non-working group will apply for a disability grant, some to start them off financially after their discharge, and others as permanent income.

It is also interesting to note that some respondents from both the working and non-working group mention that they know they will not get employment, because of the label attached to people with mental illness, which is also mentioned in the literature.

4.3.14 WHAT DO RESPONDENTS DO IN HOSPITAL IF THEY ARE NOT WORKING, AND OVER WEEKENDS?

The respondents of the working group have indicated that they do their washing, listen to the radio, help staff in the ward, talk to staff and patients, and sleep over week-ends, if they are not working. They report there is nothing constructive to do and most have indicated that they are bored over weekends.

Respondent Four says that he gets lonely and bored at the hospital and sometimes feels lonesome. Respondent Six adds that he does nothing, he sits around, eats lunch times, sleeps, eats and sleeps. He says times goes slowly. He does not like to sleep and do nothing. Respondent Eight mentions that he sometimes watches when others gamble, and Respondent Ten says he gambles over weekends.

The responses from the non-working group were as follows. Respondent Thirteen says he is not bored in hospital as he works some days of the week and keeps himself occupied doing exercise or helping the staff. Respondent Seventeen is also not bored, as he keeps himself busy by doing cleaning for the staff in the ward. Respondent Sixteen, who is working at the Tuckshop, says that when he is not at work he is bored, as there is no entertainment for the patients in the ward.

Eight of the non-working respondents indicated that they are bored in hospital. These respondents say that every day is the same, the same routine, and the same people one sees. They have nothing constructive to do, and most of the time is spent in the ward. They sleep most of the time, or talk and smoke. Respondent Fourteen indicated that he is tired of all the sleeping. He thinks of how he could help his mother at home, but now he is in hospital doing nothing. They indicate that there is very little available for them to do. Some watch TV, others help in the wards. They suggest that there should be more jobs available and patients must be paid more.

All the respondents from the non-working group reported that they help clean their wards and some reported cleaning the ward's garden. Some reported that the staff sends them to the kitchen, dispensary and matron's office.

All the respondents report that they sleep a lot, talk to friends, they sit, smoke, walk to other wards to visit friends and some watch TV. Respondent Fifteen says he plays dice and gambles. Respondent Eighteen sometimes washes the staff's cars. Six respondents of the non-working group (Twelve, Fourteen, Seventeen, Eighteen, Nineteen and Twenty) report that there is "nothing" to do in the hospital, every day has the same routine, the same people. Whiteford (2000: 200-204) in her study of occupational deprivation, pointed to the positive relationship between time spent engaging in meaningful occupation and the perceived well-being, against lack of time spent engaged in meaningful occupation in prison setting that appeared detrimental to health and well-being. The prison inmates reported sleep as a predominant response to occupational deprivation. With few occupations to provide structure

and punctuate the day, with little variety in time-use patterns, days and months felt "adrift". Many of the inmates reported a sense of hopelessness born of a deteriorating sense of efficacy for there is little or no perceived control over occupational choices. Sleep is also a predominant response by the respondents in this study to occupational deprivation, along with talking and smoking.

GENERAL FINDINGS

Respondents from both the working and non-working groups reported that they sleep a lot, talk and smoke. Sleeping is predominant in the daily routine of the respondents as was found in the study of Whiteford (2000) mentioned above, I would like to add smoking as predominant with all the respondents.

4.3.15 WHAT CAN MANAGEMENT DO?

The respondents made a few suggestions as to what the hospital management can do to motivate more patients to work. Most of the patients in hospital do not want to work, they are not interested in being employed, they are lazy, and according to Respondent One and Respondent Sixteen they are not willing to work, but they ask those patients that are working for tobacco and favours. Respondent One thinks that maybe those patients did not battle to get money at their home, and maybe their families pampered them and there was no need for them to work. Maybe they got everything they wanted from their family. What Respondent One is saying is that the non-working patients were maybe pampered and given everything by their families. This coincides with what Davidson (1991: 149) says, that society has certain expectations for people who are sick and disabled. A person who is sick usually gets exempted from regular performance expectations and usually receives special treatment, support and concern. Respondent One has no suggestions to the management.

Respondent Two says that those patients who want to work, will work. Some patients do not want to work, as they get money from their homes. He suggests that the hospital must get more jobs on the hospital grounds for patients, and that patients must be paid for work done. They will work for money, but if the money is too little, they will not work. Respondent Two sees money as a motivator for work because he says that some patients do not want to work as they get money from home. So why work if you get money? He adds that if the money for a job is too little, patients will not work.

The patients in the wards must not be allowed to sit around and do nothing, and they must be kept busy doing gardening and cleaning the wards. Respondent Three says that if you do nothing, you think about a lot of things, like absconding from hospital. He suggests that the patients must be kept busy with indoor games and there must be entertainment to break the boredom.

Respondent Four says many patients do not want to work, and they want to be given everything from the government. He says some patients start to work and as soon as they have enough money, they abscond from hospital. He does not know what management can do. Three respondents from the working group suggest that the management must keep patients busy with games like soccer and netball and they must acquire sport equipment for patients to use. Five respondents of the non-working group share this view. Management must also provide indoor games in various wards.

Four respondents (Five, Six, Eight and Nine) state that not all patients can work a full day, as they are sick, and there must be light work available for them to do. Not all patients can do hard work as they do at the factory. Respondent Ten says that the patients that are not working, and are sick, should get a disability grant of R50.00 per week. He adds that some patients are on medication, and they cannot work. Some patients are not lazy, but because of their illness nobody will employ them, and they will not be able to work a full day. He says the government must give them a grant so that they can buy themselves things like tobacco, which they now ask from the working patients.

Most of the respondents from the working group say that more patients will work in the hospital therapy department or on the hospital grounds, if the payment for work done, is better. They suggested that there must be a greater variety of work available, and that patients must be kept occupied with sport, indoor games and work in and around the wards. Some said that some patients are sick and unable to work, and should receive a grant from the government. Kulik (2000: 161-164) says that a potential reason for the rejection of employment, could be low wages. Four respondents from the non-working group (Thirteen, Fourteen, Fifteen and Nineteen) suggested that the hospital management pay patients more for work done at the occupational therapy and then more patients would be interested in working at the therapy department. Ransome (in Mitchell 1998: 346-347) indicates that most people have an expectation of reward for work carried out in their participation in employment. This usually means they earn money and can buy things that give them pleasure and satisfaction. One of the actions in the contemporary concept of work is that it is a deliberate undertaking to satisfy certain recognised needs. He adds that the related work expectation is for income and

security and that the criteria of work that is performed in return for a salary. It is often said that people with mental health problems are not different in this respect and demand real wages for real work. Hudson (1982: 126-127) says that one should not under-estimate the power of a wage packet, lack of financial incentive, rather that of ability, which may be the reason for low levels of productivity among the chronic psychiatric patients.

The opinion of Ransome and Hudson are also the opinion of four of the respondents in the non- working group and the majority of respondents in the working group, as they are of the opinion that more patients will work at the therapy department if they are paid a better salary.

Three respondents from the non-working group (Eleven, Fifteen and Twenty) suggested that the management or government pay ill patients a grant because those patients have no income and cannot work for an income. Respondent Ten of the working group also holds this opinion. The literature indicates that people who are ill sometimes evaluate themselves in a negative way. This occurs when the person sees himself or herself in a totally negative way. Mitchell (1998: 347-348) says this often is seen in institutions. In a study done by Dixon et al (2001: 22-23) the impact of health status on work, symptoms and functional outcome in severe mental illness, it was found that the patient's self perceived overall health assessment was greatly related to work motivation, chronic unemployment, self-esteem and almost all of the quality of life variables. The study suggests that it should be important for the service systems and families to appreciate that the quality of life and the functioning of persons with mental illness, can be improved by a more holistic approach to the individual's overall health. Davidson (1991: 149) says that social groups have certain expectations for people who are sick and disabled. A person who is sick usually gets exempted from regular performance expectations and receives special treatment, support and concern. Sometimes people with disabilities, severe or chronic illness, get so accustomed to the role of being sick that they have difficulty in returning to normal functioning.

Respondent Thirteen says he was motivated by his mother to work, as she taught him to solve problems. He suggests that more job opportunities must be created at occupational therapy and patients should get paid R50.00 per week. He says that some patients think they will be in hospital for a short while and are not interested in work, but later they realise they have been in hospital for a long time and they need money. Patients then realise that they will have to work for an income, and then there are no jobs available for them. Hall (1994: 92-93) is of the opinion that people learn about work values, how to feel or how to think about work. Usually work values are transmitted from parent to child This was also the case with Respondent Thirteen who says his mother motivated him to work and solve problems.

Respondent Fourteen says that the staff cannot keep on paying patients out of their pockets as they are doing now, and the government must pay patients for work done in the wards, not the staff.

Respondent Seventeen observed that patients do not want to work because they get money from parents and shared it. Hudson (1982: 127) states that the patient's family and their attitude towards the patient are often very influential on the person's work performance. Poor work performance by patients can be related to low expectations by the parents of the patient.

Respondent Seventeen suggests that the management give incentives for good behaviour. He adds that more job opportunities must be created on the grounds and outside hospital for patients. The staff tells the patients that they evaluate them according to the work they can do, but there is no work to do except in the wards. He says that if one works, one goes on leave and gets discharged easier than if you do not work. In his opinion this is unfair because some of the patients, like him, want to work, but there is no work available. Whiteford (2000: 200-202) talks about occupational deprivation which is a state in which a person or group of people is unable to do what is meaningful and necessary in their lives due to external restrictions. The state of deprivation occurs due to a force outside the person's control, as in the situation where a patient wants to work but no employment is available. This patient is deprived, as Yerxa stated "Occupation is not just something nice to do, rather, it is wired into human" Akabas and Gates (2000: 165-188) says that people with mental illness have a right to employment as an option, even if in the end it is not attainable.

Respondent Seventeen is of the opinion that the patients who are employed, go on leave to their families and that these patients are discharged easier than the patients that are not working. He mentions that the staff said that they evaluate the patients by the work they do. He is not working, as work is not available, and feels he is unfairly treated. Lindhorst et al (2000: 176-177) did research on patients residing in a state hospital, identifying the patient-related factors associated with discharge. Their study found that patients who have community passes, and who participated in community educational or vocational activities, are more likely to be discharged.

The care of the State patient is extremely costly to a mental health service as the State patients usually require hospitalisation for long periods, with a relatively high level of staff support. The Eastern Cape Provincial mental health services is of the opinion that State patients' care needs to be viewed as a specialist service and it should develop a range of community forensic services in line with the overall move towards providing more care in the

community. At this stage, it is strange that there is only one factory that accommodates patients for industrial therapy at Komani Hospital and the management has not prioritised this issue to be in line with the provincial policy (Mental Health Service 1999: 3). The view that work is crucial to mental health and to the treatment of mental illness has persisted over years. Despite this basic understanding of human functioning, the integration of work into the systems that treat severe mental illness is limited, sporadic and inadequately addressed, as in the case of Komani Hospital (Harding et al 1987: 317).

Respondent Twelve and Eighteen agree that there must be more job opportunities and adds that there must be a variety of jobs that patients can choose from, because they have different interests. He adds that patients are not all physically the same. Some can do hard work like those patients working at the factory, and others can do work that is not so demanding and management must provide for all patients' needs. Variety in work has been identified as a characteristic of motivation to work, and is an example of an intrinsic reward. Mitchell (1998: 345-346) indicates that studies have found variety of work to be influential in producing worker satisfaction. He adds that this finding underlines the need to understand and consider the factors that make a rewarding or unrewarding experience when work rehabilitation is developed. Respondent Eighteen's suggestion that there must be a variety of jobs that patients can choose from, agree with findings that variety is a characteristic of motivation to work and it satisfies workers.

Respondent Twenty says patients will need money on their discharge, as there is no money at home. They will work in hospital if the money they can earn is enough.

GENERAL FINDINGS

Most of the respondents say that more patients will work if they get more pay. Respondents agree that not all patients can work because of different illnesses, and they agree that there should be a variety of work available that patients can choose from. Light work should be available as well as odd jobs that can be done on the hospital grounds. Some respondents suggested that the management must provide sport equipment for sport, as well as indoor games in the ward, for patients to keep themselves occupied.

4.4 CONCLUSION

The biographical detail provided in Section A provides a profile of the ten working and ten

non-working respondents who were interviewed. No significant biographical differences were found between the two groups.

The working group is motivated by money as well as the opportunity to get out of hospital and socialising with co-workers, with which they all indicated they had good relationships.

Many of the non-working group are not working because of health reasons. Some respondents want to work, but no vacancies are available at the factory, and they are not prepared to work at the occupational therapy department because of the low payment.

Both groups are bored in hospital where very few recreation facilities are available. Sleeping and smoking are the predominant activities among the respondents.

The next chapter will draw conclusions from these findings and make some recommendations.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this study, the perceived value of work in psychosocial rehabilitation, the motivation to work and what respondents gain from working, were explored. The experiences of the non-working group of respondents not working, were also explored. In this chapter, the findings will be discussed. For ease of understanding, recommendations will be discussed after each theme.

5.2 CONCLUSIONS OF THE RESEARCH

The conclusions reached in each section of the previous chapter are discussed.

5.2.1 CONCLUSIONS OF SECTION A: BIOGRAPHICAL DETAILS

There is no significant difference in the areas where respondents grew up. Three working and two non-working respondents grew up in urban areas and seven working and eight non-working respondents grew up in rural areas.

The average age of the working group is 34.9 years and that of the non-working group is 33.9 years. There were no significant differences in the ages of the respondents, with the working group older than the non-working group.

The non-working group's level of education is higher than that of the working group. More of the working group has Std one and less, than that of the non-working group. The non-working group has six respondents with Std six and higher, against four of the working group.

All the respondents' fathers have worked and most of the siblings are working. From both groups, the family and the respondents have done unskilled work.

Eight respondents from the working group worked before their admission, and seven from the non-working group worked before their admission. Two respondents from the working group, and three respondents from the non-working group had never worked before their admission into hospital. Again, there is no significant difference between the two groups.

Two respondents from the working group received a disability grant before their admission into hospital. Both these respondents were previously employed, they became ill and then received the grants. Three respondents from the non-working group received disability grants. Two respondents were employed, became ill and then received grants, and the third respondent had never worked, and received a grant. There is only one respondent that had never worked, that received a grant.

Although some respondents received a Disability Grant before their admission, they are able to work from the hospital for a full day. This could be because their mental condition is stable on medication, or it could be that the work they are doing, falls within their capabilities.

5.3 CONCLUSION OF SECTION B: WORK MOTIVATION

The sample, ten respondents who work and ten respondents that do not work, is not sufficient to generalise.

5.3.1 CONCLUSIONS ON WORK MOTIVATION AND WHAT MAKES RESPONDENTS KEEP ON WORKING

Being bored was part of the respondents' motivation to work as they would rather work and be busy with something constructive, than sit around in hospital. The literature indicates that being unemployed reduces a person's daily variety in experience. The unemployed person develops an inability to structure both leisure and daytime activity. Unemployment also reduces the opportunity to make decisions, because there is little to decide about (Hall 1994: 30-32). One respondent mentioned that he decided to work to stay out of trouble because he says "when one is bored, one may think of absconding". He chose to work and stay out of trouble. Rankin (1991: 51-52) indicated that the productive system, of which a job is part, orientates and controls the behaviour of those individuals that participate in it.

The literature indicates that payment for work is one of the strongest motivators to work.

Willson (1983: 134) says that if work is to provide status, personal satisfaction and a link with a normal lifestyle, payment should have some correlation with money earned in the outside industry. The majority of respondents in this study have reported that the need for money motivated them to work. They had no income and decided that they must work to be self-supportive. The money gives them purchasing power. With the salary they receive, they can save money and take money to their families. Two of the respondents reported that they provide for their family at home from their salary.

Ransome as cited in Mitchell (1998: 346-347), states that one of the action in the contemporary concept of work is that it is a deliberate undertaking to satisfy certain recognised needs. He adds that the related work expectation is for income and security and that the criteria of work that is performed in return for a salary. It is often said that people with mental health problems are not different in this respect and demand real wages for real work. What Ransome stated is proved by the respondent's motivation to work.

Psychosocial programmes must make the most effective use of pharmacotherapies. It is the competent and judicious use and monitoring of drugs that may start the reversal of primary symptoms and allow intervention at other levels (Bachrach 1992: 1460). It emerged that some of the respondents have believed that since they started working, their health improved, and they reported feeling good and healthy. They are on medication, but at work they feel good and are active. Harding et al (1987: 317) mentions Galen who pronounced, "Employment is nature's best physician and is essential to human happiness".

The majority of respondents mentioned that they enjoy working with their co-workers from town. They enjoy the co-workers' stories, and they like being treated as "normal" people at work. They enjoy getting out of hospital, mixing with ordinary people, and they do not only have patients as company all day, as they see different people. One respondent mentioned that when he is at work, he forgets he is a patient. Another respondent mentioned feeling "free" and relaxed at work, and that work keeps him healthy and busy. Foster et al (1997: 78) indicates that employment for disabled persons should be with non-disabled co-workers. Rankin (1991: 51) adds that the work situation provides for the satisfaction of certain social needs of the individual. In the workplace, people are met and friendships are initiated and formed. Wing and Morris (1981: 82) mention that work in an industrial unit frequently necessitates patients handling materials and components to one another, or in a flow-line, where co-operation and speech are necessary, as in the case in the factory where the respondents are employed.

In conclusion, it is clear that the relationship between respondents and co-workers is good, and that the respondents enjoy their co-workers company. The respondents like socialising with the co-workers and they are treated as ordinary workers. They are encouraged by the co-workers to work. Through the contact with co-workers the respondents learn conversational skills. This finding is in contrast with what Wallace et al (1999: 1147-1149) indicated, that some mentally ill persons have difficulties with interacting with supervisors and co-workers.

This study found that respondents keep on working because they enjoy being at work. Respondents also mentioned that the type of work they do is interesting and that they can see the end product of their work. Some of the respondents mentioned that they get incentives for working, like a bonus at the end of the year, as well as braais at work. Strong (1998: 36-38) in his study, examined the relationship between the meaningfulness of work and persistent mental illness and how work impacted on the recovery process. Participants linked their changed thoughts and feelings with their work experiences. Work provides the opportunity, where respondents experienced connections with others, contributing to others and where challenges and successes can be obtained. Some respondents experienced a sense of pleasure and rhythm in their work, and a sense of competence.

The fact that they have learnt new skills while working at the factory also encourages respondents to keep on working. Respondents are presented with challenges and new experiences at work, which they enjoy.

The more skills the workers can gain and develop while in hospital, the greater their chances to live independently after their discharge. The contact with co-workers improves their communication with abled workers, and through this contact they gain understanding of what is acceptable and unacceptable to society, before returning to the community.

In conclusion, it was found that the respondents keep on working for the money they are paid, their health has improved since working, they enjoy the company of their co-workers and the manner in which they are treated at the factory, and the work they do is interesting. They are self-supportive and enjoy the incentives they get from work. Other aspects that motivated respondents, were boredom and friends.

The industrial therapy at the factory provides a link between the respondents' institutional environment and their future environment by allowing for and encouraging the rehearsal of newly adopted behaviours like socialising with co-workers, working a full day, taking responsibilities at work and living with the demands of the world outside the hospital, during

the day.

RECOMMENDATIONS

Money is the main motivator to work, but then the patient must be satisfied with the amount of money he earns. It is recommended that the hospital negotiate with the patients and employees about the payment of the patients so that all parties are satisfied with the pay situation.

Work must preferably be with non-disabled workers from the community, as patients learn to socialise with people other than patients and they can learn from these workers what will be expected from them in society.

Respondents' report their health has improved since working. This could be because patients are not under pressure in their work situation and that the pharmacotherapy is successfully implemented. It is recommended that patient's health be monitored on an ongoing basis by the ward staff as well as the supervisors in the occupational and industrial settings to ensure ongoing good health.

Work for patients in an occupational or industrial setting must be interesting to the workers, and they should be able to see the end product.

Workers must feel that their co-workers and the management of the industrial setting accept them.

The respondents report that they feel healthier since working. This could be because they do not feel under pressure at work, that they feel accepted, and therefore it is important that the patients, as well as the workers, be prepared for working and socialising with each other.

5.3.2 CONCLUSIONS ON WHY RESPONDENTS ARE NOT WORKING

Health reasons are given as reasons why respondents do not work. These respondents feel that because of their illness, they cannot work. This is in spite of the senior psychiatrist, at Komani Hospital having identified the respondents as mentally fit to work. Crist and Stoffel, as cited in Mitchell (1998:347-348), state that people who are ill sometimes see themselves totally in terms of their illness, and that it is often seen in institutions. They elaborate that only if the

person can move away from the sick role, can it help him/her to develop and maintain a non-illness self-concept. Dixon et al (2001: 22-23) did a study on the impact of health status on work and he suggests that it should be important for the service systems and families to appreciate that the quality of life and the functioning of persons with mental illness can be improved by a more holistic approach to the individual's overall health.

Two respondents from the non-working group are working on the hospital grounds, employed by staff members, and they are satisfied with the salary they receive. They are prepared to do work on the hospital grounds because they are satisfied with their salaries.

Some respondents have indicated that they want to work but that there are no vacancies available at the factory and they are not interested in working in the occupational therapy department because the salary is too little. Surveys done by Roger, as mentioned by Mueser et al (1997: 419), on competitive employment for persons with psychiatric disorders, have indicated that psychiatric patients are dissatisfied about not working, and they expressed a desire for competitive, integrated employment, like the respondents in this study are doing. To add to this, Tully (1986: 154-155) states that appropriate efforts should be made to integrate disabled people into a workplace. Mitchell (1998: 345-346) states that variety in work has been identified as a characteristic of motivation to work and is an example of an intrinsic reward. He also adds that variety of work is influential in producing worker satisfaction.

The majority of respondents are adamant that they will not work at the occupational therapy department, because of the low salary patients are paid. They will rather be without an income than work for what they think is too little money. This attitude indicates that money can be a motivator to work. The literature indicates that low wages and health reasons can be potential reasons for rejecting employment (Kulik 2000:161;164), as was found in this study. Willson (1983: 134) adds that for many patients, inadequate rewards will amount to reduced motivation to work. Society places a monetary value on people and low payment can be in the eyes of the patient, a low valuation on his own ability or existence.

In conclusion it can be said that some respondents do not work because of health reasons. Some of the respondents want to work, but there are not enough work opportunities for all the patients. There is work available at the occupational therapy department, but according to the respondents, the payment is too little.

It must be difficult for the multi-disciplinary team to have a rehabilitation plan for patients, to develop working skills when there are no job opportunities for the patients. The rehabilitation

goal cannot be achieved when needed because the resources are not available, which may result in the patient staying longer in hospital so that the needed skills can be developed, or otherwise the patient is discharged without proper skills development.

RECOMMENDATIONS

It is recommended that the payment of patients at the occupational therapy department be revised and a new payment system be implemented so that patients can be satisfied with payment and not feel misused with the little pay they get.

There must be more variety of work available in hospital and in the community as variety may encourage more patients to work, as people's interests differ.

It is recommended that the patient be made part of his rehabilitation programme and that they be motivated to participate in the success of such a programme. This should include informing patients about their health status and whether they can participate in a work programme.

5.3.3 CONCLUSIONS ON WHETHER THE WORKING GROUP GETS ANYTHING EXTRA FOR WORKING

The majority of respondents think they do not receive anything special because they are working and all the respondents indicated that they do not want anything special.

Two respondents get favours from the staff in the ward, one does not help clean the ward and one borrowed money from the staff to buy tobacco, and he repays them when he gets his salary. Some of the respondents indicated that they see the opportunities they have to work as a privilege, and they do not need anything extra.

The majority of the non-working respondents mention that the working group is not getting anything special because they are working. Only one respondent indicated that the working group gets leave to go home to their families. He associated work with leave.

There is no different policy in the hospital on the treatment of working patients, they are all treated the same. Some patients think they get special treatment in their ward, but nothing significant.

In conclusion it was found that the working group of respondents in general do not get anything extra or special because they are working.

RECOMMENDATIONS

I am of the opinion that if the patients that are working get some incentives from the hospital, like leave to go shopping or attend soccer matches in town, it will encourage more patients to work. It is therefore recommended that incentives are given to the working patients to encourage them and other patients to work as part of their rehabilitation. This should be done within the legal framework of the State patient.

5.3.4 CONCLUSIONS OF WHAT TWO GROUPS THINK OF EACH OTHER'S STATUS

Some respondents feel that the non-working group is jealous of the working group because they are working and earn money. Van Weeghel and Zeelen, as cited in Bachrach (1992: 1456-1458), mention some advantages of pursuing vocational rehabilitation and mention that work provides an income, which allows the person's autonomy in gaining goods and services. Pilling (in Landman 1994: 125), refers to the relationship between work and well-being and says that work gives status and identity. In this study respondents have indicated that they have some status because they are working and are self-supportive.

The non-working patients ask the working group for tobacco and money. Respondents from the working group are felt needed by the non-working group and other patients because they provide them with tobacco. These respondents also mentioned that some patients from the non-working group want to work, but there is no work available. It is mentioned that not all patients can work as that they have different illnesses and some are on medication.

This study has found that the non-working group indicates that the working Respondents, give them tobacco and money. Respondents from the non-working group have indicated that they would like to work, but that there was no work available with an acceptable salary.

The majority of the non-working group envies the workers for working and having the chance to earn a salary. They say the workers are "lucky" to have work and that they can work with people from town. One respondent mentioned that some of the working groups think they are

better than the non-working group, especially the younger ones. The non-working respondents say that those patients who stay in hospital every day have the same daily routine, they see the same people, and nothing is new. One respondent was of the opinion that the working group are enriching themselves, because they are provided by the government with what they need and also get a salary at the factory.

In summary it can be said that the non-working respondents envy the working group for being employed, earning a salary and having contact with people from the community. Some of the non-working respondents would like to work but there is no work available.

RECOMMENDATIONS

Patients should not be jealous of each other because work is available for some and not for others. Work with a salary should be available and a natural option for each patient that is able to work.

5.3.5 CONCLUSIONS ON WHO ENCOURAGES RESPONDENTS TO WORK

Most of the respondents informed or tried to inform their family that they were working. The families approved of the respondents working and they had positive feedback from the families on the fact that they are working.

There have been changes in health care delivery over the years and expectations of the traditional patient's role, where the individual was viewed as dependant and less able to be actively involved in getting well, to a role where an individual is expected to collaborate actively in goal-setting and goal-achievement (Davidson 1991: 149). Half of the working respondents were encouraged by nursing staff in their ward to work. Some respondents were self-motivated to work. One respondent reported that his father used to encourage him to work.

To restore hope to the individual who, because of his psychiatric illnesses, has suffered setbacks in functional capacity and self-esteem, is a concept of psychosocial rehabilitation. Staff attitudes are all-important to encourage patients to work. According to Wing and Morris (1981:83) conventional over-protection can be disastrous. Mental health workers should endeavour to regard themselves as teachers of self-help and other skills. High levels of

expectations of patients have an influence them. The aim should be to make it possible for a patient to achieve a mini-success in work, in the hope that the experience will encourage him/her to future effort. Most of the non-working respondents were encouraged by staff in their ward to help in the ward. The ward staff also encouraged respondents to work at the factory when work is available, but they have indicated to the respondents that there are limited working opportunities.

RECOMMENDATIONS

The family of patients should be part of the rehabilitation plan for the patient so that the family can also encourage patients to work and prepare themselves for their discharge. This would also help the family to see the patient as a person with a potential to work and live in the community after their discharge.

All mental health workers should encourage patients to work as part of their psychosocial programme.

5.3.6 CONCLUSIONS ON WHAT RESPONDENTS DO WITH THE PAY THEY RECEIVE AND WHERE DO THE NON-WORKING GROUP GET THEIR INCOME FROM

Tully (1986: 154-155) states that mentally ill and disabled adults have a basic right to paid employment because employment provides an earned income and opportunities for the interacting with abled people, and becoming more integrated into mainstream society.

The majority of the working group respondents save some of their money for when they go on leave to family and for personal needs. Two respondents provide financially for their families at home. All of the respondents use some of their money on cigarettes and/or tobacco and some give money/tobacco to the other patients in their wards. In conclusion it can be said that the respondents have purchasing power, they are in many ways self-supportive and by handling their own money affairs, they gain money management skills.

Two of the respondents from the non-working group who do casual work on the Hospital grounds use their salary to buy what they need. One respondent washes staff vehicles and uses his pay to buy things he needs.

Tully (1986: 155) mentions that many ill and disabled people live in congregated residences like after-care homes and hospitals. They are usually involved in work which is related to the maintenance of residential facilities, like work in the kitchen, laundry, and gardens. These jobs are usually unpaid. Tully adds that where patients choose to work in this way, and it is consistent with their individual plans and do not exploit them, payment should be made and patients should be helped to explore alternative rewarding lifestyles. This study has indicated that the majority of the non-working group works in the wards and gets money/tobacco from the staff for the work they do in the ward, which gets paid out of staff's own funds, as there are no funds from the hospital available to pay patients for work done in the wards. Two respondents have indicated that they request and receive tobacco from patients that work at the factory.

RECOMMENDATIONS

If more work opportunities are available, patients will be able to work and will not have to ask fellow patients for favours.

The staff should not pay patients for work done in the wards, as staff are paid to do the work in the wards. Patients should be encouraged to work at occupational therapy and do industrial therapy. It is not an ideal situation for patients to be in the wards most of the day as this can easily contribute to institutionalisation if patients do not socialise or break everyday routine in hospital.

Patients should not get into the habit of begging from others in hospital as this habit can be continued up after discharge, which can make the patient's adaptation in society more difficult.

Payment should satisfy the worker, and the workers should have the opportunity to administer their own money.

5.3.7 CONCLUSIONS ON WHAT RESPONDENTS LIKE ABOUT THE WORK THEY DO AND WHO TAUGHT THEM

Juhasz (in Mitchell 1998: 347-348) identified the work role as one of three major role dimensions, in addition to the family and individual roles. The work role will help the individual to develop a more positive self-concept and to move away from the patient's role.

The participating workers in Mitchell's study saw the development of new skills and the acquisition of new knowledge as an important aspect of their involvement in the project. Dickerson (in McKinlay 1993: 70) states that the ideal is that the individual will learn a new skill and this will ensure that the individual's chance to get employment after discharge will be better. This study revealed that all the respondents, except one, learnt new skills while working at the factory. The respondents do different kinds of work in the factory, and each one knows his own work. Co-workers and supervisors taught all the respondents, except one, how to do their specific work. All the respondents, except one, mentioned that they have learnt more than one new thing at the factory, excluding the specific work they are doing.

One respondent said that he is self-supportive since working at the factory. Another mentioned that he has met friends at work and socialised with co-workers.

One respondent mentioned that the factory management listens to them as respondents, and they try to help if they can. The objective of work performance as mentioned by Lloyd (1988; 187) was achieved by most respondents. They learnt to carry out tasks, developed good work habits, and learnt how to relate to fellow workers and to follow instructions.

Two of the respondents mentioned that they enjoy the incentives they receive for work done. Some respondents, as a reason, also mention the fact that there are no complaints about their work.

In conclusion it can be said that the respondents obtained knowledge of their abilities to learn new working skills, and gained knowledge of their strengths and weaknesses in a particular work setting. They gained insight into their own job behaviour and their ability to work with co-workers and supervisors.

RECOMMENDATIONS

Workers must have the opportunity to gain new working skills while working that can assist them to prepare for work outside hospital.

Disabled workers can be taught skills by co-workers and supervisors if the relationships between these parties are good.

Patients should receive incentives for work because this can motivate them to work even more and participate in their own rehabilitation programme.

5.3.8 CONCLUSIONS ON WHETHER THE RESPONDENTS FEEL NEEDED BY THE FACTORY

The literature indicates that the value of work in psychosocial rehabilitation lies in the concept that work is a normal activity that can best be associated with status, reward, satisfaction and acceptability. To be effective, work should be realistic and be of some recognisable value to society. An apparently pointless task is unlikely to contribute towards an environment that promotes self-respect and constructive behaviour.

This study revealed that all the respondents mentioned that they felt the factory needed them. The respondents each have their own job, and if they are absent from work, there is no-one to take over their work. The respondents feel they satisfy their employer and supervisors' and there are no complaints about their work performance. Some respondents mentioned that their supervisors sometimes praise them for work done. Respondents learnt about the operating of a factory, that one job follows another, and if they are absent from work, there is nobody to take over their specific job. One respondent indicated that the people at the factory like the respondents and they will miss them if they are not at work.

The above-mentioned findings are consistent with what Strong (1998: 36-37) found in her study on how work impacted on the recovery process of the mentally ill person. It was found that by persistent efforts at work, workers were redefining themselves, and that they were capable of being more than just a patient, but a person, and thereby transcended society's labels. They were proud of their successes at work, taking initiative and added responsibilities at work. Work becomes the modality to practice and develop the interests, skills, and habits necessary for the roles of worker and friend.

In conclusion it can be said that when the respondents focus on their purposeful activity at work, it means that their ability for independent occupational performance is maximised. The workers gained self-confidence in their work ability through the positive feedback they received from their supervisors. The work they do and the product they produce is meaningful to society. This is also why all the respondents did not hesitate to report that they think they are really needed by the factory. These skills, tasks and roles the respondents mastered at work will be transferred to their adaptation back into the community after their discharge.

RECOMMENDATIONS

Patients should feel needed to do their specific job as this gives them a feeling of self-worth.

This will only materialise if patients do work that produces something of meaning where they can earn money.

It is necessary that patients get feedback about their work performance as this gives them a feeling of mastery and satisfaction.

5.3.9 CONCLUSIONS ON WHETHER THE RESPONDENTS WILL SEEK EMPLOYMENT AFTER THEIR DISCHARGE

Six of the working group will seek employment after their discharge. Two respondents from the working group want to further their education. If their families cannot assist them financially with the education costs, they will seek employment. One respondent from the working group wants to restart his hawking business, which he had before his admission into Komani Hospital.

One respondent from the working group indicated he wants a disability grant after his discharge. He worked before, started getting fits, received a disability grant and then was admitted to Komani Hospital. The respondent claims that he would not get employment because of the fits, and that other firms would not understand his illness like the factory, where he is employed.

Modiba (2000: 11-12) indicates that there are barriers preventing people with mental illness from participating in the open labour market which include: social stigma, consumers, family members, employers, economic incentives of social grants, professional attitudes and the lack of follow-up support. Six respondents from the non-working group have stated that they will apply for a grant because of their health problems. One of the six mentioned that there is no work in the town where he comes from, and that he will apply for a grant.

One respondent of the non-working group wishes to complete his Matriculation and will need a grant to pay for his schooling. He mentioned that he wants a grant because he knows that if people know that one has been in a mental hospital, one would not get employment.

In conclusion, it is clear that the majority of the working group will seek employment after their discharge. Only one respondent from the working group indicated that he wants a grant because he received a grant before his admission and he knows that other firms will not accommodate him with the fits he get, as does the firm where he is working now.

The majority of the non-working group will apply for a grant because they are ill. Respondents from both groups mentioned the stigma of being mentally ill and that job opportunities for them are non-existent.

RECOMMENDATIONS

It seems that successful employment while in hospital encourages patients to work after discharge. More patients should be encouraged to work while in hospital, as more patients should then be motivated and prepared to work after their discharge.

The fact that some of the respondents mentioned that they want to further their studies and schooling, is a sign of hope for their future. The hospital management should evaluate patients who are interested in further studies and literacy courses and involve the community in educating patients while in hospital.

5.3.10 CONCLUSIONS ON WHAT RESPONDENTS DO WHEN THEY ARE NOT WORKING AND WHAT RESPONDENTS FROM BOTH GROUPS CAN DO NOT TO BECOME BORED

The majority of respondents from the working group indicated that there is nothing constructive they can do over weekends when they are not working. They keep themselves busy with cleaning and washing tasks, socialise with fellow patients, watch TV, and listen to the radio.

One respondent from the working group mentioned that he can work in the kitchen and in a ward garden over weekends, but because there is no payment for these jobs, he is not prepared to work without pay. One respondent from the working group mentioned that he gets lonely and bored over weekends.

The majority of respondents from both working and non-working groups stated that they sleep a lot. One respondent adds that time goes slowly. Two respondents from the non-working group mention gambling, while one patient gambles, the other one watches.

The majority of the non-working group (eight) respondents indicated that they are bored in

hospital. They stated that every day has the same routine, involves the same people, and there is nothing constructive to keep themselves occupied with, as most time is spend in the wards. The majority of respondents mention that they sleep, sit, talk and smoke with friends, which is their predominant occupation. Respondents indicated that there are no sport facilities or entertainment available for the patients.

The majority of the respondents are of the opinion that there is very little they can do not to be bored. They indicated that if there were sport facilities and other entertainment, they would participate.

There is no psychosocial rehabilitation programme available for individuals because of the unavailability of facilities for patients. Patients are kept in the wards with the same daily routine. No demands are made on patients and this situation can increase apathy, withdrawal, and antisocial behaviour. Work opportunities are insufficient and patients are not paid adequately, according to them, for work done.

RECOMMENDATIONS

The hospital management should prioritise the appointment of an occupational therapist to initiate the development of recreational and leisure activities for patients in hospital.

5.3.11 CONCLUSIONS ON WHAT THE HOSPITAL MANAGEMENT CAN DO TO MAKE MORE PATIENTS INTERESTED IN WORKING

Half of the working group indicated that not all patients in hospital can work because some are ill and are on medication. From these views of the respondents, it can be said that they do not see work as a part of a patient's rehabilitation process and Anthony and Blanch (in Sullivan 1997: 195) assert, that "all people, regardless of the severity of their disability, can do meaningful, productive work, in normal settings. If that is what they chose to do, and if they are given the necessary support", is not part of the respondents' insight into the rehabilitation process in hospital.

Three respondents from the working group and one respondent from the non-working group that work on the hospital grounds indicated that patients do not want to work and that patients

are lazy. Two respondents from the working group and one respondent from the non-working group said that patients receive money from their families and that they do not have to work for an income. One respondent of the working group says that some patients expect everything from the government.

A suggestion by both working and non-working groups was that the hospital management must provide more jobs for patients at factories and on the hospital grounds, and patients must be paid more for work done in the hospital. They suggested that the patients be paid more at the occupational therapy department, then more patients would be interested in working there. Some respondents mention that the ill patients cannot work a full day nor do difficult work as the respondents working at the factory are doing, and light work should be available for patients on the grounds.

Other suggestions from both the groups were that the management must provide sport equipment for patients, as well as indoor games in various wards. One respondent from the working group and three respondents from the non-working group suggested that the hospital management must give the ill patients a grant to provide for their needs, as these patients cannot work for an income. One respondent from the non-working group said that, at present, the staff must pay patients for work done in the wards, and that the management should pay the patients, not the staff.

In conclusion, it is clear that there are very little recreational and leisure facilities available for patients in the hospital. Respondents mentioned the need to work and requested more job opportunities with adequate payment.

RECOMMENDATIONS

The hospital management should make use of hospital open days and mental health days to promote insight into mental illness, and to get the community involved in the rehabilitation of patients.

The management should motivate more employers to accommodate the patients to work in their firms and should promote the Employment Equity Act of 1998.

The advantages of work as part of psychosocial rehabilitation should be advocated to patients by the multi-disciplinary team.

5.4 FUTURE RESEARCH

It is hoped that this study will stimulate others to carry out similar studies, as the State patients and other patients in hospital can benefit from it. It may be necessary to duplicate this study with State patients in other psychiatric hospitals to determine whether the description of work motivation given in this study, reflects the general opinion, rather than just that of one unique group in one hospital.

Future research should be done on:

- Ways in which patients can use time more constructively in hospital with limited funds available.
- How to change a patient from the "sick role" to an active partner in the psychosocial rehabilitation programme.
- How does the fact that patients work at occupational therapy or industrial therapy influence their discharge?

5.5 CONCLUDING COMMENTS

This study has revealed that money motivates State patients to work while in hospital. The workers enjoy the company of abled co-workers, and workers and supervisors can have good relationships. The majority of workers gained new skills and experience while working. The respondents' health improved since working, which underlines that work increases well-being.

The study also revealed that there are limited work opportunities at Komani Hospital. There is very little that patients can do to keep themselves occupied, and there are few leisure facilities available, and limited sport activities. The hospital management should involve the community in service-delivery to the patients to prevent institutionalisation. The hospital management should inform the communities and families of patients, about psychiatric rehabilitation and its message of hope to the general public.

Some patients see themselves in their sick role and should be educated that all patients have the potential to do something constructive.

BIBLIOGRAPHY

Akabas S H & Gates L B. 2000. A Social Work Role: Promoting Employment Equity for People with Serious and Persistent Mental Illness. Administration in Social Work 23(3/4): 164-182.

Arnold J, Cooper C L & Robertson I T. 1998 (3rd edition). Work psychology, understanding human behaviour in the workplace. London: Pitman Publishing.

Auster C J. 1996. The sociology of work, concepts and cases. London: Pine Forge Press.

Bachrach L L. 1992. Psychosocial rehabilitation and psychiatry in the care of long-term patients. The American Journal of Psychiatry, 149(11): 1455-1462.

Bargal D. 2000. The future development of occupational social work. Administration in Social Work, 23(3/4): 139-153.

Behr A L. 1983. Empirical research methods for the human sciences. Pretoria: Butterworths.

Bemak F, Chung R C & Bornemann T H. 1996 (4th edition). Counselling and psychotherapy with refugees in, Counselling across cultures, edited by Pedersen P B and Draguns J G et al, London: Sage publications.

Christiansen C H. 1999. Defining lives: An essay on competence, coherence, and the creation of meaning. The American Journal of Occupational Therapy. 53 (6).

Christiansen C H, Backman C, Little B R & Nguyen A. 1999. Occupations and well being: A study of personal projects. The American Journal of Occupational Therapy. 53 (1).

Coffey A & Atkinson P. 1996. Making sense of qualitative data. Complementary research strategies. London: Sage publications.

Constitution of the Republic of South Africa, 108 / 1996. Pretoria: Government Printer.

http://members.mint.net/scrate/psychosoc.htm/Crate S C Psychosocial Rehabilitation. 14/3/2001

Creswell J W. 1994. Research design: qualitative and quantitative approaches. London: Sage publications.

Criminal Procedures Act, 51/ 1977. Pretoria: Government Printer.

Davidson H. 1991. Performance and the social environment, in Occupational therapy, edited by C Christiansen & C Baum, New Jersey: Slack Incorporated.

De Vos A S. 1998. Research at grassroots. A primer for the caring professions. Pretoria: J L van Schaik publishers.

Dipboye R L, Smith C S & Howell W C. 1994. Understanding an industrial and integrated organisational approach psychology. Florida: Holt, Rinehart and Winston, Inc.

Dixon L, Goldberg R, Lehman A & McNary S. 2001. The impact of health status on work, symptoms, and functional outcomes in severe mental illness. The Journal of Nervous and Mental Disease, 189(1): 22-23.

Dovey K A & Graffam J H. 1987. The experience of disability: social construction and imposed limitation. Burwood: Victoria College Press.

Employment Equity Act, 55 / 1998 Pretoria: Government Printer.

Fielding N. 1993. Qualitative interview, in Researching social life, edited by N Gilbert. London: Sage Publications.

Fontana A & Frey H. 2000 (2nd edition). The interview, in Handbook of qualitative research, edited by N K Denzin and Y S Lincoln. London: Sage Publications Inc.

Foster D, Freeman M & Pillay Y. 1997. Mental health policy issues for South Africa. Pinelands: Multimedia Publications.

Grinnell R M. 1988 (3rd edition). Social work research and evaluation. Itasca: F. E. Peacock Publishers.

Hall D & Hall I. 1996. Practical social research: project work in the community. Malaysia: MacMillan Press Ltd.

Hall R H. 1994. Sociology of work, perspectives, analyses, and issues. London: Pine Forge Press.

Harding C M, Strauss J S, Hafez H & Lieberman P B. 1987. Work and mental illness; Towards an integration of the rehabilitation process. The Journal of Nervous and Mental Disease, 175(6): 317.

Hudson B L . 1982. Social work with psychiatric patients. London: The Macmillan Press Ltd.

Kaplan H I. & Sadock B J. 1998 (8th edition). Synopsis of psychiatry. Philadelphia: Lippincott Williams & Wilkins.

Kruger A. 1980. Mental health law in South Africa. Durban: Butterworth.

Kruger A. 2000. Empowerment in social work practice with the psychiatrically disabled: modal and method. Smith College Studies In Social Work 70 (3).

Kulik L. 2000. The impact of education and family attributes on attitudes and responses to unemployment among men and woman. Journal of Sociology & Social Welfare, XXXVII(2): 161-164.

Landman M. 1994. Mobilisation of social support for State patients in Lebowa. Unpublished Ph. D. dissertation : UNISA, Pretoria.

Landy F J. 1989 (4th edition). Psychology of work behaviour. California: Brooks/Cole Publishing Company.

Liberman R P, Kopelowicza and Smith T E. 2000 (7th edition) Psychiatric rehabilitation, incomprehensive textbook of psychiatry, edited by Sadock B J and Sadock V A. Philadelphia: Lippincott, Williams & Wilkins.

Lindhorst D M, Turner M A and Woodward C. 2000. Factors associated with the discharge of patients from a long-term state psychiatric hospital. Social Work Research. 24(3): 169-177.

Lindqvist P & Skipworth J. 2000. Evidence-based rehabilitation in forensic psychiatry. British Journal of Psychiatry. 176: 321-322.

Lloyd C. 1988. Occupational therapy in forensic psychiatry, in Occupational therapy in mental health, principles in practice, edited by D W Scott and N Katz. London: Taylor &

Francis.

Lloyd C, Kanowski H & Samra P. 1998. Developing occupational therapy services within an integrated mental health service. British Journal of Occupational Therapy, 61(5): 214-218.

Lombard A. 2000. Enhancing A Human Rights Culture Through Social Work Practice And Training. Social work, 36(2): 133-138.

Lowenberg G & Conrad K A. 1998. Current perspectives in industrial/organizational psychology. Boston: Allyn & Bacon.

Mamasels C S & Landman M. 1991. Role of the social worker in forensic psychiatry. Social Work Practice. 2.91: 20-23.

Marlow C. 1993. Research methods for generalist social work. Pacific Grove: Brooks/Cole Publishing Company.

Marlow C. 1998 (2nd edition). Research methods for generalist social work. Pacific Grove: Brooks/Cole Publishing Company.

Marshall C & Rossman G B. 1999 (3rd edition) Designing qualitative research London: Sage Publications.

McKinlay I. 1993. Werkskepping as deel van die taak van die maatskaplike werker in die rehabilitasie van gestremdes. Ongepubliseerde MS-verhandeling Universiteit van Pretoria, Pretoria.

Mental Health Act, 18 of 1973. Pretoria: Government Printer.

Merriam S B. 1988. Case study research in education: A qualitative approach. San Fransisco: Jossey-Bass.

Miles M B & Huberman A M. 1994 (2nd edition). Qualitative data analysis. United States of America: Sage publications.

Mitchell D. 1998. Promoting enjoyment and self-belief through work rehabilitation. Archives of Psychiatric Nursing. XII: (6). 344-348.

Modiba P. 2000. Factors influencing the employment of persons with mental illness: An overview of a study in progress. REHABNET Psychosocial rehabilitation. 3(1).

Mudrick N R. 1991. An underdeveloped role for occupational social work: Facilitating the employment of people with disabilities. Social work, 36(6): 494-495.
Mueser K T, Becker D R, Torrey W C Xie H, Bond G R, Drake R E and Dain B J. 1997. Work and Nonvocational Domains of Functioning in Persons with Severe Mental Illness: A Longitudinal Analysis. The Journal of Nervous and Mental Disease. 185(7): 419-422.

Oppenheim A N. 1997 (new edition). Questionnaire design, interviewing and attitude measurement. London: Printer Publishers.

Rankin P. 1991. Industrial social work. An explanation and an assessment of the practice of social work in industry in South Africa. Unpublished D Phil: Rhodes University, Grahamstown.

Reynolds P. 1997. Vision: Well being and suffering in Mental health policy issues for South Africa, edited by Foster D, Freeman M and Pillay V. Pinelands: Medical Association of S A.

Ridley C R & Lingle D W. 1996 (4th edition). Cultural empathy in multicultural counselling in Counselling across cultures, edited by Pedersen P B, Draguns J G, Lonner W J and Trimble J E. London: Sage Publications.

Robbins S P. 1996 (7th edition). Organizational behaviour - concepts -controversies - applications. London: Prentice-Hall International, Inc.

Royse D. 1991. Research methods in social work. United States of America: Nelson-Hall Inc.

Rubin A & Babbie E. 1997 (3rd edition). Research methods for social work. Pacific Grove: Brooks/Cole Publishing Company.

S A Federation For Mental Health. 2001. Reasonable Accommodations for Persons with Psychiatric Disability. Braamfontein: Information and Resource Centre.

Schultz D P & Schultz S E. 1998 (7th edition). Psychology and work today. New Jersey: Prentic Hall.

Schurink E M. 1998. The methodology of unstructured face-to-face interviewing, in Research at grass roots, edited by A S De Vos, Pretoria: J. L. van Schaik.

Serfontein M. 1993. Introduction to occupational therapy notes. Department of Occupational Therapy, Komani Hospital; Queenstown.

South Africa. Directorate: Mental Health and Substance Abuse. 2001. Quarterly Newsletter, Second quater. Pretoria: Government Printer.
South Africa, National Progressive Primary Health Care Network. 2000. Training Manual For Implementors Of Health Rights. Braamfontein: National Centre.

South Africa. Eastern Cape transformation plan for mental health services Compiled by the Provincial Task Team with assistance from the Hospital Transformation Project. 1999. Bisho: Government Printer.

South Africa. Guidelines on forensic psychiatric services in terms of the stipulations of the Mental Health Act, 1973 (Act 18 of 1973) and the Criminal Procedures Act, 1977 (Act 51 of 1977). Department of National Health and Population Development. 1992. Pretoria: Government Printer.

South Africa. Province of the Eastern Cape. Department of Welfare: Hospital Social Work Services Principles and Guidelines. 1998. Bisho: Government Printer.

South Africa. White Paper for Social Welfare. 1997. Pretoria: Government Printer.

Spencer J, Daybell P J, Eschenfelder V, Khalaf R, Pike J M & Woods-Petitti M. 1998. Contrasting perspectives on work: An exploratory qualitative study based on the concept of adaptation. The American Journal of Occupational Therapy. 52 (6) 481.

Strong S. 1998. Meaningful work in supportive environment: Experiences with the recovery process. The American Journal of Occupational Therapy. 52 (1) 36-37.

Sullivan W P. 1997. On strengths, niches, and recovery from serious mental illness in The strengths perspective in social work practice, (2nd edition) edited by D Saleebey, New York: Longman Publishers.

Tesch R. 1990. Qualitative research: analysis types and software tools. New York: Falmer.

The Employment Equity Act of 1998. Pretoria: Government Printer.

Tully K. 1986. Improving residential life for disabled people. London: Churchill Livingstone.

Uys L R. 1997. Psychosocial Rehabilitation Counselling Manual. Durban: Dept of Nursing, University of Natal.

Uys L R. 2000. Psychosocial Rehabilitation: A Consensus Statement For South Africa. REHABNET Psychosocial Rehabilitation 1(4): 14.

Vithal R & Jansen J. 1997. Designing your first research proposal. Cape Town: Juta.

Wallace C J, Tauber R & Wilde J. 1999. Teaching Fundamental Workplace Skills to Persons With Serious Mental Illness. Psychiatric Services, 50(9): 1147-1149.

Whiteford G. 2000. Occupational Deprivation: Global Challenge in the New Millennium. British Journal of Occupational Therapy, 63(5): 200-204.

Willson M. 1983. Occupational therapy in long-term psychiatry. New York: Churchhill Livingstone.

Wing J K & Morris B. 1981. Handbook of psychiatric rehabilitation practice. New York: Oxford University Press.

Zabow T. 1981. Management of the mentally ill offender in South Africa: the assessment and rehabilitation programme in Cape Town. International Journal of Law and psychiatry (4) 449-456).

APPENDIX A

5 Peacock Street
QUEENSTOWN
5320

6th March 2001

The Superintendent
Komani Hospital
QUEENSTOWN
5320

Dear Dr. Shrestha

PERMISSION TO DO RESEARCH

As discussed with you, I have registered for Masters in Social Work. I need to do a research project and I would like to do the research at Komani Hospital with State Patients, researching the value of work for working and non-working patients, and make a possible recommendation to the Hospital Management and Regional Office.

Could you please give me your written consent to do the research.

Yours faithfully

A.P. CROCKER

APPENDIX B

INTERVIEW SCHEDULE

INTERVIEW WITH STATE PATIENTS WHO ARE WORKING

1. Where did you grow up?
2. How old are you?
3. What is the highest level of education you have?
4. Which of the people in your family work?
5. What kind of work do they do?
6. Did you work before your admission?
7. What kind of work did you do?
8. How long did you work?
9. Why did you stop working?
10. Did you receive a disability grant at any time?
11. For what reason did you receive the grant?
12. Please tell me why have you chosen to work at the factory?
13. What do you get from working?
14. Do you get anything extra or special because you are working from the hospital?
15. What do you get?
16. Do you think you should get special privileges because you are working?
17. If yes, why and what?
18. What do the other patients say about you working?
19. What does your family say about you working?
20. Who in hospital encourages you to work?
21. What are the three most important things that make you keep on working?
22. What do you do with the pay you are getting?
23. You work with workers from town, can you explain how they treat you?
24. What kind of job are you doing at the factory?
25. Did you know how to do it?
26. If not, who taught you?
27. Is there anything else that you have learnt while working at the factory?
28. What are the two things you like most about your work?
29. Do you think you are really needed by the factory to do your specific job?

30. Why?
31. If you are discharged, do you think you will look for a job?
32. What do you do in hospital during weekends or holidays when the factory is closed?
33. What do you think the hospital management can do to get more patients interested to work from or in hospital?
34. Apart from your job at the factory, have you any other way of earning money?

APPENDIX C

INTERVIEW SCHEDULE

INTERVIEW WITH STATE PATIENTS WHO ARE NOT WORKING

1. Where did you grow up?
2. How old are you?
3. What is the highest level of education you have?
4. Which of the people in your family work?
5. What kind of work do they do?
6. Did you work before your admission?
7. What kind of work did you do?
8. How long did you work?
9. Why did you stop working?
10. Did you receive a disability grant at any time?
11. For what reason did you receive the grant?
12. You spend most of your time in hospital, what do you do during the day?
13. Please tell me why are you not working at the factory or at occupational therapy?
14. Do the patients that are working, get anything extra or special because they are working from the hospital?
15. What do they get?
16. What do you think about those patients that are working?
17. Did you have any encouragement from someone at home or in hospital to work?
18. If yes, who?
19. Do you think that you will work after your discharge? Explain.
20. Have you got any way of earning money in hospital?
21. If yes, how?
22. Where do you get money from to buy things like tobacco?
23. Do you sometimes get bored in hospital?
24. If yes, what do you think the hospital can do to solve this boredom?
25. What can you do not to be bored?
26. What do you think the hospital management can do to make patients interested to work from hospital or at occupational therapy?

APPENDIX D

IMBUZO KWIZIGULANA EZINGAPHANGELIYO

1. Ukhulele phi?
2. Iminyaka yakho mingaphi?
3. Uyeke kweliphi ibanga esikolweni?
4. Ngobani abantu abaphangelayo ekhaya?
5. Benza msebenzi mni?
6. Wakhe waphangela ngaphambili?
7. Wawusenza msebenzi mni?
8. Wasebenza ixesha elingakanani apho?
9. Kwathini ukuze uyeke?
10. Wawungumntu ofumana inkam-nkam?
11. Isizathu soko besiyintoni?
12. Ingaba imini yakho apha esibhedlele uyichitha njani?
13. Yintoni isizathu sokuba ukhethe ukungaphangeli apha esibhedlele okanye efemini?
14. Ingaba izigulana ezisebenzayo kukho okunye abakufumanayo kunani apha esibhedlele?
15. Ukuba kunjalo bafumana ntoni?
16. Ucinga ngaba basebenzayo?
17. Ingaba ikhona inkuthazo owayifumanayo kumntu osekhaya okanye esibhedlele ngokusebenza?
18. Ukuba kunjalo ngubani?
19. Ucinga ukuba ungasebenza emva kokukhululwa esibhedlele? Chaza.
20. Ingaba ikhona enye indlela oyisebenzisayo yokufumana imali apha esibhedlele?
21. Ukuba kunjalo wenza ntoni?
22. Uyithatha imali yokuthenga izinto ezifana necuba?
23. Ingaba ngamanye amaxesha uyakruquka / udikwe kokuhlala apha esibhedlele?
24. Ukuba kunjalo yintoni enokwenziwa sibhedlele ukunqanda oko
25. Ucinga yintoni into onokuyenza ukze ungadinwa kukuhlala apha esibhedlele.
26. Yintoni enokwenziwa ngabaphathi besibhedlele ukwenza izigulana zibe nomdla wokusebenza apha esibhedlele.

APPENDIX E

IMBUZO YABO BAPHANGELAYO

1. Ukhulele phi?
2. Iminyaka yakho mingaphi?
3. Uyeke kweliphi ibanga esikolweni?
4. Ngobani abantu abaphangelayo ekhaya?
5. Benza msebenzi mni?
6. Wakhe waphangela phambi kokuba uze apha esibhedlele?
7. Wawusebenza msebenzi mni?
8. Wasebenza ixesha elingakanani?
9. Yintoni eyabangela uyeke ukuphangela.
10. Wakhe wayifumana indodla / inkam-nkam ngapha-mbili?
11. Sasiyintoni isizathu sokuba uyifumane?
12. Nceda, uxele kutheni ukuze ukuphangela efemini?
13. Yintoni oyifumanayo njengokuba uphangela?
14. Kukho okuthile okufumanayo apha esibhedlele kuba usebenza?
15. Kuyinntoni oko?
16. Wena ucinga ukuba kumele ukuba niphathwe ngcono kuba niphangela?
17. Ukuba kunjalo kutheni kwaye kuyintoni?
18. Ezinye izigulana zintoni ngokuphangela kwakho?
19. Bona ekhaya bathini ngokuba uphangela.
20. Ngubani onikhuthazayo apha esibhedlele ukuba niphangele?
21. Khawundixelele izinto zibentathu esibalulekileyo ezikwenza ukuba uphangele?
22. Wenza ntoni ngale mali uyifumanayo njengoko uphangela?
23. Phaya emsebenzini uphangela nabanye abasebenzi abahlala elokishini, khawatsho impatho yabo kuni injani?
24. Wenza umsebenzi onjani efemini?
25. Wawusazi ukuba wasenziwa njani?
26. Ukuba akunjalo, wafundiswa ngubani?
27. Ingaba sikhona esinye isakhono osifundileyo njenngokuba uphangela efemini?

28. Ntozini ezimbini ozithandayo ngomsebenzi wakho?
29. Ucinga ukuba phaya emsebenzi ufuneka mpela ukuba wenza umsebenzi othile?
30. Utsho kuba kutheni?
31. Za unokukhululwa esibhedlele, ingaba uza kufuna umsebenzi?
32. Wenza ntoni apha esibhedlele ngempelaveki okanye xa kuvaliwe emsebenzini?
33. Ucinga ukuba yintoni enokwenziwa phatise besibhedlele ukuza izigulana zibe nomdla wokuphangela?
34. Ngaphandle kokuba usebenza ikhona enye indlela efumana ngayo imali?

APPENDIX F

QUESTIONS TO STATE PATIENTS

WHO ARE NOT WORKING

1. **Where did you grow up?**

   I was born and grew up in Cradock location.

2. **How old are you?**

   I was born in 1960, the 12th of July. I am 40 years old.

3. **Did you work before your admission?**

   I was earning a disability grant in Cradock. I got the grant because I was disabled. They sent me to Tower Hospital, from there I was at home and then to Komani Hospital. I got the grant for about 8 years.

4. **Which of the people in you family work?**

   My mother was a domestic worker, working in the kitchen. My father was a plumber, he died in 1970. I have six brothers, they all died, it is now only me and my 2 sisters. My one brother was a bricklayer, the other one a plumber, one worked at the railway station, the other a policeman. They all died. My one sister is married to a policeman, they live in Port Elizabeth. They have a house in Port Elizabeth. The other sister lives in Cape Town at my mother's family. My mother was born at Worcester.

5. **What is the highest level of education you have?**

   I was at school before I got a grant. I was in Std 9. I left in June in Std 9. **Why?** Because my mother was battling financially and my sister was not working then and staying at home. My mother was earning only R40 per month and she could not afford to let me go on with school. I did work for about one year as an apprentice

6. **Please tell me why are you not working at the factory or at occupational therapy?**

   I am not working in hospital therapy or at the factory. I help in the ward. I sometimes go to Mrs. Lombo's house, she is a staff member, on the hospital grounds and help her in the garden.

   The doctor has promised me a conditional discharge, but Mrs. Lombo is still working

on it, with my sister. I want conditional discharge.

7. **How often do you work at Lombo's house?**

I sometimes work 3 days a week at Lombo's place and Sundays I wash her car and her husband's car.

8. **How much do you earn?**

They give me R10-00 for the two cars and I get R50-00 a month for the garden work, every 15th of the month.

9. **What do you think about those patients that are working?**

There are patients working at Quality Coffins. Those patients are enriching themselves. They get everything from the Government and they still get paid at the factory, about R50-00 a week. They get everything from the hospital, they are getting food, clothes, water, toiletries and food and recreation from the government. They should not get anything more from the hospital, they get everything for free from the government, that is enough. They get money from the factory.

10. **Do the patients that are working, get anything extra or special because they are working from the hospital?**

Those patients working are treated like all other patients. They take bread to work, dinner and night plate is kept for them in the ward. They eat when they are back from work.

11. **Did you have any encouragement from someone at home or in hospital to work?**

I like the way Mrs. Lombo is treating me while I work there, she is treating me like her child at home. That is the encouragement I get to work and keep on working.

12. **You spend most of your time in hospital, what do you do during the day?**

I help clean the ward for the staff, clean the kitchen, taking the box to the dispensary or CSSD or letters to Matron's Office. They like us to be clean and behave like a normal person. I also work for the staff.

13. **Do you think that you will work after your discharge?**

If I am discharged, I want to carry on with my apprenticeship to be a bricklayer and if not so, the government must give me a disability grant because I have no mother or father to look after me, they died.

14. **Where do you get money from to buy things like tobacco?**

With my pay I buy myself tobacco, a R7-00 packet of tobacco, teabags and a small

packet of sugar.

15. **Do you sometimes get bored in hospital?**

I do exercise so that I am not bored. I was a judo champion at school, now I am training, doing somersaults, khatas.

16. **Do you train other patients?**

I do the exercises alone, the others are not interested. I keep myself fit. I used to play for a soccer club at home. I used to do shoe repairs at Therapy, but the pay is too little. We used to play soccer here at Komani, we used to play a lot and also against Tower Hospital, but now there is nothing.

17. **What do you think the hospital management can do to make patients interested to work from hospital or at occupational therapy?**

The management could start weight-lifting, gym work for patients to keep fit. I do not know how the hospital management can motivate people to work. I got my motivation from my mother at home. She taught me to solve problems, she taught me one should work. Some patients are lazy, I think they misuse the treatment, use it as an excuse not to work. Some patients think they will stay in hospital for a short period and are not interested to earn money, but later they seen they are not discharged. Other patients think their family should give them money while they are in hospital, they should not work for it.

The management should start soccer, dances, other games like cards, dominoes. I will suggest that the therapy should have more jobs and the pay must be at least R50-00 a week. They must teach the patients new skills like the shoe therapy, carpentry, welding. They money now is too little. People will work for money.

APPENDIX G

QUESTIONS TO STATE PATIENTS

WHO ARE WORKING

1. **Where did you grow up?**

   I was born and grew up in Sterkspruit.

2. **How old are you?**

   Born 1969, 32 years old.

3. **What is the highest level of education you have?**

   I left school in Std. 4 because my parents did not have money for me to go further at school.

4. **Which of the people in your family work?**

   My mother and my brothers after me are working. My father passed away. He used to work on the mines. My brothers also work in the mines. My mother is a domestic worker.

5. **Did you work before your admission?**

   I used to work in Welkom on the mines.

   I used to work with the modern drill which does the sides. I worked for more than three years. I left the work because I got ill.

6. **Please tell me why have you chosen to work at the factory?**

   I started to work at the factory because my family does not send my any money. I cannot buy tobacco or cooldrink without money. Now that I am working, I can buy those things. I buy myself eats and clothing.

7. **What do you get from working?**

   I get money from working. I get the change to get out of hospital and see and speak to other people not just patients everyday.

8. **Do you get anything extra or special because you are working?**

   The staff treat us all the same in the ward. We that are working do not get special treatment. Other patients work during the week in the ward and we help them weekends. I get no extra treatment.

I do not expect special treatment because I work, it is already a privilege.

9. **What do the other patients say about you working?**

The patients that are not working treat me well, they are not jealous of us working. Some are sick.

10. **What does your family say about you working?**

My mother knows that I am working. She once came to the Komani Hospital to visit me. She brought me some shoes and clothes and though I was not working. I told her I am also working and I gave her R100-00 so she could see that I am also working. She was very glad that I was working.

11. **Who in hospital encourages you to work?**

The sisters in the ward encourage me to work and that I should not stop working. My friends also encourage me to work, to go on working.

12. **What are the three most important things that make you keep on working?**

I like the money best of all. I get entertained at work, I talk to the other workers, I have no financial worries, I am happy that I am working. I now can make friends with the women in the hospital and buy them small things.

13. **What do you do with the pay you are getting?**

I save my money until I have enough to buy clothes. I buy tobacco.

14. **What kind of job are you doing at the factory?**

My work at the factory is to use the machine to suck all the dust, it works like a broom. I do the whole factory. My supervisor showed me how to work the machine.

15. **Is there anything else that you have learnt while working at the factory?**

I worked in the garden before. I have learnt a lot at the factory. I worked in the spray room, I can spray now. I have learnt a lot. I have learnt to work the machine that cut the bottom of the coffins.

I can now work many things, machines. I know about wood and the process of making a coffin.

16. **You work with workers from town, can you explain how they treat you?**

The other workers treat us very well, I work well with them. I cannot complain about them. We talk to each other, we are friends.

17. **Do you think you are really needed by the factory to do your specific job?**

They will miss me very much when I am not at work. Each worker is doing his own

job. If I am not at the work, there is no-one to do my job. If they replace me with another worker, that worker's place will be empty. My supervisor Mr.de Kock praises me at work, he is happy with my work.

18. **If you are discharged, do you think you will look for a job?**

If I am discharged, I will go to the mine and look for a job there again. I would also not mind if I can work here permanently at the factory because I know this work now.

19. **What do you do in hospital during weekends or holidays when the factory is closed?**

If it is weekend or holiday I just sit at hospital, I do nothing the whole day, I just eat lunch times and sleep, eat and sleep. The time goes slow. I do not like it to just sleep and do nothing.

20. **What do you think the hospital management can do to get more patients interested to work from or in hospital?**

I do not think the hospital management can do a lot. Some of those patients are on heavy medication like Modecate, they will not be able to work and fit into the factory work. They should look for work at the occupational therapy department. They should start there and get better pay. They should work in the staff private residence gardens and earn money that way. That should encourage them to work.

21. **Apart from your job at the factory, have you any other way of earning money?**

I sometimes buy a bag of oranges and sell the loose oranges to make a profit and that is how I try to make more money.

APPENDIX H

THE PATIENTS' RIGHTS CHARTER

For many decades the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to health care services. To ensure the realisation of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa (Act No. 108 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and therefore proclaims this PATIENTS' RIGHTS CHARTER as a common standard for achieving the realisation of this right.

A HEALTHY AND SAFE ENVIRONMENT

Everyone has the right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection.

PARTICIPATION IN DECISION-MAKING

Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision-making on matters affecting one's health.

ACCESS TO HEALTHCARE

Everyone has the right of access to health care services that include:

i. **receiving timely emergency care**

at any health care facility that is open regardless of one's ability to pay;

ii. **treatment and rehabilitation**

that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;

iii. **provision for special needs**

in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, person living with HIV or AIDS patients;

iv. **counselling**

without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;

v. **palliative care**

that is affordable and effective in cases of incurable or terminal illness;

vi. **a positive disposition**

displayed by health care providers that demonstrate courtesy, human dignity, patience, empathy and tolerance.

vii. **health information**

that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient.

KNOWLEDGE OF ONE'S HEALTH INSURANCE/MEDICAL AID SCHEME

A member of a health insurance or medical aid scheme is entitled to information about that insurance or medical aid scheme and to challenge, where necessary, the decisions of such health insurance or medical aid scheme relating to the member.

CHOICE OF HEALTH SERVICES

Everyone has the right to choose a particular health care provider for services or a particular health facility for treatment provided that such choice shall not be contrary to the ethical standards applicable to such health care providers or facilities, and the choice of facilities in line with prescribed service delivery guide lines.

BE TREATED BY A NAMED HEALTH CARE PROVIDER

Everyone has the right to know the person that is providing health care and therefore must be attended to by clearly identified health care providers.

CONFIDENTIALITY AND PRIVACY

Information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or an order of the court.

INFORMED CONSENT

Everyone has the right to be given full and accurate information about the nature eof one's illness, diagnostic procedures, the proposed treatment and the costs involved, for one to make a decision that affects anyone of these elements.

REFUSAL OF TREATMENT

A person may refuse treatment and such refusal shall be verbal or in writing provided that such refusal does not endanger the health of others.

BE REFERRED FOR A SECOND OPINION

Everyone has the right to be referred for a second opinion on request to a health provider of one's choice.

CONTINUITY OF CARE

No one shall be abandoned by a health care professional worker or a health facility which initially took responsibility for one's health.

COMPLAIN ABOUT HEALTH SERVICES

Everyone has the right to complain about health care services and to have such complaints investigated and to receive a full response on such investigation.

RESPONSIBILITIES OF THE PATIENT

- Every patient or client has the following responsibilities:
- To take care for and protect the environment.
- To respect the rights of other patients and health providers.
- To utilise the health care system properly and not abuse it.
- To know his or her local health services and what they offer.

- To provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counseling purposes.

- To advise the health care providers on his or her wishes with regard to his or her death.

- To comply with the prescribed treatment or rehabilitation procedures.

- To enquire about the related costs of treatment and/or rehabilitation and to arrange for payment.

- To take care of health records in his or her possession.