AN EXPLORATORY STUDY OF THE NEEDS AND CAPACITIES OF MENTALLY ILL ADULTS LIVING IN A SUPPORTED HOUSING FACILITY

by

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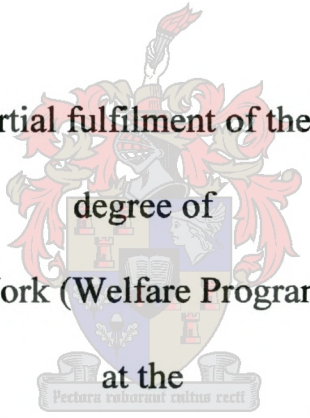

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

SIGNATURE: DATE:

ABSTRACT

The basic premise underlying this research is the ability to gain a deeper understanding of a person with a mental illness, and more specifically the residents living in a supported housing facility. It is significant for social workers to establish a basic profile of the individual in order to understand and realize the resident's specific needs. The aim of the study is to present a description of the personal needs, capacities and socio-emotional functioning of a mentally ill person living in a supported housing facility.

The research report includes identifying the personal needs and capacities of people with a mental illness living in a supported housing facility. This comprises of aspects applicable to the daily living conditions and lifestyles of people with a mental illness residing in such a care facility, including needs and concerns, capacities, strengths and limitations and the role of the family in the individual's life. The report also investigates the social welfare services essential in the intervention and rehabilitation of people living in a supported housing facility, by utilizing various perspectives applicable to social workers.

The empirical study consisted of using a quantitative method in order to explore the pragmatic aspect of the study, which would allow an investigation into the nature of the needs, capacities and socio-emotional functioning of people with a mental illness living in a supported housing facility. Information was gathered by means of a questionnaire and subsequently analysed in order to attain valid conclusions from the research.

These findings were consequently noted, and conclusions and recommendations drawn. The findings of this research can be used as guidelines for social workers and other social welfare practitioners working with people with a mental illness.

OPSOMMING

Die studie is daarop gemik om 'n beter begrip te ontwikkel van geestesiekes, en in besonder die inwoners van 'n ondersteunde behuisingsfasiliteit. Dit is van groot belang vir maatskaplike werkers ten einde 'n basiese profiel van die individu saam te stel en sodoende die inwoner se spesifieke behoeftes te verstaan en te bevredig. Die doelwit van die studie is om 'n beskrywing van die persoonlike behoeftes en kapasiteit van 'n geestelik versteurde persoon wat in 'n ondersteunde behuisingsfasiliteit tuisgaan, daar te stel.

Die navorsingsverslag sluit dus die identifisering van die persoonlike behoeftes en kapasiteit in van geestesiekes in 'n ondersteunde behuisingsfasiliteit. Dit behels aspekte van toepassing op hulle daaglikse lewensomstandighede en lewenstyl, insluitend behoeftes en bekommernisse, kapasiteit, sterkpunte, beperkings en die rol van die familie in die individu se lewe. Die verslag ondersoek ook die maatskaplike dienste wat van belang is vir die behandeling en rehabilitasie van mense wat in 'n ondersteunde behuisingsfasiliteit tuisgaan.

Die empiriese studie bestaan uit beide kwalitatiewe en kwantitatiewe metodes ten einde die pragmatiese aspek van die navorsing te ondersoek. Dit het 'n ondersoek moontlik gemaak na die persoonlike behoeftes, kapasiteite en sosio-emosionele status (funksie) van geestesiekes in 'n ondersteunde behuisingsfasiliteit. Inligting is ingewin deur middel van 'n vraelys, en is daarna ontleed ten einde geldige gevolgtrekkings op grond van die navorsing te maak.

Die bevindings van hierdie studie kan gebruik word as riglyne vir maatskaplike werkers en ander maatskaplike praktisyns wat met geestesiekes werk.

DEDICATION

I dedicate this thesis to my grandfather, Christoffel Johannes Jacobs (1917-1995). Thank you for telling me that if I follow my dreams, I will achieve great things. With God's guidance, support from the family and faith in me, your words have evolved.

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CHAPTER 1

INTRODUCTION

CHAPTER 2

PERSONAL NEEDS AND CAPACITIES OF PEOPLE WITH A MENTAL ILLNESS LIVING IN A SUPPORTED HOUSING FACILITY

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CHAPTER 1

INTRODUCTION

1.1 INTRODUCTION

A mental illness is a disorder characterized by disturbances in a person's thoughts, emotions or behaviour. Mental illnesses refer to a wide variety of disorders, ranging from those that cause mild distress to those that impair a person's ability to function in daily life (National Centre on Workforce and Disability (NCWD), 2004).

Many mental illnesses are believed to have biological causes, similar to cancer, diabetes and heart disease, but some mental disorders may be caused by a person's environment or something they may be experiencing in their lives. Mental illness knows no age limits, economic status, race or gender (National Centre of Workforce and Disability (NCWD), 2004).

When one puts negative labels on those with mental illnesses, it is a barrier that discourages individuals and their families from seeking help. Stigma is not just a matter of using the wrong word or action. Stigma is about disrespect. It causes fear, mistrust and violence against people living with mental illnesses. It also has the ability to cause families and friends to turn their backs on their loved-ones with mental illnesses.

Not only do mental illnesses affect the individual, but they affect the family and society as well. Families as well as society experience a great deal of stress when living with and helping a relative with a mental illness.

1.2 MOTIVATION FOR THE STUDY

People who experience social problems in their daily lives look for support wherever they are able to find it. This support comes mostly from the people around them. It is imperative to remember that specialist help is needed for specific social problems and needs. Yet not all people understand this, or know where to go for help (Pincus and Munahan, 1973). This results in increased stress experienced by the individual. Mentally ill people often do not have the resources to seek professional help. Mental health societies where social workers are employed also facilitate psychosocial rehabilitation programmes for people with mental disorders with a view of re-integrating them back into the community after their discharge from a psychiatric institution. Community service organizations specializing in services for people with mental illnesses, afford a range of services for persons with mental illnesses including special care, schools, protective works, home-based training and adult residential care.

People with mental health conditions are psychologically, emotionally and some times physically inept of taking care of themselves. When an individual develops a mental health condition, families often become incapable of taking care of them. The rationale for this is frequently as a result of lack of knowledge or education concerning the disorder, fears, and finances or because the individual is so ill, it becomes unfeasible for them to remain in the family home. As a result of this ambiguity, the family members may decide that it would be beneficial for themselves as well as for the patients to be placed in a facility, which is able to accommodate and provide for their particular and meticulous, needs. Based on these grounds, the individual may be placed in a supported housing facility.

Supported housing is a comparatively new initiative in South Africa. A supported housing facility, endeavors to accommodate those individuals who suffer from a mental health condition, who are incapable of caring of themselves, who have little or no family sustenance or who are unable to resume their place in the community as a consequence of having a mental health condition.

Deinstitutionalization was intended to improve the lives of persons with serious and persistent mental illness by replacing institutional care with community-based services. A research study conducted in the USA, by Bradley and Conroy (1983), established that various fundamentals of a mentally ill individual's lifestyle might progress once removed from a hospital setting and placed in an environment where continuous assistance, care and support is provided. Their conclusions recognized that the resident's independent functioning increased by 59-68% with elements such as; developmental growth, personal rate of development, quality of living environments as well as responsibility and independence levels (Bradley & Conroy. 1983). However, sometimes mentally ill people are unable to be placed back in their homes with their families as a result of the illness. Subsequently, they are placed in community-based facilities such as Comcare, which seek to provide for their distinctive needs. These facilities bestow on the individuals a sense of belonging. This is principally due to the houses being positioned in areas located within the community. This also presents the individuals with the capability to function as a citizen in this region.

The research anticipates an exploration into the personal needs and competences of these individuals in order to determine their socio-emotional status.

1.3. AIM AND OBJECTIVES

The aim of the study is to present a description of the personal needs, capacities and the socio-emotional functioning of people with a mental illness living in a supported housing facility. The following objectives have been formulated:

- To discuss the personal needs and capacities of people with a mental illness living in a supported housing facility.
- To explain the social welfare services imperative in the rehabilitation of people with a mental illness living in a supported housing facility.
- To investigate the nature of the socio-emotional functioning of people with a mental illness living in a supported housing facility.

1.4 DELIMITATION OF THE STUDY

The study was executed at Comcare supported housing facility, which caters specifically for mentally ill people. This facility provides affordable, established accommodation within the community for adults with chronic psychiatric mental health conditions. Residents have the opportunity for living a normal life, within their local community. Trained staff members provide a level of care, support and supervision that complements the skills and capacity of the residents. Currently, the facility where the research was concluded operates five group homes, and one block of flats in and around Cape Town.

At present they accommodate 50 people with a mental health conditions in these residences (Comcare website – www.comcare.co.za).

1.5 RESEARCH METHOD

In this section the research design, the research sample, sampling strategies and the methods of data collection will be described.

1.5.1 Types of Research

1.5.1.1 Research Design

According to Bless and Higson (1995:41), there are various types of research accessible to the researcher. These types of research are dependant on what the aim is of the research project, including the object of the research, the aim of the research and the nature of the data, which needs to be collected.

The aim of the research was to describe the needs, capacities and socio-emotional functioning of people with a mental illness living in a supported housing facility. An exploratory study was thus required, as the research aims to gain more insight and knowledge to the phenomenon. According to Babbie (1992:90-91), Mouton and Marias (1990:43) and Grinnell (1985:235), this type of study is utilised for this exact purpose.

1.5.1.2 Population/Universe

According to Grinnell (1985:133), a fundamental prerequisite for good sampling is to accurately specify the population from which the sample will be drawn. The universe or

the study population may thus be regarded as the number of people to be used in the research in order to draw accurate and reliable conclusions.

The respondents mandatory for this study were residents themselves. The reason for this was to ensure enough irrefutable data to conclude a proportional study.

1.5.1.3 Type of Research

This type of research is characterised by two variables, namely the relationship between the respondents involved in the research and the use of research as a tool for action, and to increase human knowledge. Participatory research encourages the respondents to become more active in the intent of the research. In this manner, the respondents are empowered to become involved in all aspects of the project (Babbie & Mouton. 2001: 314; De Vos. 1997:18).

1.5.1.4 Sampling Units

The Comcare housing facility comprises of 5 homes with 10 residents living in each house. This concludes that there are 50 residents in sum.

The study utilised 10 residents from the various houses. This means that sufficient people were used to conduct the study and make it pertinent and adequately representative of the universe.

1.5.1.5 Methods of Data Collection

The study was conducted by using quantitative and qualitative research methods. The quantitative research was utilised in order to gain a more accurate understanding of the selected topic. This, more objective and numerically based research method provides a more focused and factual framework to base the research on, which will allow some form of value to be placed on the data. As stated by Sheafor, Horejsi and Horejsi (2000), quantitative research is more statistical in nature and thus is mostly concerned with numbers and numerical values of various investigated items. The research method, which was utilised for the purpose of data gathering, was a personal questionnaire (appendix A). The presentation of the data was illustrated through the use of tables and graphs.

As a result of the abundance of positive responses from the respondents, the researcher conducted a follow up interview with the social worker of the housing facility (appendix B). The aim of this interview was to gain a better understanding with regards to the statements that were asked of the respondents. The social worker was able to present a more accurate indication with regards to probable reasons for the optimism of the respondents.

1.6 LIMITATIONS TO THE STUDY

The literature review showed that there is ample information regarding mental illness, but there is very limited information regarding supported housing facilities or mentally ill

individual's lives whilst living in these facilities. A lot of the information gathered was more focused on disabilities, which meant that the information had to be adjusted in order to be more applicable to mental health.

The new Mental Health Care Act, 2002 (Act No. 17 of 2002) was implemented in January 2005, but for the purpose of this study the Mental Health Act no 18 of 1973, was utilised, as this Act was in use whilst this study was being conducted.

A pilot study was conducted to ensure that the correct research would be concluded. According to the social work dictionary (1995: 45) a pilot study may be referred to as "*a process whereby the research design for a prospective survey is tested*". In the pilot study, it became apparent that the residents of the supported housing facility were unable to motivate statements and questions asked. For this reason, the researcher asked once sentence statements. It was found that a follow up interview with the social worker of the facility would be necessary in order to ensure that the information gathered was accurate and reliable.

1.7 ETHICAL ASPECTS

The study appreciates other factors, which needed to be taken into consideration, namely the ethical aspects to the research process. Permission needed to be attained from the various respondents who participated in the research (appendix C). Permission was benevolently granted by the institution, which allowed the research to be conducted there.

1.8 LITERATURE STUDY

According to De Vos (1997:104) a literature study serves several essential purposes. She states that it demonstrates the underlying assumptions behind the general research questions. This study should display the research paradigm that underpins the study, and describes the value, which the researcher brings to the research enterprise. The literature study also demonstrates that the researcher is knowledgeable about related research and other factors, which support the research. Through the literature study, the research explored certain facets including:

- To distinguish and explore the personal needs and capacities in the daily lives of people with a mental illness living in a supported housing facility, in order to conclude an accurate socio-emotional status of the target population.
- To determine the roles and functions of applicable social welfare services as well as community-based rehabilitation of people with a mental illness.

1.9 PRESENTATION OF THE STUDY

The study comprises of five chapters:

Chapter one comprises of the introduction and motivation for the research. This chapter includes factors such as the aim and objectives as well as the various research methodologies utilised.

Chapter two describes the nature of the personal needs and capacities of people with a mental illness living in a supported housing facility as well as their daily life. This chapter includes aspects applicable to the daily living and lifestyles of mentally ill people

in such a care facility, including needs and concerns, capacities, strengths and limitations and the role of the family in the individual's life.

Chapter three describes the social welfare services significant for the care, support and supervision of residents in a supported housing facility for people with a mental illness. This chapter will also describe the relevance of community-based rehabilitation. The role players including policies and legislation applicable to people with mental illness are also explained. The social worker's role in the rehabilitation of these individuals is also discussed.

Chapter four provides the empirical study of the research. In this chapter the socio-emotional functioning of people with a mental illness living in a supported housing facility is determined. This chapter comprises of the data, which has been collected, and analysed in order to draw conclusions and recommendations for the final chapter in the thesis.

Chapter five comprises of the findings and recommendations of the analysis. This chapter is based on both the literature study and the empirical study. These conclusions and recommendations may be used as guidelines in the assessment and rehabilitation of people with a mental illness living in a supported housing facility.

CHAPTER 2

PERSONAL NEEDS AND CAPACITIES OF PEOPLE WITH A MENTAL ILLNESS LIVING IN A SUPPORTED HOUSING FACIITY

2.1 INTRODUCTION

When considering an individual's personal needs and capacities and the manner in which s/he sees the world, one needs to consider certain critical elements, which need to be explored and examined in order to attain such information. The socio-emotional needs of an individual include all those requirements which the individual may deem necessary in order to develop and grow as a person within a certain environment or context.

As will be discussed in this chapter, the ecological perspective (Germain & Gittermann. 1980) offers a framework that can be used as a theoretical framework for the assessment of an individual's needs and capacities. Certain authors (Becker & Becker, 1986; Coulton, 1979; Hoffmann, 1987) have established that the ecological perspective (Germain & Gittermann 1980:6) seems to have meticulous agreement to people with disabilities; this may include mental health disorders. Germain (1977:323-327) advocates that the purpose of the ecological perspective is to advance the quality of service delivery amid people and environments, in order to match people's potential with their environments. Psychosocial and physical components may be outlined in the environments for investigation. This is subsequent to the fact that the environment forms

part of the general human ecosystem and is defined as the surroundings or context of the person's experience and behaviour (Janoski, 1984:41-56).

Hepworth, Rooney and Larsen (1997); Potgieter (2004) and Sheafor, Horejsi and Horejsi (2000) present major guidelines for assessment of the nature of the socio-emotional needs and capacities of individuals. These guidelines, aim at understanding the client as an individual, and to focus on the needs as well as the capacities which impact on the individual's understanding of reality and life, development and growth (Potgieter. 2004:134). According to Sheafor, Horejsi & Horejsi (2000:129), the term *capacity* refers to the "...abilities and resources that people or clients bring to the change process". Such resources may include time, energy, finances, skills, knowledge, self-discipline and self-encouragement. These are all areas, which can be used in order to develop a contour regarding the daily life functioning of an individual, as well as for the life functioning of an individual.

In this chapter the personal needs and capacities of adults with chronic mental health conditions will be described. These needs vary from physiological needs to self – actualisation needs. Another significant factor to be explored is the family dynamics the individual practices.

One of the objectives of this study is to discuss the personal needs and capacities of people with a mental illness living in a supported housing facility. In order to conclude this, one needs to consider the daily living circumstances of the individual as well as

his/her competence levels. This would thus lead to the depiction of the nature of the socio-emotional status of people with a mental illness living in a supported housing facility.

2.2 NEEDS OF THE MENTALLY ILL ADULT

In this section the needs of people with a mental illness will be described. It is the first area of assessment.

Burkey (1993:3-5) identified needs such as air, water, adequate food, physical and emotional security, physical and mental rest and appropriate clothing and shelter as man essential basic needs. Swanepoel and De Beer (1996:24-25) went a step further in including self-reliance, happiness and human dignity as the most significant abstract needs of man. Potgieter (2004:136) states that when considering the needs of an individual, it is elementary to consider Maslow's Hierarchy of Needs. Maslow developed a visual representation, in a pyramid form entailing the possible needs, which an individual necessitates. Cronje, Du Toit and Motlatla (2000:183-184) pronounce that people's needs establish their behaviour. People's behavioural patterns are engaged in the satisfaction of primary survival, security, social and egoistic needs. The following figure presented by Cronje, Du Toit and Motlatla (2000:156-157), seeks to briefly explain the depiction of the needs pyramid.

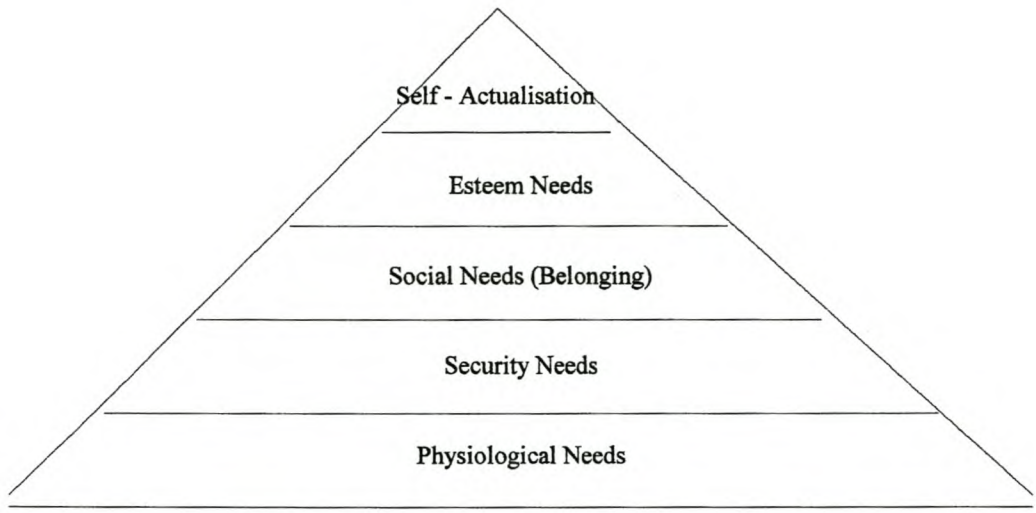


Figure. 2.2 Maslow's Hierarchy of Needs Source: Cronje, Du Toit & Motlatla.2000:156

The above figure will now be described and explained from the first level; physiological needs to the ultimate goal of any individual, self-actualisation. The capacities of people with a chronic mental illness are largely dependant on their needs and the satisfaction thereof in order to attain competence and self-actualisation.

2.2.1 Physiological needs

The first level of Maslow's hierarchy of needs is the satisfaction and attainment of one's physiological needs. Physiological needs may be considered to be those needs required for daily survival. It includes fundamentals such as food, clothing and shelter. If a person is uneducated or incapable of sustaining an occupation, these needs may not be fulfilled adequately. Such fulfilments of needs, which most people usually take for granted everyday, are an integral part of a person with a mental illness' daily challenges. A practical example may be a chronic mentally ill individual being unable to do everyday grocery shopping. This task, which most individual's complete without hesitation or

obscurity, may prove to be an excessive challenge for a mentally ill person as a result of a lack of required resources, such as transport to get to the shops, because the individual is not able to drive a motor vehicle. Prevailing economic situations tend to drive mental illness aside and the unmet needs govern reality. Costa and McCrae (2000) argue that it would be difficult to overcome mental health problems before the physical needs of the individual are satisfied. Yet, in order to satisfy one's basic physical needs, one should be able to complete the necessary tasks (shopping) without difficulty.

2.2.2 Security needs

The second level of Maslow's hierarchy is one's security needs. Security needs are regarded as a prerequisite for the protection and safeguard of an individual. In order for individuals to be protected, they need to have sufficient protection from harm and destruction. Many people within society seek protection from the wrongs of the world. People are afraid to go for a walk or to play with their children in the parks as a result of being afraid of what may happen to them. As a result of this fear some people become 'stuck' on this level of the pyramid (Gwynne, 1997). In the instance of the role of a supported housing facility where an individual with a chronic mental health condition lives, the task of the facility is to protect and look after these individuals. Such facilities are able to protect a mentally ill person from the dangers and harms found in the larger society.

2.2.3 Social needs

The third level of Maslow's pyramid is the social needs of an individual. Social needs are those needs, which people require in order to feel part of the community. It embraces relationships, friendships and acquaintances (social interaction). Part of this also includes love, support and social acceptance. In the supported housing structure, mentally ill people are able to establish social relations within the community and learn to interact with other people in the facility itself. They are able to form friendships with people who find themselves in very similar situations and circumstances. House et al (1988:293-318) stated that a lack of supportive relationships may allow for a risk factor for mortality. People who feel they have no one to confide in become ill and die earlier than those experiencing satisfying interpersonal relationships.

2.2.4 Esteem needs

Reber (1995:702) defines self-esteem as "the degree to which one values oneself". It may also be referred to as egoistic needs. The fourth level of Maslow's hierarchy of needs consists of aspects such as status, success, value and dignity and material possessions. Adler, a contemporary psychologist and follower of Maslow's theory, stated that inferior feelings resulting from not having these needs met were at the top of most of societies problems, and Maslow agreed (Boree, 1998). If a mentally ill person is placed in a supported housing facility with people who experience similar issues, self-esteem issues may be dealt with. This would be as a result of people not had to judge them or label them according to a stereotype. All residents are equal and they are thus understanding to one another's issues and situations. Lee (2001:145) indicates that

people with disabilities face prejudice and discrimination, which has a negative impact on their self-esteem. Lee also states that these stereotypical labels may be internalised by the individual, which may lead to an even lower self-esteem.

2.2.5 Self-actualisation needs

The final level of Maslow's hierarchy of needs pyramid comprises of the individual attaining his/her expression of self. Self-actualisation may be considered as the concluding and ultimate constituent of the needs pyramid. When one attains this degree of need, it may be stated that one has advocated oneself toward self-expression, or to be one's true self. This may be regarded, as the most intricate need to accomplish. Every day society may never reach this level, and as an adult with a chronic mental health illness this becomes even more difficult if not impossible to attain. Maslow states that this level of need is not a deficiency need and thus is not generated by a lack of something, but it is rather a growth need. This means that is may be regarded as a motive to develop and expand one's skills and abilities (Westen, 1995:376). This may be representative of empowerment.

Aiding people on an individual as well as a communal level to exercise control over their lives and the decisions they make concerning their lives, is a fundamental foundation of social work. Helping an individual accomplish the various levels mentioned above encompasses empowering the individual to attain each level and improve his/her life. Most of the people that social workers work with are either subjugated or discriminated against by society who deems that these individuals are incapable of changing their

situation (Beaulaurier & Taylor, 2001:81; Germain & Gitterman, 1980:31; Miley et al, 1995:68; Sheafor et al; 2000:481).

All people experience the need to be wanted and to be loved, and being part of a family may satisfy that specific need. It is also important to consider the family situation when wishing to assess the socio-emotional functioning of an individual with a chronic mental health condition. The following section will elaborate on the familial dimensions essential in such as assessment.

2.3 CAPACITIES OF MENTALLY ILL ADULTS

The second area of assessment is the capacities of the adult with a chronic mental health condition.

2.3.1 Social, Interactional and Environmental Capacities of mentally ill adult

Another element contributing to the assessment of people with a mental illness are the interactions practiced between themselves and other individuals as well as their interaction with their environment. The social or interactional role exhibited by any person, may be viewed as that behaviour which is apt according to his/her roles in society (Potgieter.2004: 136). This includes his/her role as employee, spouse, parent and so on. Social functioning and the enhancement of social interactions are fundamental to the social work vocation (Sheafor, Horejsi & Horejsi.2000: 61). As social workers, one of the main purposes is to permit the client to develop and improve his/her social functioning within his/her environment. It is pivotal to take this into consideration when

drawing up a profile of a certain population of a group of people, as it may affect their growth as an individual, development and learning abilities (Sheafor, Horejsi & Horejsi. 2000:5). Social functioning may be defined as "... a clients ability to accomplish the activities necessary for daily living.." (Karls & Wandrei.1998: 1). Morales and Sheafor (1986:10) define social functioning as the "... way people interact with their physical and social environment and with the people and social institution with which they are in contact". As a result of this inter-reliant affiliation between the social interface/functioning and the environment, people's quality of life becomes affected. This quality of life refers to the resources utilised and the needs of the individual either being met or not being met. This may impinge on the individual's functioning, efficiency and contribution to society (Hepworth, Rooney & Larsen, 1997:5).

Humans have a number of interpersonal needs (Weiss, 1986). Social relationships with other individual whom one can share a confidence, are essential for both physical and mental health. As stated previously those persons practicing satisfying social relations tend to live longer than those individuals who tend to isolate themselves from other people (Westen, 1995:397).

When assessing an individual's social and interactional functioning, Barker (1998:79) states that it is imperative to contemplate the various roles an individual assumes when in various environments or situations. Hepworth and Larsen (1997) provide certain criteria when considering how to gauge an individual's social functioning and interpersonal interactions. These criteria will now be discussed accordingly.

2.3.1.1 Biophysical functioning

This mode of functioning comprises of the health, physical and genetic factors one possesses which may influence one's interactions with people around one. According to Hepworth and Larsen (1997), physical factors may comprise of any form of disability one may hold. It may encompass the perception one has of oneself. This, in accordance with dress and grooming, often divulges much concerning a person's morale, values and lifestyle. The residents living in a supported housing facility interact with other residents within the facility, thus with a commonality among them, namely a mental health condition. They all attain differences such as gender, cultural background, race and other such biophysical factors, but are bound through their mental health situation.

2.3.1.2 Cognitive/Perceptual functioning

The second type of functioning refers to the manner in which the residents respond in their daily life experiences and circumstances, and how this impacts on how they distinguish themselves and the world around them. People's thought precedents are influenced by an array of factors including, their values, interactions with their environment and those people around them. Other factors impacting on the individual's cognitive or perceptual characteristics include their intellectual functioning. This intellectual functioning comprises of coherence, values, misconceptions and the self-concept, as well as the manner in which a person is able or unable to make accurate judgements. All of these aspects collectively, may be regarded as the interaction between cognition, emotions and behaviour. Part of the purpose of this study is to determine how

chronic mentally ill individuals perceive their world and the factors, which influence this perception (Barlow and Durand, 1999:468-487).

2.3.1.3 Emotional functioning

Another aspect related to the functioning of an individual regards the levels of control they exercise over their emotions. Some people are so out of touch with their emotions that they are unable to feel the positive emotions people experience everyday (Sheafor, Horejsi and Horejsi, 2000:168). Occasionally, this lack of emotional control may impact on relationships the individual has or may develop. There are numerous factors to be considered when taking into account, an individual's emotion. According to Hepworth, Rooney and Larsen (2000:51) these include cultural factors, the range of emotions practices, as well as the suitability of the emotion being exposed. This may be slightly more difficult in a mental health setting as the majority of mentally ill people have emotional issues, which they have to deal with as a result of the mental health condition they carry, such as depression or bipolar mood disorder.

2.3.1.4 Behavioural functioning

In reality, change causes a shift in an individual's behaviour patterns. This shift may mar the social functioning of the person, or it may allow the individual to experience appropriate, effective social functioning. The selection of the behaviour may be subjective to the disorder the individual has. This behaviour, although associated to the disorder, may not always be apt according to societal expectations. For example a person with schizophrenia will hallucinate and visualise effects in their minds, yet expect a sane

individual to see the same thing. In order to make a complete assessment of the behaviour, Hepworth and Larsen (1997) articulate that a practitioner needs to contemplate, when, where and how the behaviour transpires, as well as how frequently and the level of severity it holds. As with the emotional aspect, this may be difficult. Depending on the mental health disorder the individual has, behaviour may the primary issue or reason (anti-social disorder) that the individual resides in a supported housing facility.

2.3.1.5 Motivational level of the individual

In order to make an accurate assessment of the individual's level of motivation, it is crucial that the practitioner gain a deeper tolerance regarding the manner in which the individual perceives him/herself in relation to his/her milieu. This is important as the driving force of an individual may impact on the manner in which s/he interacts with the environment and those people within the environment. Compton and Galaway (1999:16) state that in order to encourage a client the practitioner may also make use of the strengths based model in order to facilitate the client's focus on his/her vigour and to work with that rather than focus on the negatives and the functions s/he will be less likely to practice. The empowerment approach may also be seen as a contributor to an individual's motivational functioning in that it seeks to empower people who experience oppression on personal, interpersonal and political levels (Gutierrez, 1990; Lee, 2001).

It can be detected from the above mentioned facets of functioning, that it is essential to determine the level and type of social, interactional and environmental relationship an

adult with a mental illness experiences in order to conclude an accurate assessment of his/her development. All of the above mentioned facets might be considered to be directly related to the individual's environment and the interactions between the individual and his/her environment.

Empowerment through micro practice in social work to be discussed in the preceding chapter may be applicable in this instance. This is due to the level of interaction experienced. Micro practice according to Gutierrez (1990: 149-153) occurs when a social worker mediates and helps an individual understand his/her environment and the interactions occurring within the environment. This may help the individual attain an emotional balance with regards to his/her capacities and competences.

The emotional and spiritual capacities of an individual with a chronic mental health condition will further be explored in the next section.

2.3.2 Emotional Capacities of a mentally ill adult

The subsequent aspect for the assessment of an adult with a chronic mental health conditions comprise of the emotional capacities of the individual. The emotional and capabilities of an individual may be viewed as the aptitude of the individual to remain in control of his/her feelings. It also comprises of the inability to control anger and aggression, depression and mood fluctuation (Hepworth, Rooney & Larsen, 1997: 51). A person should have the ability to sustain equilibrium with regards to his/her feelings and emotions. It is vital that an individual experience a multiplicity of feelings, although it is

not beneficial if an individual experiences abrupt mood changes or feelings of emotions. If a resident in the housing facility experiences mood transformations as a result of his/her mental health condition i.e. depression, this may be taken into consideration, although these mood changes should be sustainable as a result of the medication (Montgomery, 1994:447-457).

The emotions of an individual have the ability to effectively influence the behaviour an individual portrays to the world (Hepworth, Rooney & Larsen, 1997:249). People are heaved from one emotion to another in order to compact the impasse of the emotions and feelings being brought to the fore. There are certain factors, which need to be considered when probing the emotional and spiritual facades of an individual. It is pivotal for a social worker or any other professional practitioner working with an individual who has a chronic mental illness to understand these factors and to take them into consideration when assessing the individual. These factors will consequently be described and discussed according to Hepworth and Larsen (1997:249-251) as they form an integral factor in the assessment of an individual.

2.3.2.1 Emotional Control

It may become characteristic of a person to become out of touch with his/her feelings and emotions. This means that the individual does not allow him/herself to feel certain feelings or emotions. This may include joy, hurt, pain, and excitement. Such individuals may experience intricacy in maintaining secure relationships with people around them (Hepworth, Rooney and Larsen, 1997:249). In the instance of mentally ill adults

experiencing a chronic mental health condition, emotional control may prove to be difficult as these factors are biologically influenced and as a result of the disorder the individual does not have control over the feelings and emotions s/he experiences (Westen, 1996: 407-413).

2.3.2.2 Range of Emotions

As a consequence of human beings experiencing various circumstances and interactions, it is essential that one have the capacity to articulate a variety of feelings and emotions. When a person's feelings and emotions become constrained, interpersonal relationships suffer as a result (Hepworth, Rooney and Larsen, 1997: 250). Some people experience what is known as '*anhedonia*'. This term is defined by the Dictionary of Psychology as a 'condition marked by a general lack of interest in living, in the pleasures of life; a loss in ability to enjoy things. It is regarded as a defining feature of depression...' (Reber, 1995:37). In essence it means that a person is incapable to communicate congenial feelings. Other people have become habituated in order to not experience negative or painful feelings. This results in them blaming themselves for situations and episodes, and they are progressively more prone to apprehension and high levels of stress. Persons who are emotionally healthy master the ability to articulate and experience a wide array of emotions and feelings, which are pertinent to the situation or incident. Mentally ill people are often not able to rely on their feelings, as they may not be sure about how they are genuinely feeling.

2.3.2.3 Appropriateness of the Emotions

This term refers to people expressing the erroneous feelings or emotions at the incorrect moment, situation or incident. For example, if one experiences the loss of a loved-one and a person laughs or makes jokes, it may be considered that the individual is depicting inappropriate emotions in concurrence to the situation. On the other hand, if an exultant situation occurs and a person begins to cry or throw tantrums, this behaviour may be considered inapt with regards to the situation. When people become emotionally detached, this emotional apathy may be indicative of a mental health disorder. If a person experiences these distorted emotions as well as a possible thought disorder, it may be considered that the individual is psychotic. Manic behaviour for example experienced by bipolar sufferers is relatively rare. It is apparent that such individuals require medication in order to relay the appropriateness of such emotions. (Hepworth, Rooney & Larsen, 1997:251).

According to Sheafor, Horejsi and Horejsi (2000:167-173) emotions are complex, physical, biochemical and psychological responses to conscious and unconscious interpretations of an event or experience. Understanding emotions proves to be very intricate as normal emotions can become askew and result in a permitable depression. Emotions are able to direct us to persevere in realizing goals and objectives. They are able to caution us of danger and protect us from harm. However, sometimes people experience a chemical imbalance in the brain, which causes a mental health condition, and the feelings and emotions become unpredictable and sometime inappropriate.

2.3.3 Spiritual Capacities of a mentally ill adult

The spiritual capacity of an individual is also imperative in the assessment of the functioning of people with a mental illness. The spiritual capacities of an individual refer to the quality of his/her inner self or soul. It is an entity, which is personal and internal, and not something which is visible to the outside world (Sheafor, Horejsi & Horejsi. 2000: 31). This may impact on the individuals' beliefs and value system. Each person is unique and should be treated with respect and with uniqueness in mind. Each person's values differ from one another and this disparity needs to be considered when drawing up a profile of these individuals.

In the DSM-IV (United States of America. 1994) a statement appears to the extent that, a religious or spiritual category can be used when the focus of clinical attention is a religious or spiritual problem. Such examples include distressing experiences that involve loss or questioning of faith, problems associated with conversation to a new faith or questioning other religious values, which may not necessarily be related to an organised institution such as a church.

From a psychological point of view, religion is universal. There are few societies in which religion plays no significant role. There are also relatively few people who at one time or another has not experienced some religious stirring. From this perspective one can draw the conclusion that religion performs some adaptive function, which is evoked to satisfy universal needs of people. Personal value and judgements of religious beliefs play a significant role in determining treatment for some people with mental illnesses.

Treatment may sometimes be prohibited by certain cultures or religions (Kaplan and Sadock, 1998:862).

2.3.4 Intellectual Capacities, Experiences and Developmental Capacities of a mentally ill adult

The next factor deliberated for the assessment of an individual with a chronic mental health condition; embrace their intellectual and developmental capacities and the experiences of these individuals. Hepworth and Larsen (1997:234) describe one's intellectual functioning, as the capacity to measure the person's strengths and weaknesses related to his/her general understanding of reality. These authors state various factors, which need to be considered in order to assess the intellectual abilities of a person. As a result of the individual's mental health challenges these facets may be difficult to attain, yet are significant enough to be cited irrespectively. According to the above mentioned authors the following factors may be regarded as the facets on which a person with a mental illness' intellectual capacities and experiences may be based.

2.3.4.1 Intellectual functioning

Intellectual functioning encompasses the individual's aptitude to clench ideas and articulate themselves, as well as to analyse circumstances or facts plausibly and logically. Statistically, the evidence suggests that low intelligence is often present at the onset and progression of a mental health disorder. Intelligence may even continue to deteriorate in the case of such individuals (Kaplan and Sadock, 1998:475).

2.3.4.2 Judgement

Judgement encompasses the individual's capacity to structure a belief and to attain a conclusion based on accessible reality. Reber defines judgement as a critical evaluation of some thing, event or person (Reber.1995: 398). Kaplan and Sadock (1998:286) state that a person with a mental illness is strictly capable of impaired judgement, thus having a diminished ability to understand a situation correctly and to subsequently act appropriately.

2.3.4.3 Reality Testing

Reality testing comprises of the individuals mental health. It includes perceiving effects accurately, making suitable and precise judgements concerning circumstances and being able to be lucid or genuinely aware of aspects regarding the present.

2.3.4.4 Coherence

Coherence defines the rationality and logic ability of an individual. Mental illness may be characterised by confused and illogical speech of an individual instigated by fragmented and disengaged thought patterns (NIMH, 1998).

2.3.4.5 Cognitive Flexibility

Cognitive flexibility refers to an individual's competence to be amenable to new ideas, and to scrutinize and acclimatize to the situation. It embraces the person's ability to identify with certain situations, to develop and grow as an entity and to master the capacity to empathize and understand other people. The DSM-IV acknowledges that

psychiatric disorders can exhibit a degree of cognitive impairment as a symptom of a disorder (Kaplan & Sadock, 1998:318).

2.3.4.6 Misconceptions

Misconceptions may be regarded as a misinterpreted dynamics of an individual's existence. It is indispensable to identify these fallacies and rectify them in order to compose precise appraisals of individuals. In the case of chronic mentally ill person, hallucinations may be considered to be misconceptions. Hallucinations according to Kaplan and Sadock (1998:284) may be regarded as disturbances in perception. It is associated with delusions.

2.3.4.7 Self-Concept

The manner, in which people conduct themselves or behave, may be consequential to the person's self-concept. This may be regarded as the manner in which an individual envisions him/herself. Karen Horney, a psychoanalyst from Berlin stated that persons with a mental health condition often experience distorted influences, which prevent the personality from growing (Kaplan & Sadock, 1998:226-227).

2.3.4.8 Developmental capacities

Sheafor, Horejsi and Horejsi (2000) give a detailed description of the developmental capacities and restrictions of a person with a severe mental health condition. They believe that as a consequence of a person having a mental health condition, their functioning may become impeded. They begin to develop delusions, hallucinations,

distorted thinking, inappropriate effect and extreme extraction from society. This in turn is usually assimilated with a poor appetite, disrupted sleep patterns, loss of energy, loss in interest of people and activities and diminished ability to think logically to name but a few. This in turn means that they may lose touch with realism, have problems with their memory, judgement or feelings and have a very low self-esteem.

As a result in these developmental capacity barriers, these people become outcasts in society and are placed in institutions. Society deems that people with a mental illness may in some way be detrimental not only to themselves but to those around them included. Such people are institutionalised or left with professionals who comprehend the disorder and is able to look after the individual. This impedes on the patients developmental abilities and capacities, as they are no longer able to deal with their own problems or conflicts as they become accustomed to being nurtured and taken care of by the professionals who will 'protect' them (Hepworth and Larsen, 1997:454). This may impede on their ability to deal with conflict. It may also pose to be a problem once the individual is placed back within society.

Kaplan and Sadock (1998:250-255) state the use of the above-mentioned capacities as part of a mental status examination, performed on mentally ill patients by psychiatrists. The mental status examination is the description of the patient's appearance, speech, actions and thoughts during the interview. This is imperative as the above factors are very closely related to mental health on the whole. People suffering from a chronic mental health condition often have difficulty experiencing any of the above capacities.

This assessment would aid the social worker in identifying the strengths and problem solving capacities of the people they are working with. By doing this, the social worker does not focus on the problem or failure of the individual but rather on the personal capacities and strengths of the individual (Saleeby, 1999:15).

2.3.5 Strengths and Limitation Capacities of a mentally ill Adult

The coping strategies of an individual can be differentiated along a direct (problem-focused, active approaches) and indirect (emotional-focused, avoidant approaches) continuum (Causey & Dubow, 1992:47-59). The more direct tactics are related to increase positive functioning while the circuitous strategies are coupled with poorer adjustment. Both strategies are however used by people facing very stressful circumstances and may be both beneficial and detrimental at different times in the coping process (Roth & Cohen, 1986:813-819). The interrelationship between coping abilities and personality is uncertain. Coping mechanisms are employed in dealing with intrapsychic and interpersonal problems. It is also likely that coping processes may play a part in both the onset and course of psychological disturbances following stress or adversity (Parker, Brown and Blignaut, 1986:561-565).

It is important for the social workers and other such professionals to focus on a client's strengths and positive aspects of his/her life in order to facilitate focus on the good things in their lives. This may be largely based on a strengths perspective. Saleebey (1992:6) states that the strengths perspective allows the practitioner to "...be guided by the

awareness of and respect for the clients' positive attributes and abilities, talents and resources and aspiration". It aims to consider how the client has managed to thus far survive or thrive in an oppressed environment.

Many individuals have been conditioned to think of themselves and their situations in negative terms. Such negative thoughts generate important obstacles in the way of change and often become a self-fulfilling prediction. The systems of which the individuals have become a part of may also contribute to the focus on negativity and weakness. Dubois and Miley (1996) state that in order for these individuals to become more optimistic concerning their life situations and lifestyles, it is important for the social work practitioner to focus on the good rather than on the bad factors in their lives and to work with the client to promote a positive change. This may be closely related to the strengths perspective, which conveys that the individual should be brought out of the capsule of discrimination and oppression and rather focus on his/her abilities and competences (Saleeby, 1998:3). The strengths perspective has been discussed earlier in this chapter.

The family can play in promoting in the recovery of an individual with a mental health condition. In particular, the attitudes of loved ones towards the individual, and how they understand and react to the individual's experiences are important. They can also influence the extent to which the individual is able to recover (Barker, 2000:181-188).

2.4 FAMILIAL DIMENSIONS OF A MENTALLY ILL ADULT

The forth area of assessment of adults with chronic mental health conditions is the familial dimensions, which concern the family and the familial facets of the individual. This is an essential facet to consider when assessing a person with a chronic mental illness, as family plays a significant role in the lives of these individuals (Hepworth and Larsen, 1997:276-277). According to Sheafor, Horejsi and Horejsi (2000), certain principles relate when considering the dynamics of a family. The following section will explore and investigate the role of the family in the case of a person with a mental illness.

2.4.1 The Role of the Family in the life of a chronic mentally ill individual residing in a supported housing facility

In order to endeavour an improved perceptive value to the type of family customary in a supported housing facility, one needs to discover what the term *family* refers to. The persons residing in a supported housing facility may deem those residing with them in a house as their family unit. This may be accredited, as the term family has copious dynamics. The term family is defined by Sheafor, Horejsi and Horejsi (2000:359) as a 'group of person's related by biological ties, a legal relationship, and/or long-term expectations of loyalty and commitment, often comprising at least two generations and usually inhabiting one household; moreover, some of the adults of this group must have the intention and also the capacity to carry out all or most of the functions common to a family'.

In order to assess the circumstances of a chronic mentally ill adult as well as to empower the individual to attain his/her ultimate potential, the familial background and understanding of the individual needs to be determined. A family needs to execute convinced roles in order to permit the family to cultivate and develop as an entity.

Sheafor, Horejsi and Horejsi (2000: 361), catalogue certain dynamics essential within a family. They state that the family has the duty to provide for the nurturing and socialisation of children. This includes preparing the children for adulthood, educating them regarding the indispensable skills crucial, in order to function within society with a sense of responsibility, values and self-acceptance. The family also carries the responsibility to afford an emotionally secure milieu for sexual expression amid consenting adults and to afford its members with a nous of intimacy and belonging. This is more of an expression of love and acceptance of the family members. The domicile and the family serves as a haven for the family members, and endeavours to keep them content and exultant when and where probable.

There are certain characteristics unambiguous to the functioning of a family. The family also serves as a fiscal entity. This encompasses the making of decisions regarding any financial facets, warranting the provision of food and attire for the family members, a home to live in and so forth. Ultimately the role and duties of a family are to protect, assist and heed for those family members who are vulnerable or incapable care for themselves. This includes children, elderly members of the family, ill (mental health conditions) or disabled persons. Such support allows the family to utilise community

resources. This encompasses the parents and other affiliates of the family, utilising the community resources available to them, including hospitals, clinics, churches, schools.

The White Paper for Social Welfare (R.S.A. 1997) emphasises the fact that the family is the "basic unit of society". It highlights the fact that the family life should be strengthened and promoted through family orientated welfare policies and programmes. Problems or inadequacies in family relationships can contribute to social disintegration of social dislocation. In the case of person with a mental illness, many times the families choose to abstain from contact with their loved-one as they prove to become more of a burden than a pleasure, thus loosing the sense of family. It is emphasised in this document that impoverished human relationships can create as much misery as do inadequate social institutions. Therefore, the importance of family and community-based family programmes should be empowering, and the enhancement individual and family capacities (Sturgeon, 1998:38; Green & Kruger, 2002:225).

2.5 SUMMARY

The rationale of this chapter was to exemplify the fundamentals according to which a profile of the socio-emotional status of people with a mental illness may be drawn. The elements presented in this chapter bestow the ability to compose the significant correlation between the type of person being dealt with in this study (mental illness), and the authentic criteria, utilised in order to consider these people's personal needs and capacities. The dimensions explored in this chapter, which may be regarded as essential in concluding an accurate socio-emotional status of chronic mentally ill adults living in a

supported housing facility. Each dimension was discussed in order to present a framework for the personal needs and capacities of chronic mentally ill people living in a supported housing facility.

Assessment according to Potgieter (2004:142) is the thinking process that strives to put information about the problem into a frame that will assist in the understanding of all the different factors that have an impact on such a condition. It connects events and behaviour with available knowledge and identifies strengths and limitations that may affect problem resolution (Pincus and Minahan, 1973:102). Assessment is the core activity in the helping process. The purpose of assessment is to supply answers to a problem. It helps the social worker determine intervention strategies and facilitate change.

Once an individual's socio-emotional capacities and needs have been assessed and established, the social welfare practitioner is then able to gain more insight into the type of individual s/he is working with. Once this has been recognized the practitioner should then consider the nature of the care and support of these mentally ill people residing in a supported housing facility.

The subsequent chapter will portray the social welfare services available for people with a mental illness, as well as the various roles players who embrace a significant element in dealing with and helping a mentally ill individual.

CHAPTER 3

SOCIAL WELFARE SERVICES FOR MENTALLY ILL ADULTS

3.1 INTRODUCTION

In order to explore the social welfare services available for adults with a mental illness, a comprehensive definition needs to be established and understood regarding what mental illness comprises of. Mental illness may be considered to be the conception of a mental disease, which derives from the medical model of abnormal behavior. This operates on a resemblance from diseases of the environmental or of the mind (somatic). Hence any psychological maladjustment or behavioral disorder may be classified as a mental health disorder. Once the dominant term, now the synonymous term, mental illness is more common (Reber: 1995: 451). According to Reber, the generally accepted connotation of this term (and its close synonym – mental illness) is that of a psychological or behavioral abnormality of sufficient severity that psychiatric intervention is required (Reber: 1995: 452).

The definition of a mental health disorder according to the DSM-IV classification manual concludes, "each of the mental disorders is conceptualised as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. A painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.... Whatever its original

cause, it must be currently considered a manifestation of a behavioral, psychological or biological dysfunction in the individual".

Care workers, comprising of social workers, residential support workers, auxiliary workers as well as volunteers, play an imperative role in providing support to people with mental health problems. A strong sense of support and loyalty means that, despite feelings of stigma and shame, care and support is an important source of assistance in efforts to cope for mentally ill people. Mental health professionals play a significant role in the treatment and rehabilitation of people with a mental illness and should maintain stringent intervention efforts with the individual as treatment evolves over time.

When continuing treatment and supportive care is available, the individual can learn to manage the symptoms, identify early warning signs of relapse, develop a relapse prevention plan, and succeed in vocational and social rehabilitation programs. For the vast majority of people with a mental health condition, the future is bright with optimism and new and more effective medications on the horizon. Neuroscientists are learning more and more about the function of the brain and how it goes amiss in mental health disorders, and rehabilitation programs are increasingly successful in restoring functioning and quality of life.

The aim of this chapter is to describe the various social welfare services available to people with a mental illness. It also aims at exploring the various role players significant in the lives of these individuals as well as illustrating community-based rehabilitation and the significance of the supported housing facility.

3.2 POLICY AND LEGISLATIVE REQUIREMENTS FOR THE CARE OF MENTALLY ILL ADULTS

This section comprises of a description of the roles players in the care and support available to the residents at supported housing facilities. This section will explore the various legislative factors contributing to the role, the various individual roles performed by the human resources in the mental health care sector.

3.2.1 Government Legislation and the White Paper

According the White Paper for Social Welfare (R.S.A. 1997), a total of 155 social workers and eight social auxiliary workers are employed by mental health societies. These workers afford the full range of specialized mental health services in all nine provinces and are unable to address all the mental health requirements, which have been identified by communities. The scarcity of staff within mental health training is critical.

Mental health societies impart therapeutic and counseling services, group work, home-based training, public education, and the administration of grants, social relief, support groups, skills training and a few income-generating projects. A total of 81 residential facilities operate under the support of mental health societies serving 6 655 persons while a further 142 non-residential facilities serve 11 223 persons. Mental health societies also operate psychosocial rehabilitation programmes for people with mental disorders with a view of re-integrating them back into the community. In addition to mental health societies there are about 110 other community service organizations specializing in services for people with a mental illness. These organizations afford a range of services

for people with a mental handicap such as special care, schools, protective works, home-based training and adult residential care. The total number of people accommodated for is approximately 15 000. (White Paper for Social Welfare. R.S.A. 1997).

3.2.2 Mental Health Act No. 18 of 1973

It is crucial that the services provided by any institution within the field of mental illness, adhere to the aspects stated in the Mental Health Act. No. 18 of 1973 (R.S.A). This act provides for the reception, detention and treatment of people who are mentally ill as well as to provide for incidental matters (Mental Health Act No. 18 of 1973. R.S.A.). This means that this crucial document provides guidelines for admitting; treating of mentally ill patients, policies to be followed and implemented for forensic issues, as well as guidelines for subsidiary issues related to mental health conditions.

3.2.3 Government and the social welfare profession

Government is encouraging and supporting local authorities to improve the health of their local communities and to address mental health problems which arise. Local government working in effective partnership with the agencies and organisations in the public sectors as well as the private, voluntary and community sectors is seen as fundemental to address the mental health problems in their local areas.

By building the capacity and skills of staff and volunteers throughout the public health sector, welfare organisations will help to promote better understanding of mental health issues as well as aids to address these problems.

Welfare organisations have a key role to ensure that addressing mental health issues is a priority and that it is seen to efficiently and effectiely. They are able to highlight action on inequalities, both in the way that the services are delivered and through the contribution to the regeneration of deprived communities.

3.3 PERSPECTIVES AIDING THE EMPOWERMENT OF CHRONIC MENTALLY ILL ADULTS

Certain vulnerable populations are unable to cope effectively with stressful situations and to reward themselves with resources in the environment as a result of a sense of powerlessness experienced by them. In order to gain and retain a sense of power requires that certain resources become available within the environment (ecological theory) in which these individuals reside. This will allow for a greater sense of confidence, competence and self-esteem (strengths perspective) within the individual. By empowering (empowerment approach) individuals, they are able to regain the capacity to interact with the environment, which will enhance their needs satisfaction (Hepworth and Larsen, 1997:460-461).

The ecological perspective and its relevance will now be discussed.

3.3.1 The Ecological Perspective

The ecological perspective in social work focuses on the influence that the person and the environment encompass on one another. This embraces of the relations between people and their physical environments, rather than the mere impact of the environment on

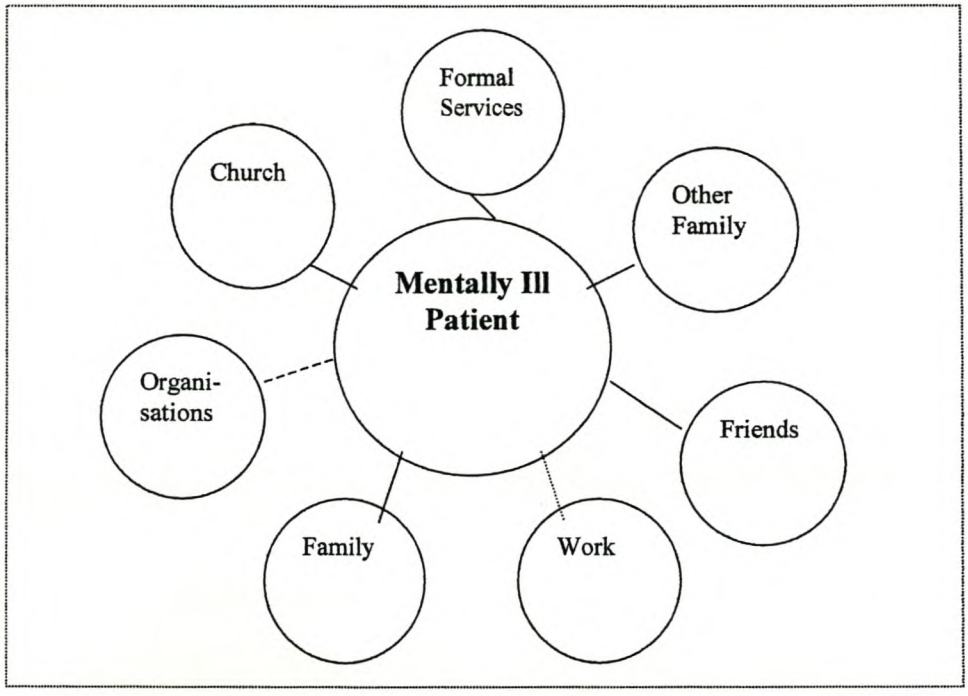
human functioning. The interaction between people and their environment may also be referred to as person in the environment fit, which refers to the association between the needs, capacities and goals of the individuals and the characteristics of the environment (Derezotes, 2000:47; Germain & Gitterman, 1980:8; Miley, O'Melia & Du Bois, 1995:35; Hepworth & Larsen, 1997:15).

People with chronic mental health conditions are scrutinised by their interactions with society, as well as by the resources accessible to them. When exploring the person in environment, the intricacy of the disorder may be minor through the synergy between the needs of the individual and the resources available to them.

Social workers needs to become aware of the various types of social support available to clients, how to identify them and to determine whether or not these support networks are present in the daily lives of the client. Researchers had developed a number of measurement tools aimed at helping the practitioner during interviewing a client, planning the intervention strategy and the helping process of that specific client. Structural measures describe the existence or quality of social relationships and the functional measures assess various types of supportive exchanges. Tracy and Whittaker (1990: 461-470) identify three of these tools. For the purpose of this study only the eco-map will be described in order to illustrate the ecological perspective and the significance of this perspective to the social work practitioner.

3.3.1.1. Eco-map

This assessment tool is referred to as the eco-map. According to Compton and Galaway (1999) it maps in a dynamic manner the ecological system and boundaries present in the clients life. Fig 2.4.1A is an example of such a map.



_____ indicates a strong connection between the parties

---------- indicates a feeble connection between the parties

..... indicates no or a very poor connection between the parties

Figure 3.3.1.1. Eco-Map

The map is considered to be indicative of the mentally ill individual's life and the nature of his/her relationship with each sub-system.

The eco-map provides an overview of the individuals situation, and portrays the connections between the client and his/her environment as is portrayed by Germain and Gitterman's (1980) ecological perspective, discussed earlier in this chapter.

A circle is drawn in the center of the page and the clients name written inside the circle. Surrounding the center circle are several smaller circles indicating the various sub-systems evident in the clients life. These sub-systems are labeled accordingly. The lines between or connecting the circles indicate the specific nature of the relationship between the parties. Each line indicates a communication process, for example;

Although this may be perceived to be a visual representation of clients' sub-systems, the one disadvantage of this assessment tool is that it is difficult to determine the exact relationship between the client and his/her sub-systems (Tracy & Whittaker, 1990:463).

When the relationship between the individual and his/her environment is prejudiced, the individual will not be able to attain his/her needs or realise his/her ambitions and self-development. If we consider at a mentally ill individual, their person in environment fit may not always be a positive one, as society has already established an expectation of a mentally ill individual and has already determined that they should not be part of the community or society in general as they may pose a menace.

Stresses may be experienced by the individual when negative relations between the person and his/her environment exists. Lee (2001:39) identifies the ecological perspective as a basis for the empowerment approach. A discussion regarding this facet pursues.

3.3.2 An empowerment approach for adults with a chronic mental health condition

Empowerment may be viewed as realizing the power within people, individually and collectively. This is why authors such as Beaularier and Taylor (2001:81) are not of the opinion that empowerment is a new standard for practice but rather a new expression for a conventional mode of working with people. The majority of the people that social workers work with are oppressed or discriminated against by both social and economic dynamics beyond their control. People with mental illnesses are components of the minority that have been discriminated against by society and who may deem themselves as powerless to change their circumstances (Beaulaurier & Taylor, 2001:81; Germain & Gitterman, 1996:31; Miley et al, 1995:68 and Sheafor et al, 2000:481).

Empowerment refers to the formulation of assessments and procedures of the social worker, to aid people in appreciating the social and economic milieu of their situation and includes recognizing and exercising their personal and political power to be decisive and improve their situation. Personal power is also referred to as power on a micro or individual level, as opposed to political power on a macro or collective level (Beaulaurier & Taylor, 2001:81; Sheafor et al, 2000:481; Germain & Gitterman, 1996:31). According to Miley et al (1995:68) personal empowerment refers to a client's own sense of competence, ability, strength and capacity to affect change.

According to Sheafor et al (2000:481) and Germain & Gitterman (1996:31) an empowerment approach emphasizes helping the client enhance their participation in decision-making and to function autonomously. It is further explicated by referring to empowerment as a transformation within the individual and not a change from the

subjugation. Lee (2001:32) states that social workers can thus support people and empower them towards self-determination and freedom from their inequity.

An example of the meaning of empowerment for a chronic mentally ill adult can be taken from the writings of Terry DeRocher (2003) who presented a talk at the National Summit of Mental Health Consumers and Survivors in Portland, Oregon. He stated that "... empowerment and reconnection are the core experiences of recovery (for a mentally ill person)...". He stated that people with mental illnesses should assume responsibility for themselves and their destinies in order to be empowered. He explained the need to be active, and sometimes aggressive, participants in the planning of their own recoveries and in making certain that those who serve them coordinate their efforts to meet client needs. Many of the mentally ill patients are seen first and foremost as individuals with psychiatric needs rather than as people utilizing services, to meet professional, educational, employment and health care needs, intended to meet their meticulous mental health service needs. To address these needs is to allow mentally ill individuals the same opportunities for a well-rounded life as those enjoyed by the non-disabled. Their needs are related to the very core of what recovery means: "Recovery offers the promise of managing one's illness and moving ahead with one's life...". The strengths perspective in social welfare is the foundation on which empowerment is based.

Saleeby (1999:14) points out that empowerment is not about returning power to clients, but about ascertaining the power within clients. This means focusing on the client's strengths rather than his/her setbacks.

3.3.3 Strengths based Perspective

Lee (2001:217) presents the need to focus on the strengths of the individual in the process of empowering the individual. Saleeby (1999:15) urges that the social worker be attentive to the client's strengths during assessment and intervention. In using the strengths perspective when working with people with chronic mental illnesses, the social worker needs to be conscious of how exploited individuals have endured their situation or ordeal. This would aid the social worker in identifying the strengths and problem solving capacities of the people they are working with. The social worker needs to distinguish what the client has done, how s/he has utilised their resources and the knowledge produced from it. By doing this, the social worker does not centre on the problem or failure of the individual but rather on the innate strengths of the individual to cope with trauma and adversity (Saleeby, 1999:15).

3.3.3.1 Principles of the strengths perspective

Taken from the views of Saleeby (1999:15-20) and Sheafor et al (1997:75) the following principles have been identified and can be applied in the assessment and intervention of chronic mentally ill adults.

a) Focus on individual strengths rather than on pathologies

Individuals develop and grow according to their personal strengths and interests. Subsequently, a social worker should focus on what the client likes and wants rather than on the failures and things s/he will not accomplish and achieve. The utilisation of the strengths perspective can also boost the motivation of a client. If the social worker

focuses on the problems, weaknesses, failures and deficits in the assessment of the client, it leaves the client feeling despondent. Focussing on the client's strengths during the assessment could prompt the client to become progressively more self-sufficient.

b) The client/social worker relationship is essential

Social workers working with people who have a mental illness may require more time with clients as such clients may take longer to understand or respond during interviews and assessments (Saleeby,1999:15-20; Sheafor et al, 2000:75). A positive client/social worker relationship is crucial to the strengths perspective.

c) Client self-determination

This principle follows the theory that the client rather than the social worker should pilot the process of change. The client should direct the help s/he requires. When assuming responsibility for the client it is essential that the social worker confer with family members in order to ascertain the level of treatment required.

d) People can continue to develop despite hindering conditions

The principle of understanding that people can continue to develop is founded on the premise that the problem affecting the client is only one part of their being. The strengths perspective centres the social worker on other aspects of the individual in order to better the client's life.

e) The community should be viewed as a resource

The clients' behaviour and well-being is in large determined by the resources available to the community, the expectations of the community members and the accessibility of resources that they need. Zimkin and McConachie (1995:64) state that no amount of counselling by the social worker can compensate for the lack of income to provide housing and healthcare which are critical to early intervention with people with disabilities or a mental health condition. Social workers should be encouraged to explore the availability and enthusiasm of informal resources prior to referring clients to formal resources. For example a social worker could refer a client who does not have a place to live, to a shelter. Here, the client will be fed, allocated a bed and is protected from the elements.

As stated above it is imperative that social workers focus on the strengths of the client rather than his/her weaknesses and failures. In order for an individual to function as a self-regulating entity it is essential that such an individual have the competencies and abilities to have enough faith in themselves to carry out this independence. Social workers refer clients to the various resources available in the community, such as clinics, churches and so on, and thus the community is also able to aid in the development and empowerment of people with a mental illness. This way the individual feels a part of the community and the community is empowering them.

It is crucial that a social worker have a sound theoretical framework as a foundation for helping a client (Sheafor et al, 2000). People do not generally know how to ask for help

and by the time that they reach the social worker the problem may have escalated to severe proportions. For this reason various assessment tools may be used in order to identify the problem and endeavor to solve it as quickly and effectively as possible.

3.4 COMMUNITY-BASED REHABILITATION OF A CHRONIC MENTALLY ILL ADULT

"Community based rehabilitation is a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities. This treatment is implemented through the combined efforts of disabled people, their families, the surrounding community, and the appropriate health, education, vocational and social services" (WHO Rehabilitation Unit 1995:10).

Through an understanding of the above description of community-based rehabilitation, the critical role of a supported housing facility can be determined. A supported housing facility may be regarded as a form of community-based rehabilitation.

3.4.1 Characteristics of a Supported Housing Facility

This section will consist of an explanation of a supported housing facility. This includes describing the aim and purpose of a supported housing facility.

3.4.1.1 Aim/Purpose of a supported housing facility

A supportive housing development facility provides affordable, established accommodation within the community for adults with chronic psychiatric mental health

conditions. Residents have the opportunity for a normal life, in their local community. Trained staff members provide care, support and supervision that complement the skills and capacity of the residents. Comcare, a supported housing facility that currently operates five group homes, and one block of flats in and around Cape Town, is an example of a community based housing facility (Comcare website - http://www.Comcare.co.za: 2004).

Supported housing is accommodation-providing support for individuals who suffer from a mental illness and are unable to look after themselves. Such facilities include intensive or supportive housing management. It offers a way to living fully independently in their own homes, and provides regular support, which help the patients maintain their independence in the community, rather than living in a psychiatric institution or at home with their families (Comcare website -http://www.Comcare.co.za: 2004).

Accommodation consists of good quality, safe and supportive housing set-ups with the aid of a support worker living on the premises. Support is provided through visits by support workers everyday as well as on weekends. These support workers help the residents to manage their daily lives, including the consumption of their medication and learning to attain the skills necessary for their daily functioning, including the execution of chores (Comcare website -http://www.Comcare.co.za: 2004).

3.4.1.2 Selection of Residents living in a supported housing facility

Residents living in a supported housing facility may include persons suffering from learning difficulties, mental health related problems, and drug or alcohol related problems, at risk of offending, at risk or leaving care and people in need of intensive housing management. The residents are selected based on certain strict criteria. For example one of the criteria for residence at Comcare is that the individual have a chronic mentally health condition and is unable to function at home. The idea of a supported housing facility, aims to help those people who suffer from a mental health condition, are unable to care for themselves, have little or no family sustenance or who are unable to be placed back into the community as a consummation of having a mental health condition (Comcare website -http://www.Comcare.co.za: 2004).

Through the autocracy, which the residents enjoy as a result of living in a community, which, consists of other people with mental illnesses, and being away from their families and having to learn to manage on their own, certain developments may arise. These include the ability of the individual in participating in life to the fullest extent possible, through meaningful activities and positive relationships, the ability to change, grow, and experience a range of feelings, care for oneself and for others and focus on attention to mind, body, spirit, creativity, intellectual development, health as well as self-confidence and good self-esteem (Health guide for emotional and mental health. 2004. U.S.A.).

As a result of the residents living in a supported housing facility being chronic mentally ill adults who is incapable of taking care of themselves, and their families are also unable

to care for them, it is now essential that a description be given regarding the support by social workers or residential support workers and the roles of these individuals in the lives of a mentally ill person living in a supported housing facility. These will proceed.

3.5 SOCIAL WORKERS AND THE SOCIAL WELFARE PROFESSION

The primary role of the social worker has predominantly been the enhancement of the social functioning of the clients. It promotes individual, group and communities to function more effectively within their environments (O'Niel & MacMahon, 1996:6). Social workers not only facilitate people to adjust to their reality (micro level) but they also help amend the social realities (macro level) people face (Sheafor, Horejsi & Horejsi, 2000:6). In accordance with the objective of this chapter, namely the care and support of a mentally ill person living in a supported housing facility, it is only naturally that social worker be mentioned at this point. Social workers are able to provide assessments of the individuals as well as develop specific intervention programmes, which aim at empowering and promoting the development mentally ill individuals living in a supported housing facility.

3.5.a Micro Level Intervention and Empowerment

Direct practice with clients with disabilities remains a principal activity of social welfare workers. Social workers should guarantee that their practice remains increasingly aimed toward empowering the individual. This is very important in the case of mentally ill people as Sheafor et al (2000:481) depicts that social workers may find it challenging to find manners of empowering clients such as the mentally ill, as some practice models of

social welfare are based largely on the opinion that social workers must utilise their expertise and skills to compensate for the inadequacies experienced by their clients or patients. Practitioners should aid in the negotiation of the transition to enable people to move from the passive role of patient to the active role of informed and empowered consumers. In this regard the social work approaches that support advocating on behalf of clients have suggested useful for social workers to make the transition to empowerment of the clients (Beaulaurier & Taylor, 2001:82; Hepworth & Larsen, 1993:72 and Sheafor et al, 2000:57). In 1990 Guiterrez suggested guidelines that welfare practitioners could follow to ensure that their activities facilitate the empowerment of the client (Beaulaurier & Taylor, 2001:82). These guidelines will now be depicted, as they are relevant for practitioners who care for and support people with a mental illness living in a supported housing facility.

- The practitioner should distinguish that the client cannot take control of his/her life unless s/he comprehends the restrictions that the environment places on their disability (mental illness) and have access to the resources needed in order to address the situation.
- The practitioner should be a partner or assistant to the person with the mental health condition, who should be considered as the only connoisseur on his/her problem or situation. It therefore follows that it is the client's classification of the problem and his/her choice of addressing the problem that is most applicable to the change process.
- The practitioner should support the individual to build self-confidence. Such individuals should be encouraged to interact with people who share common or

comparable problems. This would center power of collectivity with the social worker assisting the person.

- The practitioner should assist the individual in uncovering probable strengths.
- The practitioner should enable the individual to identify with the organizations, people and other systems with which interactions are necessary in order for a process of transformation to occur.
- The practitioner should assist the individual to understand the factors and forces that donate to their approach of powerlessness.

These guidelines are applicable for the care and support of people with a mental illness living in a supported housing facility because these guidelines are aimed at empowering the client and guiding the client in such a manner that s/her attains his/her full potential.

3.5.b Macro level intervention and empowerment

The empowerment of the community is directly associated to the empowerment of the individual. Empowering individuals on a community level will therefore result in empowerment of that community. This in turn will develop the interaction among individuals when empowered. This can ultimately result in members of the community working collectively in order to advance the community as a whole. A supported housing facility comprises of a number of homes situated within the community. The residents thus feel part of the community and are empowered to achieve their optimum level of functioning as a result. When empowering on a community level, Mokwena

(1997:68) suggests various guidelines for welfare practitioners. These guidelines can be used, as they are relevant to the empowerment of people with mental illnesses.

- The social worker should help communities realize, appreciate and utilise their talents and assets. The community will then realize to what extent they are able to do things for themselves.
- The social worker should provide the community with information that may not be readily accessible to them.
- The social worker should confront feelings of powerlessness in a community should be confronted. By challenging the feelings of powerlessness, the social worker will construct positive attitudes in families and communities.
- The social worker should assist the community to participate in matters that influence them. This way they will have increased control over their lives.
- The social worker should promote the enlargement of social support and social networks, which are essential for community empowerment.
- The social worker should expand local leadership as an approach in instituting empowerment.

These above mentioned guidelines are applicable to people with a mental illness, as these individuals too need to sustain and establish support networks in order to attain the level of care and attention required to help them achieve a sense of acceptance.

Thus it may be concluded that the social work vocation may be regarded as the profession where, the enhancement and enrichment of social functioning and the addressing of common human needs and requirements is regarded as crucial, in order to empower individuals to progress and develop to become functional, prolific and contributing members of society (Hepworth, Rooney & Larsen. 1997: 4-6). This highlights the focal role the social worker plays in the field of mental health, as it is imperative that residents of a supported housing facility be empowered and developed in order to become fully functional affiliates of society.

The social workers perform significant roles within the supported housing facility. These social workers also encompass the task of supervising the residential support workers in their daily roles and functions. The program and service delivery programs are a fundamental part of the social workers obligation at this facility. The programs need to be developed in such a manner that they are of pertinent use to the resident in the housing facility, in order to fulfill their roles as members of society.

Based on various enquiries that began as early as the 1970's, a need was recognized to provide the social work profession with a personnel increment. As a result of the escalating level and intensity of client needs and the ever lack of support systems in communities, as indicated by Mitchell (1986:290-298) the need for a supporting service to social workers became indispensable, hence the requirement of the auxiliary worker.

3.5.1 Auxiliary Workers in the Social Work Field

According to the South African Social Service Professions (Republic of South Africa. 1978), in May 1989 the Social and Associated Workers Act, 1978 (Act 110 of 1978. Republic of South Africa.) was revised to the Social Work Act, 1978 (Act 110 of 1978. Republic of South Africa.). The term social auxiliary workers replaced the Act's term of associated workers. This amendment resulted in a certain amount of perplexity in some circles. Consequently, the council defined the term social auxiliary work as follows: "Social auxiliary work is an act or activity practised by a social auxiliary worker under the guidance and control of a social worker and as a supporting service to a social worker to achieve the aims of social work". Thus, it indicates that the social auxiliary worker must be of direct assistance to the social worker in the implementation of tasks. It also eliminates related occupational groups, which are not directly involved in the social worker's helping function (South African council for social service professions. Republic of South Africa. 2004).

The auxiliary workers' qualifications are approved by rule in terms of the Social Service Professions Act, 1978. These social auxiliary workers must function under the supervision and guidance of a qualified social worker at all times.

Any welfare agency employing a social worker may employ social auxiliary workers or can make arrangements that social auxiliary workers can work under the continuous leadership and direction of a social worker. Although a social auxiliary worker can progress rank-wise, such a person may not exercise a supervisory function over other social auxiliary workers.

For the purpose of this study, the residential support workers cited at supported housing facilities will be classified within the milieu of a social auxiliary worker. This is as a consequence of these support workers practising a parallel role and function as that of an auxiliary worker.

3.5.2. Residential Support Workers

As stated previously, the residential support workers may be regarded as auxiliary workers. This is due to the nature of their roles and functions within the supported housing facility. Their roles are predominantly to take care of the people living in the various homes. These care workers ensure that the residents maintain a sense of balance in their lives. They warrant that the resident eat correctly, execute their daily chores and duties and empower themselves to become functional members of society. The roles and duties of the residential support workers will be conferred further.

According to the Department of Ageing in the United Kingdom, disability and home care a residential support worker has the task of planning and implementing support plans that will improve the residents' quality of life. They provide assistance with everyday living tasks including eating correctly and hygienic disciplines. Their tasks also include supervising and arranging activities, which will enhance the physical, social, emotional and intellectual developments of the residents. The residential support workers also enjoy the duty of providing care, compassion and support to the residents (Dept. of aging, disability home care. United Kingdom, 2004.). For this reason it is essential that a positive relationship develop between the resident and the residential support worker.

Volunteers also play a pivotal role in the care of individuals who require special attention or services. The volunteers will be discussed in the preceding section.

3.5.3 Volunteers in the field of Social Welfare

Sheafor, Horejsi and Horejsi (2000:311-313) state that as a result of a lack of professional services being delivered in this field, it has become essential that sectors look to the public for assistance. They say that volunteers can help to maximise scare agency and professional resources. Such trained personnel may become an asset to the agency or organisation in administering effective programs. These authors state that the key to using volunteers successfully is being able to match the task to the volunteer's special interests and abilities. This way they are able to expand on the clients support networks (Mitchell, 1986:290-298). Volunteers follow a very stringent training program. They need to be trained regarding the organisations policies, client base, mission and purpose, goal and objectives as well as the values and principles hailed by the organisation. It is essential that the volunteers follow these elements in order to become representatives of the organisation. For example volunteers are able to spend time with mentally ill people and do arbitory activities with them such as reading, walking or just having a conversation with an individual. Volunteers primarily offer their services free of charge to the community.

3.6 SUMMARY

When considering the management of individuals living with chronic mental health conditions, it is essential that various components be explored. It is fundamental to the

individuals development to consider the type of disorder the individual is faced with, the environment within which s/he resides, the resources available to them for guidance and assistance as well as the individuals empowerment. The ecological theory, which has been intensively explored in this chapter, provides a holistic view of people with a mental illness in their environment, as illustrates how the environment within which they reside can either promote or hinder the development and empowerment of the individual. In placing emphasis of the change in the environment of the individual, the strengths perspective as well as the empowerment approach may be utilised. In order for the individual to become completely and wholly empowered, it is the duty of the infrastructure and resources to encourage and aid this process.

These means that the institution should be positive in the recovery of the individual and provide adequate services to the individual in order to promote his/her social functioning and empowerment. The duties of the various professions including the social workers, auxiliary social workers as well as the residential support workers should be based on this process of facilitation and empowerment

Once the various professions have concluded their roles in this process of assistance and guidance, then it becomes easier to determine the nature of socio-emotional needs and capacities of the individuals. This takes consists of examining the person in his/her environment and the interaction between the two. One is then able to determine how the environment provides or withholds resources according to the individual.

The following chapter comprises of the empirical chapter of the thesis. In this chapter the findings based on the research conducted will be explored and documented in order to reach conclusive findings and provide realistic recommendations.

CHAPTER 4

A SITUATION ANALYSIS OF THE NEEDS, CAPACITIES AND SOCIO-EMOTIONAL FUNCTIONING OF A PERSON WITH A MENTAL ILLNESS LIVING IN A SUPPORTED HOUSING FACILITY

4.1 INTRODUCTION

Social workers in any community need guidelines to be able to support and assist clients in meeting their social needs. It is therefore important for them to be able to identify resources that exist in a certain community. For any person with a mental illness, it is difficult to be a part of the community as there is a lot of stigma around the fact of being mentally ill.

The objectives of this study were to discuss the personal needs, capacities and socio-emotional functioning of people with a mental illness living in a supported housing facility and to explain the official and theoretical requirements imperative in the rehabilitation of a person with a mental illness living in a supported housing facility.

These objectives were formulated in such a way in order to achieve the aim of the study, which was to present a description of the socio-emotional functioning of people with a mental illness, living in a supported housing facility.

In the previous chapters the personal needs, capacities and socio-emotional functioning of people with a mental illness, living in a supported housing facility as well as the social welfare services essential in the rehabilitation of people with a mental illness were discussed. This chapter will investigate the nature of the social needs and capacities of people with a mental illness living in a supported housing facility, through the results attained from the research conducted with the respondents at Comcare. This will now be discussed.

4.2 PLACE OF STUDY

The study was executed at Comcare, a supported housing facility located near Valkenburg Psychiatric Hospital in Cape Town. As stated in chapter three, a supported housing development facility provides affordable, established accommodation within the community for adults with chronic psychiatric mental health conditions. Residents have the opportunity for a normal life, in their local community.

Supported housing is accommodation-providing support for people with a mental illness who are incapable of looking after themselves. It offers a way to living fully independently in their own homes, and provides support, which help the residents maintain their independence in the community, rather than living in a psychiatric institution or with their families.

Accommodation encompasses safe and supportive housing set-ups with support workers residing on the premises. These support workers assist the residents to manage their daily lives, including the consumption of their medication.

Residents living in a supported housing facility are individuals suffering from mental health related problems, and people in need of intensive housing management. Residents are selected according to certain strict criteria. For example one of the criteria for residence at Comcare is that the individual have a chronic mentally health condition and is unable to function at home. The idea of a supported housing facility, aims to help those individuals who are unable to care for themselves, have little or no family sustenance or who are unable to be placed back into the community as a result of their mental health condition.

4.3 EMPIRICAL STUDY

To achieve the aim and objectives of this research an exploratory study was done. According to Babbie and Mouton (2001:70) exploratory research can be conducted when a researcher is examining a new phenomenon and wishes to acquire a better appreciative of the subject at hand. According to Grinnell (1985:119) it is used to explore and gain an appreciation of the research topic. Based on information gained from Williams, Tutty and Grinnell (1995:196) the exploratory research design was chosen, as it is appropriate when little is known about the field of study.

A quantitative research method was applied and data was gathered by means of research questionnaires (appendix A), where the results were presented by means of tables and figures. The researcher was present when respondents completed the questionnaire for when respondents needed assistance with completing the questionnaire as suggested by Babbie and Mouton (2001:249).

Qualitative research was also utilised in order to gain a better personal understanding of, as well as gain better insight into the selected phenomenon (appendix B). According to Babbie and Mouton (2001: 249) the qualitative study places more emphasis on studying human action in its natural setting, and through the eyes of the respondents themselves. This counts as a more subjective or personal method of data collection. The researcher used personal interview with the social worker from Comcare in order to gain more in-depth information on the situation of the respondents. This is as a result of the assumption that by asking relevant questions, the reality of the population may become known (De Vos, 2001: 298). The questionnaire was based on the same layout as that of the questionnaire administered to the respondents, however there were some open-ended questions formulated. De Vos states that the advantage of utilizing open-ended questions is that the data is obtained relatively analytically. This facilitates the comparison of the data.

The sample for this study comprised of 10 people with a mental illness living in the Comcare facility. The respondents were randomly selected. According to De Vos (2001:193) random sampling is that method of drawing a sample of a population so that

all possible samples of the fixed number of people in the target population have the same probability of being selected. No criteria for selection were set. The respondents were selected by randomly opting for two individuals from each of the houses in the facility. Names were written on a list and the researcher randomly went down the list selecting two residents from each house.

As a result of certain limitations to the study, a follow up interview had to be conducted with the social worker at the supported housing facility (appendix B). This was important as, the pilot study conducted showed that the residents in the facility were unable to motivate statements or questions asked. Due to the mental health condition of these residents it was important that further investigation be concluded in order to attain a more accurate data spread.

4.4 RESULT OF THE RESEARCH

This research comprises of the literature study and an empirical study where adults living in a supported housing facility with chronic mental health conditions were questioned to explore their needs, capacities and socio-emotional functioning. Data was collected by means of a questionnaire, in which statements were relayed and the respondents had to reply to the various statements. The results of the study will be discussed in the same sequence as presented in the questionnaire. The responses and findings will be depicted by means of tables and figures.

4.4.1 Personal Information

Personal information was organized into various categories and will now be discussed:

4.4.1.1 Age

Age was significant as it gives an indication of the average age of residents living in the supported housing facility. Table 4.1 illustrates the average age of the respondents.

TABLE 4.1: Age of respondents

AGE	Male	Female
Under 20	0	0
20 – 29	0	0
30 – 39	3	1
40 – 49	4	1
50+	0	1
TOTAL	7	3

N= 10

The respondents were randomly selected. There were no set criteria on which the selection was based. There was no particular relevance with regards to gender or age. The greater part of the respondents (50%) fell into the 40-49 years age bracket. There were four (40%) of the respondents who fell into the age 30-39 years age bracket, and there was one (10%) respondent who fell into the age bracket of 50 years of age or older. From the above findings it may be considered true that mental illness affects people of various ages. Mental illness is not representative of the age of an individual.

4.4.1.2 Gender

Table 4.2 illustrates the gender differences between the respondents:

TABLE 4.2: Gender of respondents

MALE	FEMALE	TOTAL
7	3	10

N=10

Table 4.2. illustrates that there were seven males representing 70% of the respondents and three females representing 30% of the respondents. Again, it may be seen that mental illness does not know boundaries regarding gender and both male and female may be diagnosed with a mental health disorder.

4.4.1.3 Highest Qualification

Table 4.3 illustrates the highest qualification attained by the respondents:

TABLE 4.3: Highest qualification

LEVEL OF QUALIFICATION	f	%
Primary School	0	0
High School	5	50%
Diploma	3	30%
Degree	1	10%
Other	1	10%
TOTAL	10	100%

N=10

The above table illustrates that half (50%) of the respondents have high school qualifications; while three (30%) respondents have a diploma, one (10%) has a degree and one (10%) has a qualification of another nature. From the results it is evident that all the respondents at least have a high school qualification.

4.4.1.4 Employment status

Table 4.4 illustrates the employment status of the selected respondents.

TABLE 4.4: Employment status

STATUS	f	%
Employed	2	20%
Unemployed	8	80%
TOTAL	10	100%

N=10

The findings in table 4.4 show that the majority (80%) of the respondents were unemployed, while few (20%) of the respondents were employed. The two respondents (20%) who stated that they were employed work at the supported housing facility. According to Sherer (psychiatrictimes.com. 2004), people with mental illness are able to sustain employment. She states that they can succeed both over time and by moving up in higher-level positions, yet most employers do not understand this. This may be a possible cause as to the poor employment rate of mentally ill individuals.

4.4.1.5 Disability grant

Table 4.5 illustrates whether or not the individual receives a disability grant:

TABLE 4.5: Disability Grant

DISABILITY GRANT	f	%
Yes	10	100%
No	0	0
TOTAL	10	100%

N=10

The above table states that the totality of the respondents (100%) receives a disability grant. This comprises of an amount of approximately R520-00 allocated to people with disabilities every month. As a result of the resident's temporary or permanent disability, this qualifies them to attain a disability grant from the government. This is the amount of money that many people have to sustain themselves for the entire month.

4.4.1.6 Income sufficiency

Table 4.6. illustrates the income received by the respondents:

TABLE 4.6: Income sufficiency

INCOME	f	%
Sufficient	2	20%
Insufficient	2	20%
Unsure	6	60%
TOTAL	10	100%

N=10

The above table shows that approximately two thirds (60%) of the respondents stated that they were unsure whether or not their income is sufficient enough to sustain them. A mere two (20%) of the respondents stated that their income was sufficient and another two (20%) of the respondents stated that their income was insufficient in sustaining them. This may be considered to be in accordance with the employment status of the respondents. The two (20%) individuals stating that their income was sufficient were both employed and therefore are not only dependent on the disability grant.

4.4.2 Experiences of living in the supported housing facility

In order to investigate the experiences of the people with a mental illness living in a supported housing facility, each respondent had to rate their experiences for each of the following five statements.

Description of statements:

Statement 1: I enjoy living at the housing facility

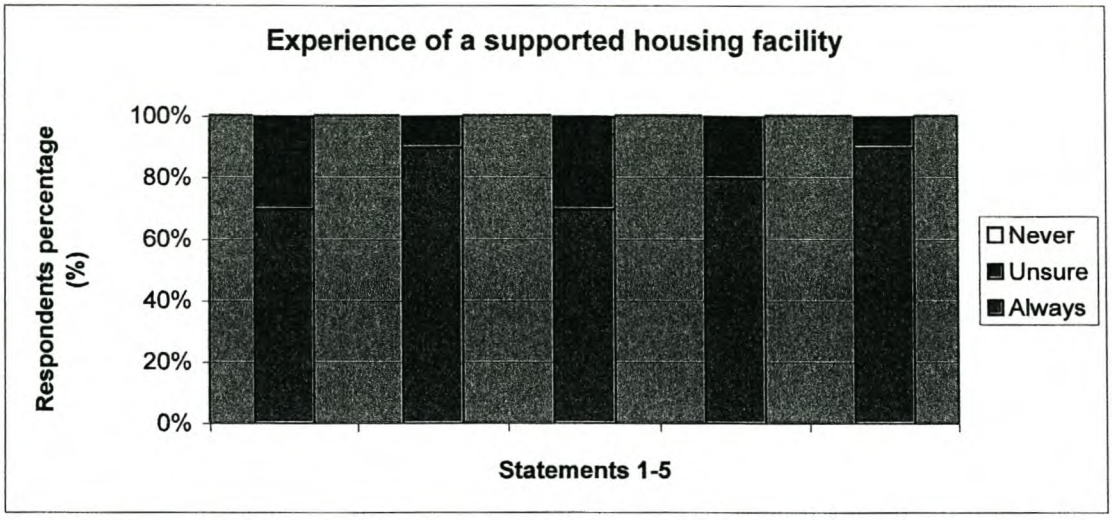
Statement 2: I feel part of the community

Statement 3: I feel independent living here

Statement 4: The services here help me

Statement 5: The staff is friendly and helpful

Each of the statements was asked in order to gain a better understanding with regards to the manner in which the respondents perceive their experiences in the supported housing facility. Figure 4.1 illustrates how the respondents experiences their daily lives in the supported housing facility and how they responded to the statements.



N=10

FIGURE 4.1: Experiences of the supported housing facility

- **Statement 1: I enjoy living at the housing facility**

Most of the ten respondents, seven (70%) stated that they enjoy living at the housing facility, while three (30%) of them were unsure.

In an interview concluded with the social worker at the housing facility, she stated that this reflection might be regarded as accurate. She stated that compared with most of the options available to the residents, the living conditions and the lifestyle they manage at Comcare are favorable. The social worker stated that the majority of the residents have intrusive families, whose expectations of the resident exceed the capabilities of the resident. *"Comcare provides a haven where the individual can be who s/he wants to be with no stigma from anyone".*

- **Statement 2: I feel part of the community**

Nine (90%) of the respondents stated that they feel part of the community, while one (10%) respondent was unsure. This may be considered to be in recognition of the aim of a supported housing facility as cited by Comcare that it is essential that the residents feel part of the community (Comcare website – www.comcare.com).

According to the social worker, as a result of the residents doing things for themselves, they are able to connect on a certain level with certain facilities in the community. This includes the shop owners, police and other people in their neighborhood. She also stated that because the residents live in inconspicuous houses in the community, they are able to *"feel more appropriate"* as no one is able to indicate that the people living in the house have a mental illness. This means that there is less stigmatization of the house and the residents.

- **Statement 3: I feel independent living here**

Seven (70%) of the respondents stated that they felt independent living in the supported housing facility, while three (30%) of the respondents were unsure.

In the interview conducted with the social worker at the facility, it was apparent that the residents gain a level of independence, as they are able to make their own decisions for the most part of their lives. The residents can make choices regarding how they live their lives, where they go to during the day or what they wish to wear, clothing wise. However, they are limited to certain choices such as daily consumption of medications,

their nutritional requirements while in the house and rehabilitation or treatment programs. This may be considered to be in conjunction with the statement made by a relative in the research study conducted by Barker, Lavender and Morant (2001) where a relative stated "He's doing what he wants to do and he's not at home with his mother. He's becoming an entity of his own".

- **Statement 4: The services here help me**

Eight (80%) of the respondents stated that the services rendered at the supported housing facility helped them, while two (20%) of the respondents were unsure. In conjunction with the aims of Comcare, it is essential that the services provided to the residents empower the residents by attain a sense of independence whilst being rehabilitated.

The services rendered to the residents of the housing facility according to the social worker, offer a form of self-improvement. This includes helping the residents follow or work out a budget for their pocket money, in depth talks with the residents regarding aspects, which may possibly bother them in the house and the welcome club. This welcome club offers the residents a certain period of time to talk freely regarding anything, which is concerning them. There is also a social worker available to the residents when necessary.

- **Statement 5: The staff is friendly and helpful**

The staff at the facility is friendly according to nine (90%) of the respondents, whereas one (10%) respondent was unsure.

This was established by the social worker in the interview conducted. She stated that the staff is trained in order to render the best possible services to the residents of the supported housing facility in order to allow the residents to develop and grow and improve their sense of identity and self-esteem. There are however certain factors which may cause the resident to respond negatively to the staff. According to the social worker "*the residents are of the perception that, should they complain about a certain staff member or the facility, they will be asked to leave the facility*",. She stated that the residents experience assertiveness issues and thus become tolerant of difficulties they might be experiencing regarding the staff. She also sated that some of the residents are so desperate for accommodation that they would rather "*let things slide*" and be unhappy than risk not having a place to live.

From figure 4.1 it can be determined that generally the residents are happy living in the supported housing facility. The respondents seemed to feel independent, yet part of the community. The services offered at the supported housing facility seemed adequate and the staff friendly and helpful. This may be in agreement with the aim and purpose of a supported housing facility. Supported housing is accommodation-providing support for individuals who suffer from a mental illness and are unable to take care of themselves. Such facilities include intensive or supportive housing management and offer a way of living independently in their own homes with regular support, which help the patients maintain their independence in the community (Comcare website - http://www.Comcare.co.za. 2004).

4.4.3 Social support systems

The following section illustrates the various social support systems, which were researched. It comprises of the assessment of support systems and how the respondents rated the support they received from each sub-system. According to Pilisuk and Parks (in Whittaker & Garbarino, 1983:4) social support systems convey something about the process of support. They describe it as "a range of interpersonal exchanges that provide an individual with information, emotional reassurance, physical or maternal assistance, and a sense of the self as an object of concern". Whittaker and Garbarino (1983:5) were of the opinion that a social support network was a set of interconnected relationships among a group of people that provided enduring patterns of nurturance and provided reliant corroboration for efforts to cope with life on a daily basis.

4.4.3.1 Social environment

The social environment comprises of the various systems in the respondent's life. This includes his/her immediate family members, other family members, work as well as the community and friends. Social work and the profession itself are precipitous in knowledge and values related to the social environment. The profession distinguishes itself from others in viewing all clients in the context of their social systems (Maguire, 1994:21).

As these components make up a significant portion of the respondent's environment it is imperative that these factors be rated. The social worker who operates with this ecological view in mind is aware of the physical environment as well as the impact of social, economic and political forces on the lives of their clients.

In order to investigate the social environment of people with a mental illness living in a supported housing facility, each respondent had to rate the type of support they receive from each of the following social environmental sub-systems:

Description of social environmental sub-systems

- Immediate family members
- Other family members
- Work
- Community
- Friends

Figure 4.2 illustrates the type of social support environment as well as the level of support that a sub-system gives the respondent.

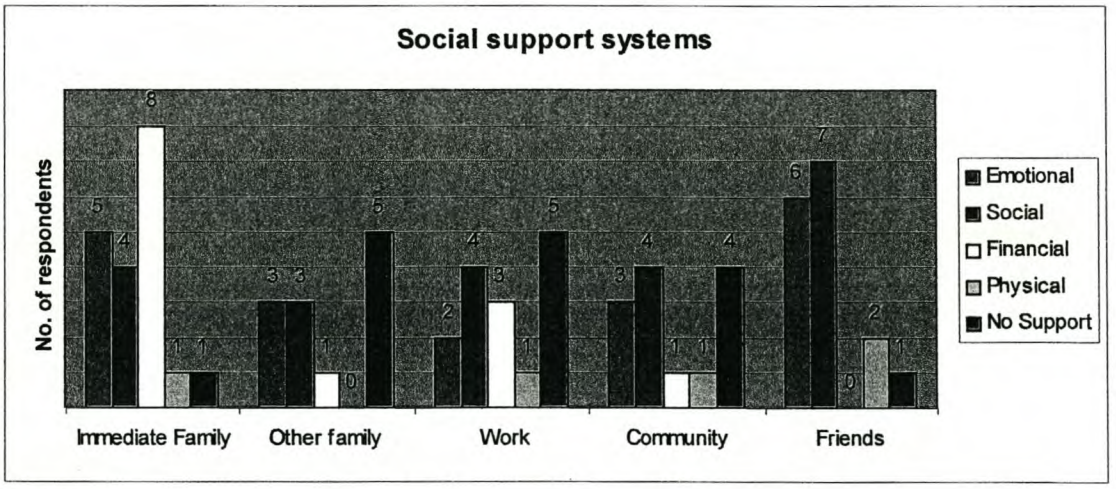


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FIGURE 4.2: Social environment

- **Immediate Family Members**

Eight (80%) of the respondents stated that their immediate family provided financial support. Half (50%) of the respondents claimed that their immediate family provided

emotional support; while four (40%) of the respondents stated that they received social support from their immediate family members. One (10%) respondent claimed physical support while another claimed no support from immediate family members.

In the interview conducted, the social worker gave more indicative reflection of the actual support given by the immediate family members. According to her information, seven (70%) of the respondents attain support from their family. This comprises of emotional and financial support exclusively. There were merely five (50%) of the respondents who attained emotional support from their family. Most of this emotional support is "purely out of duty" and some is genuine care and concern from the family members.

Maguire (1991:100) states that the individual is a product of his/her family. The families as well as the family dynamics are considered a product of the community, culture and society within which it is found. Chinkanda (1994:190) and Cochran, Larner, Riley, Gunnarsson and Henderson (1996:6) stated that any family that performs its supportive function and does not limit the potential of its members characterised by positive features. These positive features highlight the significant supportive role played by family, which is necessary for the basic functioning of an individual.

- **Other Family Members**

Half (50%) of the respondents claimed that they received no support from other family members. Three (30%) respondents stated that they received emotional support and another three (30%) stated that they received social support from other family members.

One (10%) respondent stated that s/he received financial support from his/her other family members; while none of the respondents stated that they received physical support from their other family members.

The social worker stated in the interview that other family members do not really play a significant role in the lives of these residents.

Chinkanda (1994:185) stated that strong family relationships or strong group cohesion provided a cushion or protective barrier against the negative perceptions transmitted by society. Chinkanda (1994:186) also stated that not all families provide support for their members. Some families can actually be a major source of stress for individual members, who might benefit more by severing ties with them.

- **Work**

Five (50%) of the respondents claimed that they received no support from their work place. Four (40%) of the respondents stated that they received social support; three (30%) stated that they received financial support and two (20%) respondents stated that they received emotional support from their place of work. One (10%) respondents stated that they received physical support from his/her place of work.

According to the social worker, the support offered at the resident's place of work may be debatable. She stated that the resident's employment might be regarded as a "*protected arrangement*". This means that the employment tasks and responsibilities for each

resident are based on the individual and his/her sustainability. As the residents become more confident in his/her employment position, so the employee feels that the resident is able to take on more and more responsibility. Once this happens, a situation referred to be the social worker as "*crash and burn*" occurs. This means that the job becomes too much for the resident resulting in a relapse or psychosis. The social worker also stated that the residents' interpersonal skills are challenged or limited, which means that they find it complex to deal with people continuously. This is exalted by the residents' anxiety of trying to "*fit in*" with the workplace.

People with a mental illness face the highest degree of stigmatisation in the workplace and the greatest barriers to employment opportunities. Persons diagnosed with a mental illness are more likely to experience long term unemployment, under-employment and dependency on social assistance. Many employers and employees have unwarranted fears and see persons with psychiatric disabilities as unskilled, unproductive, unreliable, violent or unable to handle workplace pressures. This stigma creates a climate in which someone who has a problem and needs help may not seek it for fear of being labelled.

Work plays an important role for a person recovering from a mental illness. The workplace provides a social support system and the opportunity for people to regain their sense of self-esteem, control and self-worth (www.mentalhealth.com - Internet mental health - Canadian Psychiatric Association – 2003).

- **Community**

Four (40%) of the respondents stated that they received social support from the community, while another four (40%) respondents claimed that they received no support from the community. Three (30%) respondents claimed that they received emotional support from the community. One (10%) respondent claimed that s/he received financial support and one (10%) respondents stated that s/he received physical support from the community.

According to the interview conducted with the social worker the resources and facilities available to the residents do offer them a fair amount of support. The residents, according to the social worker, have established good relations with the policemen specifically. The reason for this is unclear. Community facilities such as the local café, the library, recreational facilities and churches offer support for the residents. This is mostly emotional and social support.

Community support including information, accommodation, help with finding suitable work, training and education, psychosocial rehabilitation and mutual support groups. Understanding and acceptance by the community is very important (www.betterhealth.vic.gov.au - Better health channel – 2000).

- **Friends**

Seven (70%) of the respondents stated that they received social support from their friends. Six (60%) of the respondents stated that they received emotional support from their friends. Two (20%) of the respondents stated that they received physical support

from their friends while only one (10%) respondents claimed that s/he received no support from his/her friends. None of the respondents received financial support from their friends.

According to the response of the social worker in the interview conducted, the friends of the residents offer mostly emotional and social support. She stated that the residents do not have many friends outside of the house, but that the majority of friendships where genuine and accepting to the residents.

Bacon (in Henderson et al., 1981:11) quoted: "The healing support of friendship, to include both sexes, that this communication of a man's self to his friend work two contrary effects; for it redoubleth joys, and cuttith griefs in half. For there is no man that imparteth his joys to his friend, but he joyeth the more and no man that imparteth his griefs to his friend, but he grieveth the less". From this it may be concluded that the role of friendship can be very supportive.

From the above graph (figure 4.2) it is evident that the majority of support provided to residents living in a supported housing facility is attained from their immediate family members. This is followed by support provided by their friends and then their place of employment. Following that is the community and finally other family members. Humans have a number of interpersonal needs (Weiss, 1986). Social relationships with other individuals, who can share experiences and feelings, are essential for both physical

and mental health. It may be stated that the respondents experience positive relationships with their social support systems.

4.4.3.2 Relationship with friends

Friendships play a significant role in the social support systems for any individual. In the case of a mentally ill individual this is also true. This section comprises of disclosing the significance of friendships for the respondents. Figure 4.3 illustrates the relationship the respondents have with his/her friendship circle.

In order to investigate the relationship people with mental illness living in a supported housing facility have with their friends, each respondent had to rate their friendships according to the following statements:

Description of relationship with friends:

Statement 1: I like my friends

Statement 2: My friends respect me

Statement 3: I enjoy the company of my friends

Statement 4: My friends respect my privacy

Statement 5: My friends do not let me down

Statement 6: I have many friends

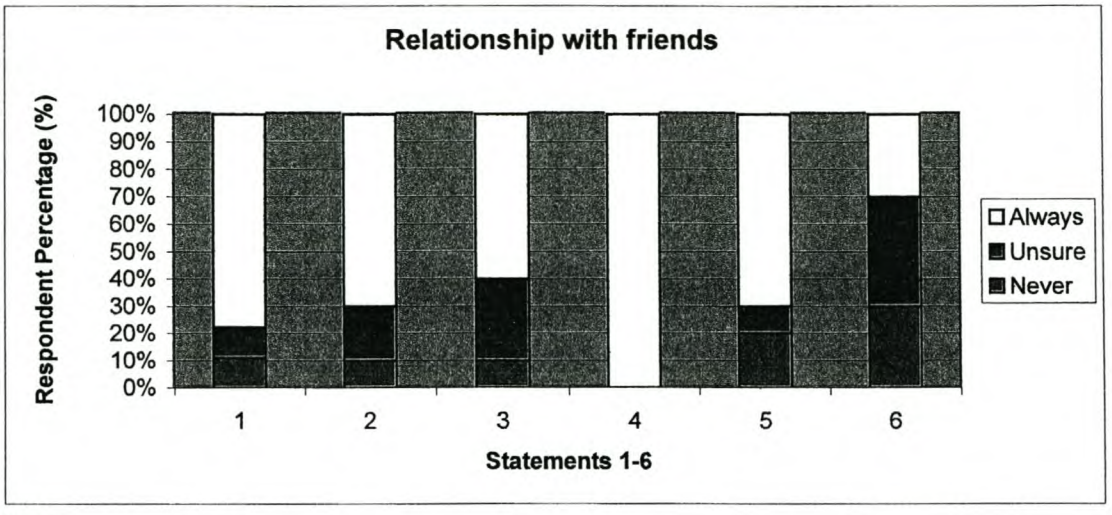

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FIGURE 4.3: Relationship with friends

- **Statement 1: I like my friends**

The above demonstrates that eight (80%) of the respondents like their friends. Only one (10%) of the respondents stated that s/he was not sure whether or not s/he liked their friends, while one (10%) of the respondents stated that s/he did not like his/her friends.

- **Statement 2: My friends respect me**

The figure shows that seven (70%) of the respondents stated that their friends respected them, two (20%) of the respondent stated that they were unsure and one (10%) stated that that his/her friends did not respect them.

- **Statement 3: I enjoy the company of my friends**

Six (60%) of the respondents enjoy the company of their friends, three (30%) were unsure and one (10%) of the respondents did not enjoy the company of their friends.

- **Statement 4: My friends respect my privacy**

All ten (100%) of the respondents stated that their friends respect their privacy.

- **Statement 5: My friends do not let me down**

Seven (70%) of the respondents felt that their friends do not let them down. One (10%) of the respondents was unsure in this regard, while two (20%) of the respondents stated that they felt their friends let them down.

- **Statement 6: I have many friends**

Four (40%) respondents were unsure with regards to having many friends. Three (30%) of the respondents stated that they do have many friends, while another three (30%) respondents stated that they do not have many friends.

According to the social worker the majority of the friendships of the residents were formed after the residents moved into the housing facility. She stated that there are about two residents who have friends from before they lived in the facility. According to the social worker the term 'friends' may be regarded as the "*people with whom the residents choose to spend time with*". The social worker stated that the respondents who stated that they did not have many friends, was resultant of personality conflicts and deprived social capacities.

The above figure 4.3 shows that the majority of the respondents experience a positive relationship with their friends, and that their friends play a significant role in their lives.

There were however, some respondents who have negative relationships with their friends, yet these were few. According to a research study concluded by Barker, Lavender and Morant (2001) clients and relatives describe how relationships had been adversely affected following the development of psychosis, and many friends had been lost. People with a mental illness are able to establish social relations within the community as well as learn to interact with other people in the facility itself. They are able to form friendships with people who find themselves in similar circumstances. As stated by Westen (1995: 397) social relationships with other individuals whom one can share a confidence, are essential for physical and mental health.

4.4.3.3 Relationship with family

Family plays a significant role in the lives of mentally ill individuals (Hepworth Rooney and Larsen, 1997:276-277). The White Paper for Social Welfare (Republic of South Africa. 1997) emphasises the fact that the family is the "basic unit of society" and points out that family ties should be reinforced and encouraged. Problems or inadequacies in family relationships can contribute to social disintegration. Impoverished human relationships can create as much misery as do inadequate social resources. Figure 4.4 illustrates the relationship between the respondent and his/her family. In order to investigate the relationship people with a mental illness living in a supported housing facility have with their family, each respondent had to rate their familial relationship according to the following statements:

Description of relationship with family:

Statement 1: I love my family

Statement 2: I feel happy when I am with my family

Statement 3: We are a happy family

Statement 4: My family respects me

Statement 5: My family has time for one another

Statement 6: I have lots of contact with my family

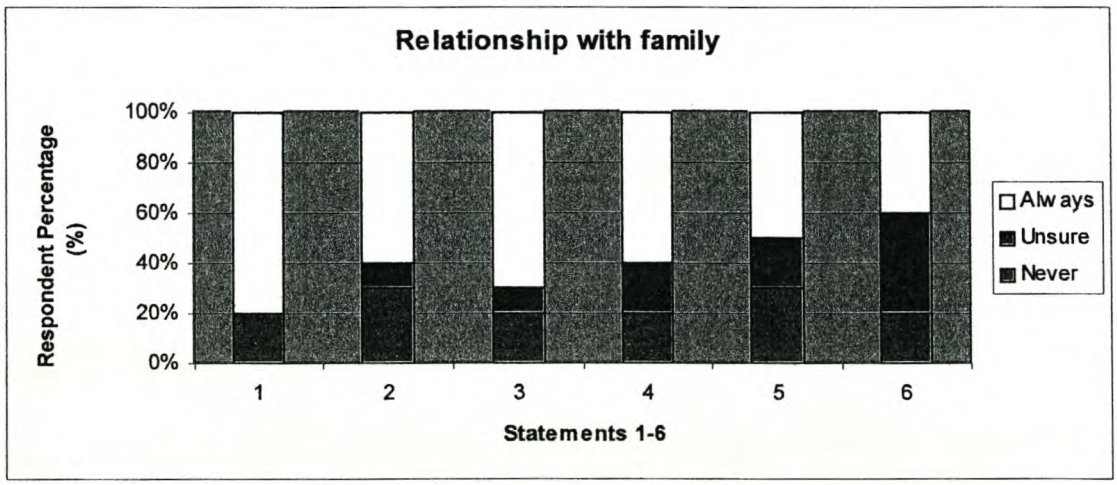

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FIGURE 4.4: Relationship with family

- **Statement 1: I love my family**

Eight (80%) of the respondents stated that they loved their family, while two (20%) stated that they did not love their family. This may be considered in accordance with the functions common to a family as listed by Shaefor, Horejsi and Horejsi, 2000:359) which includes providing its members with intimacy and a sense of belonging. This includes acceptance and love. The social worker agreed with the data attained from this statement.

- **Statement 2: I feel happy when I am with my family**

The above figure shows that six (60%) of the respondents are happy when they are with their family members; while three (30%) of the respondents stated that they are not happy when they are with their family members. Only one (10%) of the respondents was unsure how they felt when they are with their family members. This too, was agreed apon by the social worker.

- **Statement 3: We are a happy family**

The majority (70%) of the respondents stated that they are a happy family. Two (20%) of the respondents stated that they were not a happy family, while one (10%) respondent was unsure in this regard. The social worker stated that the majority of the residents were not a happy family as indicated through the research. According to the social worker four (40%) of the respondents have a happy family life, while the majority (60%) do not.

- **Statement 4: My family respects me**

Six (60%) of the respondents stated that their family respects them, while two (20%) of the respondents stated that they were unsure and another two (20%) respondents stated that their family does not respect them. The social worker stated the same as the previous statement.

- **Statement 5: My family has time for one another**

Half (50%) of the respondents stated that their family has time for each other, while three (30%) of the respondents stated that their family does not have time for one another and

the remaining two (20%) respondents were unsure in this regard. The social worker was in agreement with this statement.

- **Statement 6: I have lots of contact with my family**

From the above representation it can be seen that four (40%) of the respondents have a lot of contact with their family, while another four (40%) were unsure. The remaining two (20%) respondents said that they did not have a lot of contact with their family members.

From the above figure it may be determined that the majority of the relationships between the respondents and their family members are positive. They have a happy family relationship. This may be considered in accordance with the authors Sheafor, Horejsi and Horejsi (2000:361) who stated that the family has the duty to provide for the nurturing and socialisation of its members. This may be regarded as an expression of love and acceptance of the family members. There are however, certain respondents who do not have a positive relationship with their family members, and then there are those who are uncertain in this regard. The family also serves the purpose of protecting, assisting and caring for those family members who are vulnerable or cannot care for themselves (Shaefor, Horejsi and Horejsi, 2000:359).

The person with whom the individual lives or interacts on a regular basis has a significant influence on their rehabilitation outcomes (Lefley, 1997; Hatfield, 1997). Although most respondents expressed that their families were supportive towards them, the interview conducted with the social worker suggested that not all families were as supportive of the

individual's rehabilitation. Some family members play a key role in keeping their relative motivated, there were others who were clearly overburdened with their caring role or were very anxious that their relative would have a relapse. Many families have little support, feel very isolated and are possibly exhausted and drained after several years of caring.

According to the social worker, the findings that the family was supportive and not hostile could be attributed to the recovered state of the respondents. Though the experience of mental illness is traumatic for both the individual and their relatives and can invoke fear, hostility, and distress on both sides, these feelings may subside during the course of recovery and as both sides learn to accept, cope and adjust to the illness. This also suggests that the support networks of people with a mental illness are not fixed, and can change, depending on the stage of the illness and the needs of the individual at that point in time.

4.4.3.4 Relationship with Residential Support Workers

The role of the residential support worker as discussed in chapter three of the study stated that their single significant task is to take care of the residents. As stated by the Department of Ageing (United Kingdom. 2004), a residential support worker's task is to improve the residents' quality of life. They provide aid with daily living responsibilities. Figure 4.5 illustrates the relationship the respondents have with the residential support workers.

In order to investigate the relationship people with a mental illness living in a supported housing facility have with the residential support workers, each respondent had to rate their relationship with the support worker according to the following statements:

Description of relationship with residential support workers:

Statement 1: I have a good relationship with the support workers

Statement 2: The residential support workers encourage me

Statement 3: I trust the residential support workers

Statement 4: The support workers treat me with respect

Statement 5: The support workers understand me and my situation

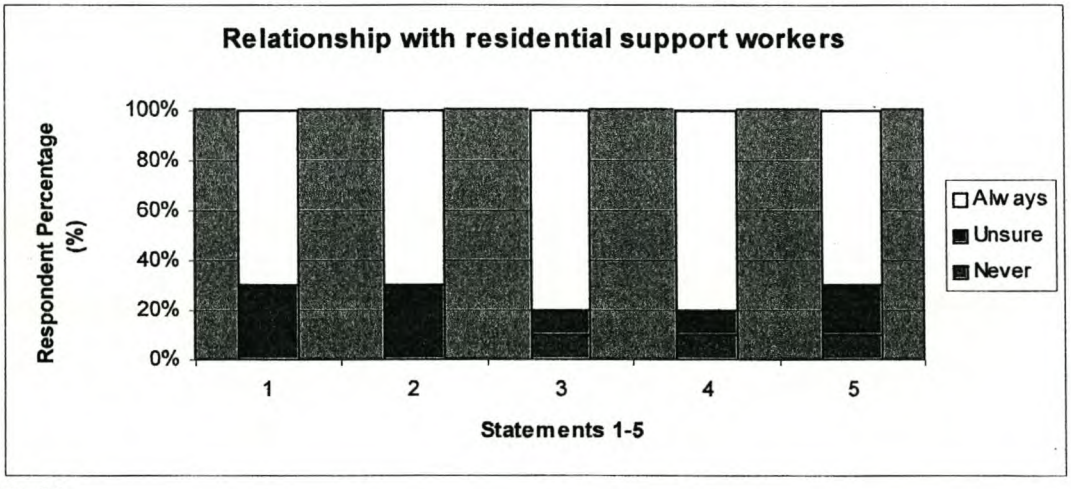

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FIGURE 4.5: Relationship with residential support workers

- **Statement 1: I have a good relationship with the support workers**

From the above figure can be seen that seven (70%) of the respondents have a good relationship with the residential support workers. Three (30%) of the respondents were unsure about their relationship with the support workers. None of the respondents stated

that they have poor relationships with the residential support workers. The social worker was in agreement with the data gathered for this statement.

- **Statement 2: The residential support workers encourage me**

Seven (70%) of the respondents feel that they are encouraged and supported by the residential support workers. Three (30%) of the respondents stated that they were unsure regarding the level of support and encouragement they receive from the residential support workers. None of the respondents stated that the residential support workers did not support or encourage them. It is essential that the residential support workers motivate and encourage the residents, as this is considered to be in line with the strengths perspective. The social worker stated that the residential support worker should encourage the residents to reach their full potential attainable to them.

- **Statement 3: I trust the residential support workers**

The majority of the respondents (80%) stated that they trust the residential support workers. Only one (10%) of the respondents was unsure in this regard. One (10%) of the respondents stated that they did not trust the residential support workers. The social worker mentioned that the majority of the respondents do trust the residential support workers, and that these support workers play a significant role in the lives of the residents as well as their rehabilitation.

- **Statement 4: The support workers treat me with respect**

Eight (80%) of the respondents stated that the residential support workers treat them with respect. One (10%) of the respondents was unsure in this regard. One (10%) respondent

stated that the residential support workers do not treat him/her with respect. This statement was agreed apon by the social worker.

- **Statement 5: The support workers understand me and my situation**

The representation shows that of the respondents, most (70%) said that the residential support workers understand them and their situation; while two (20%) of the respondents stated that they were unsure in this regard. One (10%) of the respondents stated that the support workers do not understand him/her or his/her situation. The social worker was in dispute with regards to this specific statement. She said that she was hesitant to make an assumption based on this statement

From the above figure it is evident that the majority of the respondents feel that they have a positive relationship with the residential support workers. They are able to trust them and they fell that the residential support worker provides them with enough support and encouragement. In accordance with the Department of Ageing in the United Kingdom, a residential support worker has the task of planning and implementing support plans that will improve the residents' quality of life. For this reason it is essential that a positive relationship exist between the resident and the residential support worker. Some of the respondents were however unsure about their relationship with the residential support workers and few had a negative relationship with the residential support worker. According to Hepworth, Rooney and Larsen, (1997:133) positive feedback plays a pivotal role in the change process. This will ultimately allow for the manifestation of strengths in the resident, effective coping strategies and personal growth.

The social worker stated that while the family played a significant role in shaping rehabilitation outcomes, mental health practitioners such as social workers and residential support workers constituted a significant proportion of the support network. These practitioners are also perceived as serving important emotional and instrumental functions. People with a mental illness depend on their treatment professionals. This may continue even after they have recovered from the illness. Therefore rehabilitation outcomes can be enhanced if there is close cooperation between residents and treatment professionals. However, like family members, they will need ongoing professional support and practical advice on matters such as how to provide support, supervision and treatment for the resident with a mental illness.

4.4.4 NEEDS AND CAPACITIES

As mentioned by Lee (2001:217) the necessity to focus on the strengths of the individual in the process of empowerment. It is crucial that the practitioner gain a deeper tolerance regarding the manner in which the individual perceives him/herself in relation to his/her situation. As this may be regarded as the motivation of an individual and may impact on the approach in which s/he interacts with the environment and people within it. Figure 4.6 illustrates the motivational particulars of the respondents in this study.

In order to investigate the needs and capacities of people with a mental illness living in a supported housing facility, each respondent had to rate the following statements:

Description the needs and capacities

Statement 1: I look at life with enthusiasm

Statement 2: I am hopeful about my future

Statement 3: I am goal orientated/driven

Statement 4: I strive to achieve my goals

Statement 5: I live with self-respect

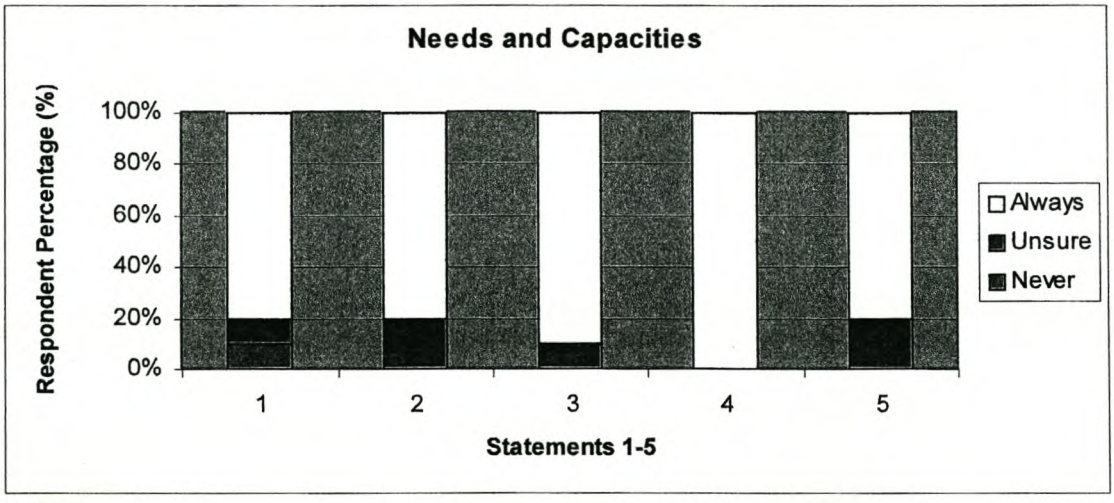

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FIGURE 4.6: Needs and Capacities

- **Statement 1: I look at life with enthusiasm**

The majority of the respondents (80%) felt that they look at life with enthusiasm. One (10%) of the respondents felt unsure and another one (10%) felt that they do not look at life with enthusiasm.

- **Statement 2: I am hopeful about my future**

Eight (80%) of the respondents felt that they were hopeful with regards to their future, and only two (20%) were unsure. None of the respondents felt despondent with regards to their future.

- **Statement 3: I am goal orientated/driven**

Nine (90%) of the respondents felt that they were goal oriented and driven. Only one (10%) respondent was unsure in this regard. None of the respondents stated that they were not goal oriented or driven. According to Hepworth, Rooney and Larsen (1997:207-208) identifying needs also serves as a vital preface to the process of attaining goals. This enhances the motivation of the resident to strive toward goal attainment and the realization of these goals.

- **Statement 4: I strive to achieve my goals**

All (100%) of the respondents stated that they endeavor to attain their goals. This may be considered in accordance with the perception of Hepworth, Rooney and Larsen (1997:208) that striving to achieve goals may result in the realization of those goals.

- **Statement 5: I live with self-respect**

Eight (80%) of the respondents stated that they live their lives with self-respect. The minority (20%) of the respondents were unsure in this regard. None of the respondents stated that they do not live with self-respect.

The social worker made a general assessment with regards to the needs and capacities of the residents living in the supported housing facility. She stated that the needs and capacities of the residents are largely based on the behavior of the residents. She stated that the resident's outward behavior portrays their needs and capacities. She said that the majority of the residents do consider life favorably, and are expectant with regards to their future. The social worker stated that the residents are goal oriented, but that the idea of goals may for example be regarded as remaining healthy or not having a psychotic episode. The goals of people with a mental illness may be regarded differently and the goals wanted by a 'normal' individual.

From figure 4.6 it is evident that the majority of the residents living in the supported housing facility realize their personal needs and capacities. They seem to be hopeful with regards to themselves as well as their future, and work hard to attain their goals and satisfy their personal needs. Swanepoel and De Beer (1996:24-25) listed self-reliance, happiness and human dignity as the most significant intangible needs of man. Maslow's hierarchy of needs pyramid comprises of the individual attaining his/her expression of self on various levels, namely self-actualisation. This level of need is not a deficiency need and thus is not generated by a lack of something, but it is rather a growth need. This means that is may be regarded as an incentive to develop and expand one's skills and abilities (Westen, 1995:376).

4.4.5 Socio-Emotional Perceptions

This section encompasses of the investigation into the respondents socio-emotional needs. This comprises of the social and emotional needs the individual requires. As cited by Potgieter (2004:136) when taking into account the needs of an individual, it is pivotal to regard Maslow's hierarchy of needs. Various authors namely, Cronje, Du Toit and Motlatla (2000:183-184) alluded to the fact that people's needs create their behaviour. People's behaviour is subsequent to the satisfaction of primary needs. Figure 4.7 illustrates the socio-emotional particulars of the respondents.

In order to investigate the socio-emotional perceptions of people with a mental illness living in a supported housing facility, each respondent had to rate the following statements:

Description of socio-emotional perceptions

Statement 1: I accept myself

Statement 2: I am satisfied with my life

Statement 3: I am a spiritual person

Statement 4: I find myself feeling happy often

Statement 5: I enjoy interacting with other people

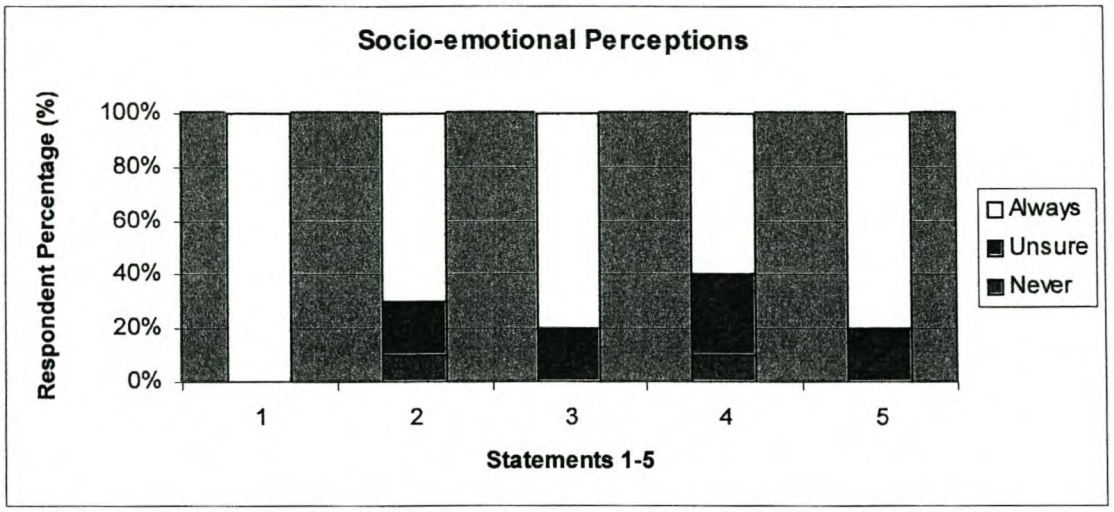

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FIGURE 4.7: Socio-emotional perceptions

- **Statement 1: I accept myself**

Every respondent (100%) stated that they accept themselves. The social worker was concerned that this statement may be the ideal for the respondents. She stated that she feels the responses attained for this statement were the goals of the residents. She said that the response might be considered favorable by the researcher.

- **Statement 2: I am satisfied with my life**

Seven (70%) of the respondents stated that they are satisfied with their life. Two (20%) of the respondents were unsure in this regard, while only one (10%) of the respondents stated unsatisfaction in life. The social worker stated that at various points in the residents' rehabilitation process, the response to this statement might vary.

- **Statement 3: I am a spiritual person**

The majority of the respondents (80%) stated that they were spiritual people, while only two (20%) were unsure about their spirituality. The social worker stated that the term 'spiritual' should be replaced with belief system. She said that a belief might be regarded as the entity "*that gives meaning to their lives*". She said that some of the respondents attend church, while others celebrate their beliefs on a more interpersonal level.

The importance of spirituality was recognized when Richmond (1917:378) advised social workers to consider the positive effect of religion and people.

- **Statement 4: I find myself feeling happy often**

Most of the respondents (60%) felt that they often find themselves feeling happy. Three (30%) of the respondents stated that they were unsure in this regard, while only one (10%) stated that they were not finding themselves often happy. Again, the social worker stated that this depends on the point at which the individual is in his/her rehabilitation process. She did however state, that the residents do seem to be happy often enough.

- **Statement 5: I enjoy interacting with other people**

Eight (80%) of the respondents stated that they enjoy interacting with other people. Two (20%) of the respondents stated that they are unsure. None of the respondents stated that they do not enjoy interacting with other people. According to Westen (1996:397) the need for affiliation may be regarded as a social motive. Most people need to associate with other individuals whether it means attaining support, sharing experiences and

socializing in general. The social worker stated that this occurs mostly within the boundaries of the housing facility. The residents enjoy interacting with one another as they find that they understand one another and are able to help one another when necessary.

The social worker made a general assessment with regards to the socio-emotional capacities of the residents living in the supported housing facility. She stated that the socio-emotional capacities of the residents are based on the point in their rehabilitation process. She said that the residents do tend to have a stable emotional profile and that it is mostly when the residents become ill or psychotic that their emotional well-being may be regarded as turbulent.

From figure 4.7 it may be stated that the majority of the socio-emotional particulars of the respondents were positive. According to Gutierrez (1990: 149-153) an individual needs to understand his/her environment and the interactions occurring within the environment. This may help the individual attain a socio-emotional balance with regards to his/her capacities. There were some respondents who were not quite as optimistic, but no one was completely unhappy. Mood transformations as a result of the mental illness may be taken into consideration, although these mood changes should be sustainable as a result of the medication (Montgomery, 1994:447-457).

4.5 SUMMARY

This study conducted was exploratory in nature and limited by a small randomly selected sample of 10 people with a mental illness, residing in a supported housing facility and more specifically Comcare. The findings of this study are important in the light of the current emphasis on preparing people who have recovered from mental illness to gain a sense of independence and become a part of the community. The results demonstrate the important role that support play in the rehabilitation outcomes.

The findings of the study show that the majority of respondents fell in the age 30 –50 years age bracket. Half of the respondents attained a high school level qualification and the others had attained another form of qualification. Eighty percent (8) of the respondents were unemployed, which meant no other income for them other than the disability grants which all of the respondents were receiving.

The study showed that the ten respondents felt positive about living in a supported housing facility. Being part of the community allowed for a greater sense of independence and thus resulting in a higher self-esteem. The respondents showed that the services being rendered at the facility were sufficient and that the staff relations are positive.

The support systems available to these individuals also proved to be beneficial. From the research done the support systems available to these residents are constructive relations. The majority of the respondents have good relationships with their families as well as

other entities such as their place of employment, the community and their friends. These support systems are able to provide support on numerous levels including emotional, financial, social and physical support. However, there were some individuals who did not experience positive relations with their support systems, but they were few. In general, the relationships between the respondents and their friends, family as well as the residential support workers were positive and optimistic.

With regards to the personal needs and capacities of the respondent, it may be stated that that the respondents have attained all of those needs and capacities relevant to their lives and according to their needs. These individuals may be considered as hopeful, goal-orientated, enthusiastic individuals who seem to look at life with optimism and hope irrespective of the mental health condition that they have to live with.

The socio-emotional circumstances of these respondents also seem to be of an encouraging nature. They seem to be happy, spiritual people who accept themselves and their life circumstances. The greatest need of these individuals was to attain more access to employment in order to increase their income.

According to the follow up interview concluded with the social worker of the supported housing facility, the data gathered from the respondents may be regarded as accurate. She stated that one needs to consider the fact that the respondents and the target population are people with a mental illness. These individuals have unpredictable behavior patterns and emotional fluctuation for the better part of their lives. It is

important to bare in mind that the resident will answer a question or respond to a statement based on where s/he is at in their rehabilitation process. The responses may even vary from day to day. According to White and Epson (1990) the way in which people with a mental illness conceptualize and communicate about themselves and their life experiences, can be understood as 'narratives'. The narrative is regarded as the dynamic way of representing oneself and considering one's relations with other. Psychotic people have difficulty making sense of their experiences. Clients in remission give accounts, which are stable over time and are consistent with external observations (Cutting and Dunne, 1989).

The final chapter of this study will suggest various conclusions and recommendations regarding the empirical study as well and the previous literature chapters.

CHAPTER 5

RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

The aim of this study was to present a description of the personal needs, capacities and the socio-emotional functioning of people with a mental illness living in a supported housing facility. From the findings of the literature and empirical study conducted, diverse conclusions and recommendations will be presented in this chapter.

5.2 CONCLUSIONS DRAWN FROM THE FINDINGS OF THE RESEARCH

In terms of the findings of this research, the following conclusions can be drawn:

5.2.1 Personal information

The ages of the respondents ranged between 30-50 years of age. There were seven (7) males in the study and three (3) females. Five (5) of the respondents had attained a high school qualification, while three respondents obtained a diploma, one obtained a degree and one obtained a qualification of another form. Eighty percent (8) of the respondents were unemployed, while only twenty percent (2) of the respondents were employed, which was indicative of the sufficiency of their income. All of the respondents were receiving a R520-00 disability grant.

Thus it may be concluded that the respondents were young to middle aged mentally ill adults. The respondents consisted of mostly males, with a high school qualification. The majority of the respondents were unemployed, and all of the respondents received a disability grant.

5.2.2 Experiences of the supported housing facility

It was apparent through the study that the respondents were jovial living in the supported housing facility. They had an encouraging attitude towards the facility and positive attitude of the facility. The respondents felt independent and part of the community. They felt that the staff was accommodating and supportive and that the services rendered by the facility were sufficient in their rehabilitation and daily living experiences.

The social worker stated that the residents would experience the supported housing facility as pleasant as this facility allows the resident to be himself or herself without the stigma of being mentally ill. She stated that the facility offers the residents the opportunity to become independent and to make decisions and choices regarding his/her daily life. The support received from the facility is of such a nature that the residents are able to relay opinions without being prejudiced. These services also allow for the residents to progress in his/her rehabilitation process.

5.2.3 Social support systems

It seemed as though the social support systems obtainable to the residents of the facility were adequate and experienced as positive by the respondents.

5.2.3.1 Social environment

The social environment comprised of those systems that may or may not play a significant role in the daily lives of the residents living in the supported housing facility. This consisted of the immediate family members, other family members, friends, community and work.

Through the study it was found that the majority of support came from the immediate family members. These members provided financial as well as emotional support. The system providing the least support was the place of employment of the residents. As stated in the previous chapter a possible reason as to the lack of support from the residents' place of employment is the fact that only two of the respondents were employed.

The social worker mentioned in the interview that it is difficult for the residents' to reflect on their lives as this opens them up to vulnerability. The residents are unable to assert themselves as this salutes abuse and neglect. The social support systems may be representative of the level of impairment experienced by the resident. This may ultimately result in a lack of tolerance or communication.

It may be concluded that in general the respondents felt that they attained sufficient support from their social environment. Each area offered its own form of support and this seemed to be satisfactory for the respondents.

5.2.3.2 Relationship with friends

For the most part the respondents had positive relationships with their friends. They felt that their friends respected them, did not let them down and respected their privacy. It may be concluded that the residents have good social relationships with their friends. There were no issues ascertaining any differently.

As stated in the empirical study, the social worker said that the term 'friends' might be regarded as the people with who the residents choose to spend time with. She stated that the majority of the residents only have friends within the facility, and that these friendships developed once the resident moved to the facility. She stated that those residents, who did have friends, enjoyed a positive friendship.

5.2.3.3 Relationship with family

The majority of the respondents had favorable relationships with their family members. They stated that they loved their family members and enjoyed spending time with them. They also felt that their families respected them and that they were a happy family. Ultimately the role and duties of a family are to protect, assist and provide for those family members who are at risk or cannot take care of themselves. According to the social worker at the facility, the families who did feature in the lives of the residents showed concern and care, while other family relationships were purely as a result of obligation to the person with the mental illness.

It may be concluded that the relationships between the respondents and their family members are mostly positive and healthy.

5.2.3.4 Relationship with residential support workers

All the respondents stated that they had a favorable relationship with the residential support workers. They felt that they were able to trust the support workers and that the support workers encouraged them and understand their situation.

It may be concluded that the relationship between the respondents and the residential support workers are of a positive nature. This means that they understand one another and there is an element of trust and understanding which exists between the two parties. However, according to the social worker, sometimes the residents may be too afraid to verbalize their grievances for fear of eviction. This is not always the instance though and the relationships are generally positive.

5.2.4 Needs and capacities

It is clear from the ecological perspective that the satisfaction of human needs requires the availability of resources within the environment as well as a positive relationship between the environment and the individual. Mismatches between the individual and his/her environment result in two major situations. The first being substantial deficiencies in resources normally needed by people at various developmental levels and the second, the unusual needs of people that result from developmental difficulties such as a chronic mental health condition. As stated by the social worker, the needs and

capacities of the resident being met, depends largely on where the resident is in his/her rehabilitation process.

The respondents seemed hopeful regarding their future and considered life enthusiastically. It seemed as though the respondents were goal-oriented and attained a lot of self-respect. It may be concluded that from the results obtained through the study the respondents felt that their personal needs and capacities were being met.

5.2.5 Socio-emotional perceptions

People with disabilities often face bigotry and discrimination, which has a negative impact on their self-esteem. If a person with a mental illness is placed in a supported housing facility with individuals who experience similar issues, esteem issues may be dealt with. All residents are equal and they are thus understanding to one another's issues and situations. Once again, depending on the resident's point of rehabilitation, his/her emotions may fluctuate.

In general the respondents seemed to be happy and accept themselves as well as their life circumstances. The respondents seem to enjoy interacting with their friends and other social systems. They seemed to be satisfied with life and often found themselves feeling joyous and happy. The most positive factor was that all of the respondents stated that they accept themselves. It may be concluded that the socio-emotional functioning of the respondents seemed to be positive.

5.3 RECOMMENDATIONS FOR APPLICATION AND FUTURE INVESTIGATION

On the basis of the conclusions drawn from the study, the following recommendations are proposed. These recommendations could suggest probable guidelines for supported housing facilities presenting the same or similar programmes for people with a mental illness.

5.3.1 Organisations that render serves to chronic mentally ill adults

It is recommended that supported housing facilities rendering services to individuals with chronic mental health conditions, should ensure that the services rendered by them are in accordance with legislation and the welfare policy.

It is recommended that social work services for individuals with chronic mental health conditions should primarily be based on social work perspectives such as the ecological and strengths perspective as these are interrelated to disability and oppression. The use of these perspectives by social workers will result in the empowerment of people with mental illnesses and thus the deployment of the empowerment strategy.

5.3.2 Needs and capacities of chronic mentally ill individuals

It is recommended that a focus be placed on the mentally ill individuals personal social functioning. This comprises of the self-care situation of the individual and his/her ability or lack thereof to look after him/herself. It is essential that residents in a supported housing facility be empowered and augmented concerning their abilities and capacities as

individuals whose livelihood encumbers a chronic mental health condition. This may be realized through developing and implementing intervention programs based on the ecological perspective, strengths perspective and the empowerment approach. Such programs will encourage the individual to become increasingly self-reliant and self-aware of the context within which s/he finds him/herself.

5.3.3 Intervention programs aimed at developing chronic people with mental illnesses' socio-emotional needs and capacities

It is recommended that intervention strategies designed by social workers should include the parties mostly involved in the daily interactions and living arrangements of the mentally ill individual. This includes the resident him/herself, the caregiver, family members as well as the various mental health practitioners involved in the recovery and treatment of these individuals.

It is recommended that all social workers and welfare practitioners be trained and educated regarding the relative mental health conditions as well as the various policies and legislative procedures existing to empower mentally ill individuals. This knowledge will help the social workers and social welfare practitioners develop and empower the residents to attain their full potential as individuals living with a chronic mental health condition.

It is recommended that social workers should play a significant role in the intervention and recovery of these residents. Social workers are able to facilitate a process of change

resulting in individuals becoming increasingly empowered and self-motivated. Social workers are also able to facilitate and promote positive social functioning within individuals, through various practice frameworks, approaches and models available for intervention. Social workers can offer counseling to residents in a supported housing facility on an individual basis, as well as in a group situation. In this manner they can facilitate discussions among the residents and thus enhance communication and interaction between the residents. Social workers can also facilitate family therapy and assistance if necessary. This will allow the family to become an integral factor in the recovery and daily living experiences of the mentally ill individual.

5.3.5 Employment assistance for people with a mental illness

It is recommended that people with a mental illness be given a fair chance at attaining and maintaining some form of employment. This will not only provide more income for the individual but it may boost their self-esteem and regards for them self. Securing and sustaining meaningful employment could be beneficial to the individual with a persistent mental illness.

5.3.4 Future research beneficial to chronic mentally ill adults living in a supported housing facility

Drawn from the conclusions of this study, the following themes are recommended for future studies.

- The role of the family in the life of a person with a mental illness living in a supported housing facility.

- Employment options for people with a mental illness.
- Measures needed by people with mental illnesses to enable them to find work.
- The reasons why residents choose to reside in the supported housing facility.
- Programmes for the re-integration of people with a mental illness into the workforce.

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APPENDIX A

UNIVERSITY OF STELLENBOSCH

DEPARTMENT OF SOCIAL WORK

AN EXPLORATORY STUDY OF A MENTALLY ILL ADULT LIVING IN A SUPPORTED HOUSING FACLITY

QUESTIONNAIRE

Instructions:

In order for accurate and reliable analysis of the questionnaire it is essential that the questions be answered as honestly and descriptively as possible. Please consider each question carefully prior to answering each one. When answering the question be as honest and sincere as possible. The information gathered and conclusions drawn from this questionnaire will benefit you in the end, in order to ensure that all your concerns and needs may be considered.

Many thanks for your time and participation in this study

Liesl Mary Jacobs

1 PERSONAL INFORMATION

Please indicate your response to the question but making a X in the appropriate block. There is ONE question, which requires a personal response, kindly write your response on the line provided.

1.1 Age

Under 20	20 – 29	30 – 39	40 – 49	50 +

1.2 Gender

Female	Male

1.3 Highest Qualification

Primary School	High School	Diploma	Degree	Other

If other, please specify _____

1.4 Are you employed?

Yes	No

1.5 How sufficient is your income to provide for your daily requirements?

Sufficient	Insufficient	Unsure

1.6 Do you receive a disability grant?

Yes	No

2 *EXPERIENCES OF THE SUPPORTED HOUSING FACILITY*

For this section please indicate your response by selecting the applicable option (ie.1,2 or3) and writing that number in the box next to the relevant statement:

1 NEVER

2 UNSURE

3 ALWAYS

2.1	I enjoy living at the housing facility	☐
2.2	I feel part of the community	☐
2.3	I feel independent living here	☐
2.4	The services here help me	☐
2.5	The staff are friendly and helpful	☐

3 SOCIAL SUPPORT SYSTEMS

3.1 SOCIAL ENVIRONMENT

For this section please indicate your response by selecting the applicable type of support (i.e E,P,F,S,N) and writing that choice on the line next to the statement:

E – EMOTIONAL

P - PHYSICAL

F – FINANCIAL

S – SOCIAL

N – NO SUPPORT

3.1.1	Immediate Family Members	_____
3.1.2	Other Family Members	_____
3.1.3	Work	_____
3.1.4	Community	_____
3.1.5	Friends	_____

FOR THE REST OF THE QUESTIONNAIRE PLEASE INDICATE YOUR RESPONSES BY SELECTING THE APPLICABLE CHOICE AND WRITING IT IN THE BOX NEXT TO THE RELEVANT STATEMENT:

1 **NEVER**

2 **UNSURE**

3 **ALWAYS**

3.2 RELATIONSHIP WITH FRIENDS

3.2.1	I like my friends	☐
3.2.2	My friends respect me	☐
3.2.3	I enjoy the company of my friends	☐
3.2.4	My friends respect my privacy	☐
3.2.5	My friends do not let me down	☐
3.2.6	I have many friends	☐

3.3 RELATIONSHIP WITH FAMILY

3.3.1	I love my family	☐
3.3.2	I feel happy when I am with my family	☐
3.3.3	We are a happy family	☐
3.3.4	My family respects me	☐
3.3.5	My family has time for one another	☐
3.3.6	I have lots of contact with my family	☐

3.4 RELATIONSHIP WITH RESIDENTIAL SUPPORT WORKERS

3.4.1	I have a good relationship with the support workers	☐
3.4.2	The residential support workers encourage me	☐
3.4.3.	I trust the residential support workers	☐
3.4.4	The support workers treat me with respect	☐
3.4.5.	The support workers understand me and my situation	☐

3.5 NEEDS AND CAPACITIES

3.5.1	I look at life with enthusiasm	☐
3.5.2	I am hopeful about my future	☐
3.5.3	I am goal orientated/driven	☐
3.5.4	I strive to achieve my goals	☐
3.5.5	I live with self-respect	☐

3.6 SOCIO-EMOTIONAL PARTICULARS

3.7.1	I accept myself	☐
3.7.2	I am satisfied with my life	☐
3.7.3	I am a spiritual person	☐
3.7.4	I find myself feeling happy often	☐
3.7.5	I enjoy interacting with other people	☐

Thank you

APPENDIX B

UNIVERSITY OF STELLENBOSCH

DEPARTMENT OF SOCIAL WORK

AN EXPLORATORY STUDY OF A MENTALLY ILL ADULT LIVING IN A SUPPORTED HOUSING FACLITY

FOLLOW UP INTERVIEW WITH THE SOCIAL WORKER AT COMCARE

The social worker was asked to respond to each of the following statements. These were the exact statements asked for the respondent's questionnaire.

EXPERIENCES OF THE SUPPORTED HOUSING FACILITY

2.1 I enjoy living at the housing facility

2.2 I feel part of the community

2.3 I feel independent living here

2.4 The services here help me

2.5 The staff are friendly and helpful

3 SOCIAL SUPPORT SYSTEMS

3.1 SOCIAL ENVIRONMENT

E – EMOTIONAL; P – PHYSICAL; F – FINANCIAL; S – SOCIAL; N – NO SUPPORT

3.1.1 Immediate Family Members

3.1.2 Other Family Members

3.1.3 Work

3.1.4 Community

3.1.4 Friends

3.2 RELATIONSHIP WITH FRIENDS

3.2.1 I like my friends

3.2.2 My friends respect me

3.2.3 I enjoy the company of my friends

3.2.4 My friends respect my privacy

3.2.5 My friends do not let me down

3.2.6 I have many friends

3.3 RELATIONSHIP WITH FAMILY

3.3.1 I love my family

3.3.2 I feel happy when I am with my family

3.3.3 We are a happy family

3.3.4 My family respects me

3.3.5 My family has time for one another

3.3.6 I have lots of contact with my family

3.4 RELATIONSHIP WITH RESIDENTIAL SUPPORT WORKERS

3.4.1 I have a good relationship with the support workers

3.4.2 The residential support workers encourage me

3.4.3. I trust the residential support workers

3.4.3 The support workers treat me with respect

3.4.5. The support workers understand me and my situation

3.5 NEEDS AND CAPACITIES

3.5.1 I look at life with enthusiasm

3.5.2 I am hopeful about my future

3.5.3 I am goal orientated/driven

3.5.4 I strive to achieve my goals

3.5.5 I live with self-respect

3.6 SOCIO-EMOTIONAL PARTICULARS

3.7.1 I accept myself

3.7.2 I am satisfied with my life

3.7.3 I am a spiritual person

3.7.4 I find myself feeling happy often

3.7.5 I enjoy interacting with other people

APPENDIX C

CLIENT CONSENT FORM

Dear Respondent,

Thank for accepting to assist me with my research for the completion of my Masters Thesis at the university of Stellenbosch.

The aim of today's visit is to complete a questionnaire concerning your daily life circumstances, which you experience in the supported housing facility (Comcare). The questionnaire should take approximately 20-30 minutes to complete. It is essential that ***ALL*** the questions be answered in order to attain accurate information. It is essential for me to highlight that the questionnaire you fill out will remain ***ANONYMOUS AND CONFIDENTIAL***.

Liesl Mary Jacobs
Social Work Student
University of Stellenbosch

PLEASE COMPLETE THE FOLLOWING IF YOU AGREE TO UNDERTAKE TO BE A PARTICIPANT IN THE STUDY TO BE CONDUCTED.

I, (name in block letters) _____ understand the aim of this visit today. All my information and responses will be treated as confidential and will only be disclosed to health service providers who may be able to assist me in my general health and/or rehabilitation management.

Signature: _____

Witness: _____

(Name in block letters): _____