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SOCIO-ECONOMIC CONSTRAINTS INFLUENCING RE-INTEGRATION OF FEMALE PATIENTS WITH MENTAL ILLNESS INTO SOCIETY: A CASE OF MATHARI NATIONAL TEACHING AND REFERRAL HOSPITAL

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Abstract: Women with mental illness face far more challenges in the society than the male counterparts, taking into consideration they are considered the homemakers and have a lot of responsibilities in caring for home and nurturing children. The general objective of the study was to identify the socio-economic constraints influencing re-integration of female patients with mental illness into the society by focusing on Mathari National Teaching and Referral Hospital. The study used Durkheim's anomie theory, which indicates that in the absence of strong social cohesion and strong social constraint in the form of norms, values, and morals, integration of people with mental illness. This study used mixed methods research and cross-sectional study design. The target population was 344 doctors, nurses, personal assistants, medical superintendent, social workers and visitors of the female patients. The sample size was 184 respondents, which was determined using Slovin's Formula. Stratified random sampling was used to select the respondents from the target population. The study also adopted purposive sampling to select the social workers and medical superintendent as the key informants. Primary data was used in this study and was collected by use of semi-structured questionnaires and key informant interview guides. Thematic analysis was used to analyze qualitative data. Quantitative data was analyzed by use of descriptive statistics such as frequency distribution, percentages, mean and Standard deviation. The data was then presented in tables and graphs. The study found that economic factors such as employment status and income levels have a positive influence on re-integration of female patients with mental illness. The study also found that while traditions, beliefs and community values influence re-integration of female patients with mental illness, ethnicity and religion had no significant influence. The study further found that community awareness about the need for reintegration of females with mental health challenges into society in Nairobi County was low. Also, the study also established existing state policies and programs regarding admission and discharge of female inmates of mental institutions in Kenya focus on admission of mentally ill individuals, power to take person suffering from mental disorder into custody and board's powers of discharge patients. The study recommends that the government of Kenya as well as mental health facilities should provide skills to female patients to help them get jobs or start small business so as to improve their income levels after the leave health facilities. In addition, the government of Kenya should develop programmes and campaigns aimed at improving communities' knowledge on the causes and treatment of mental illness.

Key Words: Socio-Economic, Re-Integration, Mental Illness, Socio-Cultural, Policies

Introduction

Mental health is a condition which includes behavioral and mental health problems e.g. depression, anxiety disorders including (post-traumatic stress disorder) and disruptive behavioral (such as attention deficit hyperactivity disorder, mood disturbances, substance use, suicidal behavior, aggressive/ disruptive behavior), are the leading causes of adjustment problem in the society today (Wong, & Solomon, 2012). On a global scale, the magnitude of undiagnosed and unaddressed mental health problems continues to be high. It is estimated that 120 million people globally suffer from depression, 50 million from epilepsy, 37 million from Alzheimer's disease, and 24 million from schizophrenia. About 1 million people worldwide commit suicide every year, and approximately 20 million unsuccessfully attempt suicide.

In Europe, mental health problems affect at least one in four people at some time in their lives. Of the 870 million people living in the European Region, at any one time about 100 million people are estimated to suffer from anxiety and depression; over 21 million to suffer from alcohol use disorders; over 7 million from Alzheimer's disease and other dementias; about 4 million from schizophrenia; 4 million from bipolar affective disorder; and 4 million from panic disorders (World Health Organization, 2015). In the United States, every year, about 42.5 million American adults (or 18.2 percent of the total adult population in the United States) suffer from some mental illness, enduring conditions such as depression, bipolar disorder or schizophrenia.

In Kenya, at least one in every four people that present to a healthcare facility do so for treatment of a mental health issue (Ndetei et al., 2011). According to the World Health Organization, Kenya's mental disorders account for 5.9% of the total global burden. Mental disorders in Kenya are more common in medical facilities than in community settings, and up to 40% of the patients in general medical and surgical wards are depressed and require treatment. The most frequent diagnoses of mental illnesses made in general hospital settings are depression, substance abuse, neurotic stress-related and anxiety disorders, and these are more frequently associated with chronic medical conditions. However, since most patients present at health facilities with medical rather than psychiatric complaints, these diagnoses may be misdiagnosed especially if the levels of somatic symptoms are elevated. This is especially so considering that some chronic medical illnesses and psychiatric disorders may produce similar somatic symptoms (Ndetei et al., 2009).

Mental illness is treatable, which means that many people who have a mental illness, and are treated, recover well or even completely. However, because there are many different factors contributing to the development of each illness, it can sometimes be difficult to predict how, when, or to what degree someone is going to get better. Recently, community integration has gained greater attention because of its relationship to recovery (Wong, Matejkowski & Lee, 2011).The integration of persons with psychiatric disabilities into the community is perceived as a principle, value, paradigm, and major goal of mental health policy (Mandiberg, 2012). The concept of community integration is premised on the notion of common citizenship—that is, individuals with disabilities have an inherent right and should be afforded the opportunity to live, study, work, and recreate alongside, and in the same manner, as their peers without disabilities (Lefley, 2011). However, People with mental illness (PWMI) and their families often experience discrimination and exclusion from economic and social activities. Due to stigma, PWMI and their families are often ridiculed and isolated, trapping them in a cycle of poverty.

A lack of access to information about their rights and support to exercise these rights perpetuates and deepens this marginalization. Over the years, the integration of people with mental illness has been poor and characterized by stigmatization and lack or employment leading to recurrence of the same disorders. Wong, Matejkowski and Lee (2011) indicate that during the integration process, mentally ill individuals suffer from low self-esteem, alienation, exclusion, loneliness, lack of connection and structure in everyday life, insufficient contact with immediate family, insufficient income in relation to the cost of living and lack of external support for broadening one's own activities and contacts. Different constraints affect the integration of mentally ill individuals back to the community.

Statement of the problem

Women with mental illness face far more challenges in the society than the male counterparts, taking into consideration they are considered the homemakers and have a lot of responsibilities in caring for home and nurturing children. In addition, different communities in Kenya have different cultures, beliefs and traditions with regard to mental illnesses. In some communities, mental illnesses come as a result of punishment from God or as a result of witchcraft or sorcery. Further, most of the mentally ill women in Kenya are unemployed, which implies that that have no income of their own and hence have to depend on their family members. Over the years, the integration of females with mental health challenges into society has been poor. This is shown by high relapse of mental cases less than 3 months after being released from the healthcare facilities. In addition, most women, reintegrated back to the society, fail to take drugs to manage their mental health after they are released from healthcare facilities. This leads to them relapsing. This study therefore seeks to identify the socio-cultural constraints influencing re-integration of female patients with mental illness into the society by focusing on Mathari National Teaching and Referral Hospital**.**

The study was guided by the following objectives;

1. To establish the extent to which economic factors affect the reintegration of females with mental health challenges into society in Nairobi County.
2. To identify the socio-cultural factors inhibit the integration of females with mental health challenges into society in Nairobi County.
3. To assess the extent of community awareness about the need for reintegration of females with mental health challenges into society in Nairobi County.
4. To evaluate relevant existing State policies and programs governing admission and discharge of female inmates of mental institutions in Kenya

Conceptual framework

This study sought to identify the constraints facing integration of females with mentally health challenges into society in Nairobi County. The independent variables were socio demographic factors, cultural factors and community's knowledge and attitude. The dependent variable was the integration of females with mentally health challenges into society.

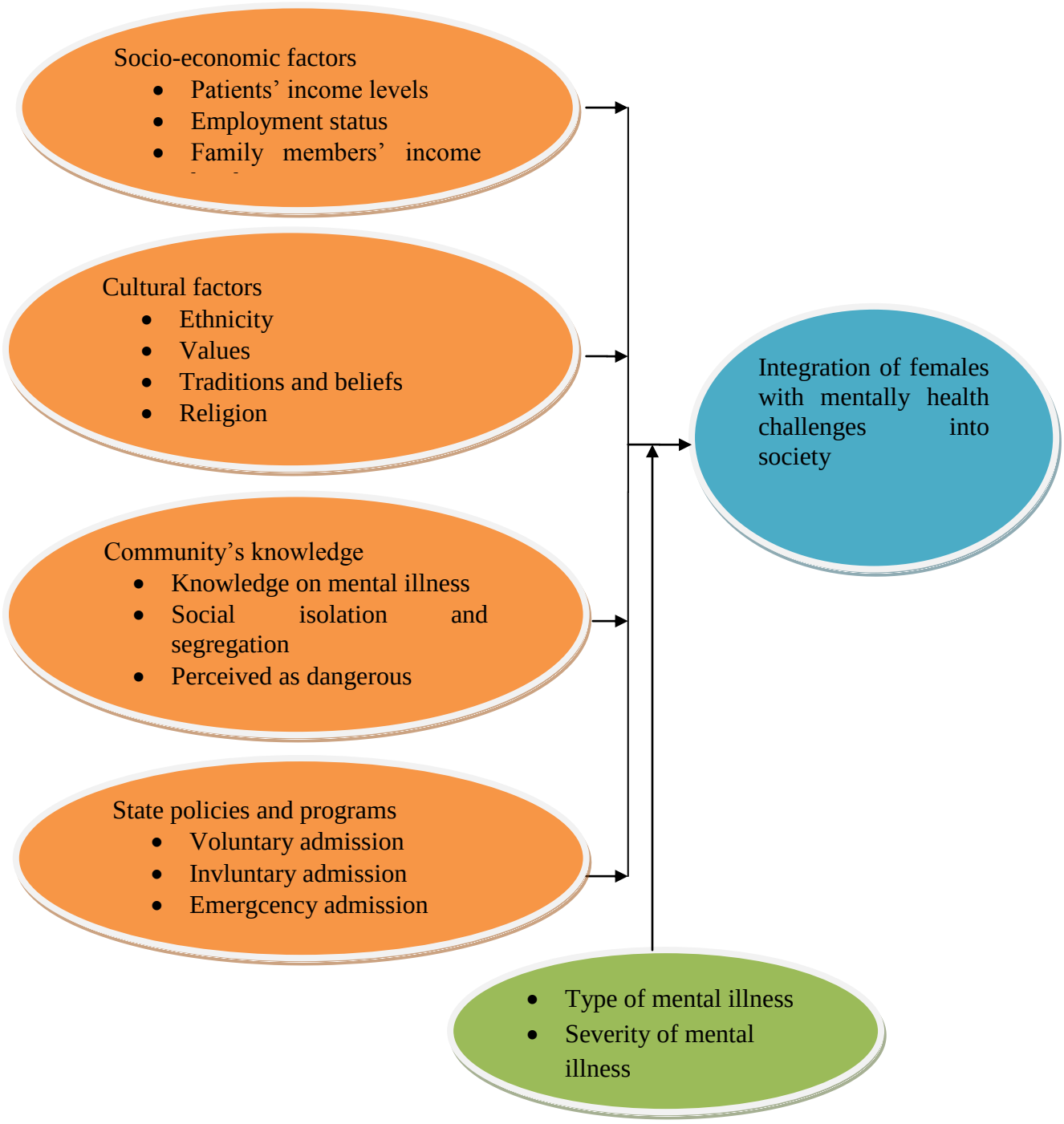

Figure 1: Conceptual Framework

Critical Review of Relevant Theories

A modern sociological theory associated with mental health is anomie theory formulated by Durkheim (1893). In his book titled *"Suicide"*, he remarkably demonstrated that suicide rate varies in function of social integration and collective regulation. Using different levels of both

concepts of social integration and collective regulation, he postulated the existence of four types of suicides (Durkheim, 1951). One of the four typologies of suicide is the *egoistic* suicide. According to Durkheim (1951), the most important characteristic of the egoistic suicide is that it is connected with a low degree of social integration. In clear terms, the egoistic suicide is committed by individuals who are not well socially integrated (DiChristina, 2016). However, these individuals who score low on social integration can avoid taking the path of suicide if the collective conscience is strong. In the absence of strong social cohesion and strong social constraint in the form of norms, values, and morals for example, these individuals are more likely to commit suicide. Another type of suicide is *altruistic* suicide. The traits of this second type are the opposite of those characterizing egoistic suicide. Compared to the egoistic suicide, which is linked to low social integration, the altruistic suicide is connected to high social integration. Thus the altruistic suicide is the opposite of the egoistic one (Antonaccio, Smith, & Gostjev, 2015).

The third type of suicide in Durkheim's system is the *anomic* one. Contrasting both with the first variety and with the second variety of suicide, this type of suicide is related to a low degree of social constraint. According to Durkheim, in the absence of a strong system of collective states of conscience, the impulse takes over the individuals' behaviors. With less social censure, the individuals give satisfaction to their wildest imaginations, which for the most part lead toward suicide (Cullen, Johnson & Parboteeah, 2014). Durkheim associates this third type of suicide to the lack of social stability and order. The fourth and the last type of suicide is designated as the *fatalistic* suicide. As it was in the case of the first two types, the fatalistic suicide is the exact opposite of the anomic suicide. These types of suicides reflect different degrees of social constraint. While the anomic suicide is associated with low level of social constraint, the fatalistic suicide is attributable to an "excessive regulation.

Anomie theory was selected as it explains clearly the relations between people in society showing their relations amongst them in the community, hence depicting clearly what integration entails which is in relation to the topic being discussed. Durkheim never uses the term *normlessness*; rather, he describes anomie as "derangement", and "an insatiable will". Durkheim used the term "the malady of the infinite" because desire without limit can never be fulfilled, it only becomes more intense. For Durkheim anomie arises more generally from a mismatch between personal or group standards and wider social standards, or from the lack of a social ethic, which produces moral deregulation and an absence of legitimate aspirations. Durkheim anomie theory has been used in the past in explaining social integration. In a study on social change conducted in Canada, Zhao and Cao (2010) indicate that social change as well as social integration requires the transformation of normative behavior patterns, traditional beliefs, old cultural values and social rules. Enhancement of social integration by dealing with factors that hinder integration reduces the probability of committing a suicide.

Effects of economic factors on the integration of females with mentally health challenges into society

The relationship between socioeconomic status and mental illness is cyclical, where having a mental illness increases the risk for poverty and low socioeconomic status increases the likelihood of developing a mental illness (Kazadi et al., 2008). People with schizophrenia are

four times more likely to be unemployed or underemployed as compared to those without the illness. Part of the reason for this cyclic relationship is that people living in poverty have fewer opportunities for education or employment, suffer exposure to harsh living conditions, have little access to good health care, and lack the financial resources necessary to maintain basic standards of living (Lefley, 2011). In Ethiopia, Fikreyesus, Soboka and Feyisse (2016) indicated that age, marital status, educational level, ethnicity, frequency of attending a place of worship, occupation, income and living condition of both the patient and members of the family were influencing psychotic relapse, which is a common sign of poor community integration. In Muhimbili National Hospital, Adellah (2012) revealed that family support, stressful life events employment and religion were viewed as protectors of relapse. Being involved in religious activities like involving oneself in church choir was said to help patients feel like other people who do not have the illness.

Given the difficulties that people with serious mental illness have in obtaining and keeping jobs, the great majority are on some form of social benefit. Even in most developed countries, the weekly amounts paid are barely sufficient for the basics of life, and the bureaucratic hurdles to claiming benefits are such that up to half the patients qualified to claim social welfare are not receiving the full amount to which they are entitled. As a result, patients cannot afford even relatively inexpensive entertainments such as attending sports events or going to the local cinema. Excluded by poverty from participation in such activities, many patients have no recourse other than to watch the endless television, often in a communal setting with other patients or community members who often do not appreciate them (Adellah, 2012). In Trans-Nzoia County, Imbwaga (2015) results indicated that lack of money also prevents many patients from buying smart of fashionable clothes, so that their air of shabbiness becomes yet another feature marking them out as different, some attempt to supplement their income by begging in the streets, in competition with mentally health but homeless people, thus become identified with the perceived lowest stratum in the society.

Effects of cultural factors on the integration of females with mentally health challenges into society

According to Niehas and others (2014), the term cultural bound syndrome, refers to any one of a number of recurrent, locality-specific patterns of aberrant behavior and experiences that appear to fall outside conventional Western psychiatric diagnostic categories. Cultural concepts, values, beliefs, influence health-seeking pathways, and traditional healers play an important role in the management of disease in many cultures where 'Western' medicine is unavailable, viewed with skepticism, or used in parallel with traditional treatment methods. Kaplan et al (2013) asserted that Western psychiatrists tend to view mental illness as culture-free, but certain disorders such as bulimia nervosa is as shaped by Western culture as koro is by Asian culture. Cultural and religious teachings often influence beliefs about the origins and nature of mental illness, and shape attitudes towards the mentally ill. In addition to influencing whether mentally ill individuals experience social stigma, beliefs about mental illness can affect patients' readiness and willingness to seek and adhere to treatment. Therefore, understanding individual and cultural beliefs about mental illness is essential for the implementation of effective approaches to mental health care.

Lefley (2011) researched insights from Third World cultures and suggested that patients may function better in developing countries because more kinship networks, buffering mechanisms, and apparently greater respect to tolerance of difficult behaviors may exist within social dynamics. For individuals with schizophrenia, there are also more opportunities for low-stress, non-competitive productive roles in communal societies and agrarian economics. In Asia, where many cultures value "conformity to norms, emotional self-control, and family recognition through achievement", mental illnesses are often stigmatized and seen as a source of shame (Abdullah & Brown, 2011). In Asian cultures, like many other cultures, family members generally do not institutionalize members. They care for them in the home. However, according to Bae and Brekke (2002), Asian families are more likely to accompany the schizophrenic patient on clinic visits and to actively participate in treatment decisions. In Kenyatta National Hospital, Mbuthia (2016) examined the challenges facing young people with mental illness seeking psychiatric treatment. The results indicated that culture in terms of beliefs, traditions, and norms influence integration of young people with mental illness into the society. The study was limited to Kenyatta National Hospital and hence cannot be generalized to mental health facilities in Kenya.

Effect of Community Awareness and Re-Integration of Females with Mental Illness

Throughout the world, people with serious mental illnesses are viewed differently from those with physical illnesses. This is attributable partly to the perceived link with violence and partly to difficulties in sharing and understanding the abnormal experiences that are induced by schizophrenia and manic-depressive illness (Kazadi et al., 2008). Members of the public wish to distance themselves from people with such illnesses, as shown by their reluctance to work with them, marry them, live close to them, and have them as friends. In developed countries, a small minority of neighbors resist the establishment of sheltered housing in their streets and become very vocal in their resistance, sometimes defeating the efforts of service providers to sway the public towards acceptance (Kinyua & Njagi, 2013).

In Tehran, Ghanean et al. (2015) results indicated that the knowledge level on mental illness was high. In addition, most individuals were not afraid to have a conversation with mentally ill people, would not be upset or disturbed about working on the same job, would maintain a friendship with them and would not be ashamed of them. In Nigeria, Gureje et al. (2005) indicated that poor knowledge on causation, treatment and re-integration of mentally ill people was common. Negative views of mental illness were widespread, with as many as 96.5% believing that people with mental illness are dangerous because of their violent behavior. Most would not tolerate even basic social contacts with a mentally ill person. In addition, 82.7% indicated that they would be afraid to have a conversation with a mentally ill person and only16.9% would consider marrying one.

Mental illness is widely misunderstood and stigmatized in Kenya. Most families have little or no knowledge about mental illness and how to support those who are ill. Mentally ill people are made fun of, blamed and criticized for their sickness. Kinyua and Njagi (2013) found that in many societies people believe that mental illness is not a disease but a curse that is caused by witchcraft and evil spirits. Many people believe that mentally ill people are the only ones who are dirty collecting rubbish on the streets and some being locked in houses. Mentally ill people

are made fun of, blamed and criticized for their sickness. In many societies mental illness is equated to madness and some equate mental illness to demon possession.

State policies and programs governing admission and discharge of female inmates of mental institutions in Kenya

Mental health legislation codifies and consolidates fundamental principles, values, goals, objectives and mental health policy. Such legislation is essential to guarantee that the dignity of patients is preserved and that their fundamental rights are protected. Shao et al. (2010) reports that to improve mental health services and to protect the rights of mentally ill persons, China began passing a series of mental health reform laws in 1985. These laws have seen limited success, and there remains much room for improvement. The study aimed at describing and analyzing current legal frameworks for voluntary and involuntary admissions of mentally ill patients in the five cities of China that currently have municipal mental health regulations. Information on the legislation and practice of involuntary admission in the five cities was gathered and assessed using the "WHO Checklist on Mental Health Legislation." The results indicated that although the mental health regulations in these five cities cover the basic principles needed to meet international standards of mental health legislation, some defects in the legislation remain. In particular, these regulations lack detail in specifying procedures for dealing with admission and treatment and lack oversight and review mechanisms and procedures for appeal of involuntary admission and treatment.

In Kenya, Article 29 of the Mental Health Bill, 2014 indicates that a person who presents himself or herself voluntary voluntarily to a mental health care facility for treatment or admission' admission shall be entitled to receive appropriate care and treatment or to be referred to an appropriate mental health care facility. Article 30 indicates that no mental health care, treatment or admission shall be accorded to a person with mental illness without the person's informed consent or that of his or her representative. Article 31 of the Mental Health Bill, 2014 stipulates that a person may be admitted involuntarily to a mental health care facility as a person with mental illness, or, having been admitted voluntarily as a person with mental illness, be retained involuntarily as a person with mental illness in the mental health' care facility, if two accredited health practitioners determine, in accordance with this Act, that the person has a mental illness or disorder (Mental Health Bill, 2014).

Article 39 indicates that a person with mental illness shall be discharged where the mental health care practitioner in charge of managing the person makes a decision to discharge the person as a result of a review. In addition, the bill indicates that a person can no longer receive any other or further treatment from a mental health care facility and appropriate efforts are being made towards re-integration of the person into the community, and for specialized and personalized alter-care service (Mental Health Bill, 2014).

Research Design and Methodology

The study adopted a cross-sectional study design and mixed methods research. The study population consisted of all staff working in Mathari Mental Hospital and the target population included doctors (17), nurses (90), personal assistants (18), medical superintendent (1), social

workers (6) and visitors of the female patients (212). The sample size was determined using Slovin's Formula. The formula was selected as it puts into consideration the population size. However, due to the small number of social workers and medical superintendent, they were not sampled.

$$n = \frac{N}{1 + NE^2}$$

Where by:
n = no. of samples
N = total population
E = error margin / margin of error (0.05)

$$n = \frac{344}{1 + (344 * 0.05^2)}$$

$$n = 184$$

The study used stratified random sampling to select the respondents from the target population. The strata in this study were all the available doctors, nurses, personal assistants and visitors of the female patients. The main advantage of stratified random sampling is that it gives a representative sample and minimizes sample selection bias by ensuring that various segments of a population are not underrepresented or overrepresented. The study also adopted purposive sampling to select the social workers and medical superintendent as the key informants.

Table 1: Sample Size

Category	Target population	Sample Size
Doctors	17	9
Nurses	90	47
Personal assistants	18	9
Medical superintendent	1	1
Social workers	6	6
Visitors of the female patients	212	111
Total	**344**	**184**

This study used primary data, which was collected by use of semi-structured questionnaires and key informant interview guides. The study used semi-structured questionnaires to collect data from the doctors, nurses and visitors. Questionnaires were utilized in this research since the component of anonymity as some of the information needed is sensitive. Key informant interview guide was used to collect data from the key informants. Key informant interviews are qualitative in-depth interviews with people who know what is going on in the community. The key informants in this study included social workers and the medical superintendent. Before data collection, a pilot test was conducted to test the reliability and validity of the data collection instruments.

Mixed methods data analysis techniques were used to analyze both qualitative and quantitative data. Thematic analysis was used to analyze qualitative data, that is, data collected from open ended questions. The results were then presented in prose form. Quantitative data was analyzed

by use of descriptive statistics such as frequency distribution, percentages, measures of central tendencies (mean) and measures of dispersion (Std deviation). The data was then presented in tables and graphs.

Data Presentation and Interpretation of Findings

The target population of this study was the 344 respondents who comprised of doctors, nurses, personal assistants, medical superintendents, social workers and visitors of the female patients. Out of the 344 respondents, 276 responses were obtained. This gives a response rate of 80.23%. A 100% response rate was not achieved as some of the questionnaires had some inconsistent information and some were half way filled and thus could not be used in the study. According to Kothari (2004), a response rate of 50% or more is adequate for analysis, which shows that 80.23% was an acceptable basis for drawing a conclusion.

General Information

From the findings, as shown in Table 2, 60.4% of the doctors and nurses indicated that they were female while 39.6% indicated that they were male. In addition, 55.2% of the visitors of female patients indicated that they were female while 44.8% indicated that they were male. This shows that most of the doctors and nurses as well as the visitors of female patients in Mathari national teaching and referral hospital were female.

In regard to the age bracket, 41.7% of the doctors and nurses indicated that they were aged between 31 and 35 years and 19.8% indicated below 30 years. In addition, 45.9% of the visitors of female patients indicated that they were aged between 36 and 40 years and 16.6% indicated that they were aged between 31 and 35 years. These findings imply that most of the doctors and nurses in Mathari national teaching and referral hospital were aged between 31 and 35 years and most of the visitors of female patients were aged between 36 and 40 years.

In relation to the highest education level, 41.7% of the doctors and nurses indicated that they had university degrees and 17.7% indicated that they had post-secondary education. Further, 36.5% of the visitors of female patients indicated that they had primary education and 33.1% had secondary education. This implies that most of the doctors and nurses in Mathari national teaching and referral hospital had university degrees and most of the visitors of female patients had primary education as their highest level of education.

Table 2: General Information

Categories	Doctor and Nurses		Visitors of female patients	
	Frequency	**Percent**	**Frequency**	**Percent**
Gender				
Male	22	39.6	45	44.8
Female	34	60.4	56	55.2
Age				
Below 30 years	11	19.8	16	15.5
31 to 35 years	23	41.7	17	16.6
36 to 40 years	8	14.6	46	45.9
41 to 45 years	6	10.4	11	11
46 to 50 years	4	6.3	8	8.3
Above 50 years	4	7.3	3	2.8
Level of education				
Primary education	0	0	37	36.5
Secondary education	4	7.3	33	33.1
Post-secondary	10	17.7	18	18.2
University	23	41.7	8	8.3
Master's Degree	9	16.7	3	2.8
PhD degree	9	16.7	1	1.1

Economic factors and Re-integration of women with mental illness

The doctors and nurses were requested to indicate to what extent they agreed with statements on effect of economic factors on the re-integration of female patients with mental illness into the society in Mathari national teaching and referral hospital. A likert scale was used where 5 represented strong agree, 4 represented agree, 3 represented neutral, 2 represented agree, 1 represented strongly agree. The results are as presented in table 4.3. From the findings, the doctors and nurses agreed with a mean of 4.437 that the employment status of the female patients influences their re-integration. They also agreed with a mean of 4.020 that employed female patients are better reintegrated than the unemployed. In addition, they agreed with a mean of 3.843 that the income level of the female patients influences their re-integration into the society. These findings agree with Kazadi et al. (2008) findings that the relationship between socioeconomic status and mental illness is cyclical, where having a mental illness increases the risk for poverty and low socioeconomic status increases the likelihood of developing a mental illness. Part of the reason for this cyclic relationship is that people living in poverty have fewer opportunities for education or employment, suffer exposure to harsh living conditions, have little access to good health care, and lack the financial resources necessary to maintain basic standards of living. Further, the doctors and nurses agreed that the income levels of the patients' family influences their reintegration as shown by a mean of 3.677. However the respondents were neutral on the statement that self-employed people are better re-integrated than employed as shown by a mean of 2.697.

Table 3: Economic factors and re-integration of female patients with mental illness

	1	2	3	4	5	Mean	Std. Deviation
The employment status of the female patients influences their re-integration	2.1	2.1	6.3	29.2	60.4	4.437	.868
Employed female patients are better reintegrated than the unemployed.	3.1	8.3	14.6	31.3	42.7	4.020	1.095
Self-employed people are better re-integrated than employed	17.7	21.9	40.6	12.5	7.3	2.697	1.125
The income level of the female patients influences their re-integration into the society	4.2	10.4	9.4	49.0	27.1	3.843	1.069
The income levels of the patients' family influences their reintegration	3.1	5.2	21.9	60.4	9.4	3.677	.839

The visitors of the female patients were asked to indicate the extent to which economic factors were influencing re-integration of female patients with mental illness into the society. A likert scale was used where 5 represented very great extent, 4 represented great extent, 3 represented moderate extent, 2 represented low extent, 1 represented no extent at all. From the findings, the visitors of the female patients indicated that income levels influence re-integration of female patients with mental illness into the society to a great extent as indicated by the mean of 4.193. They also indicated that family income levels were influencing re-integration of female patients with mental illness into the society to a great extent as indicated by the mean of 3.834. The visitors of the female patients further indicated that employment status was influencing re-integration of female patients with mental illness into the society to a great extent as indicated by the mean of 3.602.

Table 4: Economic factors and re-integration of females with mental illness

	1	2	3	4	5	Mean	Std. Deviation
Employment status	4.4	9.9	25.4	41.4	18.8	3.602	1.041
Income levels	1.1	5.5	7.7	44.2	41.4	4.194	.882
Family income levels	2.2	6.6	18.2	51.4	21.5	3.833	.915

The key informants were requested to indicate how economic factors affect re-integration of female patients with mental illness into the society. From the findings, the medical superintendent and the personal assistants reported that the society/family feel that the patients are a burden due to in/out of hospital most of the time and therefore drain them financially so they prolong their stay in the hospital even after discharge. When allowed to work, they contribute to their care especially on the side of the hospital. However, the social workers indicated that female patients from the poor backgrounds had had times recovering as compared to those from well-up backgrounds.

> *If from a poor background, it gets really tough since the medication given requires proper feeding. Also to protect them from SGBV, adequate housing and security is important. From poor backgrounds, it becomes quite a challenge* CHW2

Cultural factors and Re-integration of women with mental illness

The doctors and nurses were also asked to indicate to what extent they agreed with various statements on the effect of cultural factors on the re-integration of female patients with mental illness into the society. A likert scale was used where 5 represented strong agree, 4 represented agree, 3 represented neutral, 2 represented agree, 1 represented strongly agree. From the findings, the doctors and nurses agreed with a mean of 3.906 that community values of the patients influences their reintegration. This implies that cultural factors such as beliefs influence the integration of people with mental health challenges. The doctors and nurses agreed with a mean of 3.895 that the traditions of the patient's communities affect their reintegration into the society. In addition, the respondents agreed that the traditional beliefs on mental illness influences reintegration of the female patients into the society as shown by the mean of 3.541. These findings agree with Niehas et al. (2014) in some communities, people believe that mental illnesses come as a result of witchcraft or sorcery. The doctors and nurses were however neutral that the statement that female patients' ethnicity influences their reintegration as indicated by the mean of 2.500. With a mean of 2.375 the doctors and nurses disagreed with the statement that religion of the patients influences reintegration of the female patients into the society.

Table 1: Cultural factor and re-integration of female patients with mental illness into the society

	1	2	3	4	5	Mean	Std. Deviation
The female patients' ethnicity influences their reintegration	14.6	40.6	30.2	9.4	5.2	2.500	1.025
Community Values of the patients influences their reintegration	2.1	5.2	19.8	45.8	27.1	3.900	.929
The traditions of the patients communities affect their reintegration into the society	2.1	4.2	10.4	68.8	14.6	3.890	.774
The traditional beliefs on mental illness influences reintegration of the female patients into the society	3.1	15.6	22.9	40.6	17.7	3.541	1.055
The religion of the patients influence reintegration of the female patients into the society	16.7	47.9	21.9	8.3	5.2	2.375	1.028

The visitors of the female patients were asked to indicate the extent to which cultural factors were influencing re-integration of female patients with mental illness into the society. A likert scale was used where 5 represented very great extent, 4 represented great extent, 3 represented moderate extent, 2 represented low extent, 1 represented no extent at all. From the findings, the visitors of the female patients indicated that beliefs influenced re-integration of female patients with mental illness into the society to a great extent as indicate by the mean of 4.022. These findings concur with Kaplan et al (2013) argument that in addition to influencing whether mentally ill individuals experience social stigma, beliefs about mental illness can affect patients' readiness and willingness to seek and adhere to treatment. They also indicated that traditions were influencing re-integration of female patients with mental illness into the society to a great extent as indicated by the mean of 3.861. The visitors of the female patients also indicated that

values were influencing re-integration of female patients with mental illness into the society to a moderate extent as indicated by the mean of 3.215. They also indicated that religion was influencing re-integration of female patients with mental illness into the society to a moderate extent as indicated by the mean of 3.016. The visitors of the female patients however indicated that ethnicity was not influencing re-integration of female patients with mental illness into the society as indicated by the mean of 2.425.

Table 2: Cultural factors and re-integration of females with mental illness

	1	2	3	4	5	Mean	Std. Deviation
Ethnicity	16.6	49.7	13.8	14.4	5.5	2.425	1.096
Values	2.2	5.5	70.2	12.7	9.4	3.215	.776
Traditions	3.3	5.0	5.0	75.7	11.0	3.861	.801
Beliefs	3.9	5.0	0	67.4	23.8	4.022	.887
Religion	11.0	13.8	44.2	24.3	6.6	3.016	1.046

The medical superintendent and the personal assistants indicated that female patients with mental illness are not given a lot of freedom to be on their own; some have been denied even job opportunities, denied heading families as should be and to some extent not allowed to have more children if they already had other children. They also indicated that cultural beliefs relating to mental illness with being be-witched was affecting the re-integration of female patients with mental illness. In addition, they indicated that the responsibilities of women in the African society were affecting the re-integration of female patients with mental illness into the society.

> *Being a woman especially in the African set-up/society, female patients with mental illness cannot have children because they are bewitched, they cannot take care of their families and they are discriminated even sexually KI02*

The medical superintendent and the personal assistants also indicated that as a result of traditional beliefs and norms patients will feel discriminated therefore affecting them socially, spiritually, physically, mentally even psychologically more so eventually they feel useless and not of any benefit to the society and this worsen their illness.

Community awareness and Re-integration of women with mental illness

The doctors and nurses were also asked to indicate their level of agreement with statements on the effect of Community awareness influencing re-integration of female patients with mental illness into the society. A likert scale was used where 5 represented strong agree, 4 represented agree, 3 represented neutral, 2 represented agree, 1 represented strongly agree. From the findings, the doctors and nurses were neutral on the statement that community members are aware of mental illness is curable as indicated by a mean of 2.791. They were also neutral on the statement that community members have learnt to accept people with mental illness as shown by the mean of 2.750. With a mean of 2.635 the doctors and nurses were neutral on the statement that community members understand the importance of re-integration of individuals with mental illness. However they disagreed with the statement that there is no social isolation of people with mental illness in rural area as indicated by the mean of 2.270. These findings are in line with Kazadi et al., 2008) argument that members of the public wish to distance themselves from people with such illnesses, as shown by their reluctance to work with them, marry them, live

close to them, and have them as friends. They also disagreed with the statement that community members are aware of the cause of mental illness as shown by a mean of 2.187.

Table 3: Community awareness and re-integration of female patients with mental illness into the society

	1	2	3	4	5	Mean	Std. Deviation
Community members are aware of the cause of mental illness	33.3	36.5	13.5	11.5	5.2	2.187	1.172
Community members are aware of mental illness is curable	19.8	14.6	42.7	12.5	10.4	2.791	1.204
Community members understand the importance of re-integration of individuals with mental illness	15.6	28.1	39.6	10.4	6.3	2.635	1.067
Community members have learnt to accept people with mental illness	12.5	32.3	32.3	13.5	9.4	2.750	1.1332
The is no social isolation of people with mental illness in my rural area	25.0	47.9	9.4	10.4	7.3	2.270	1.165

The visitors of the female patients were asked to indicate the extent to which various aspects of community awareness influence re-integration of female patients with mental illness into the society. A likert scale was used where 5 represented very great extent, 4 represented great extent, 3 represented moderate extent, 2 represented low extent, 1 represented no extent at all. From the findings, the visitors of the female patients indicated that knowledge on mental illness influenced re-integration of female patients with mental illness into the society to a great extent as indicate by the mean of 4.071. They also indicated that social isolation and segregation influenced re-integration of female patients with mental illness into the society to a great extent as indicate by a mean of 4.066. In addition, they indicated that rejection by the public influence re-integration of female patients with mental illness into the society to a great extent as indicate by the mean of 4.016. Further, the visitors of the female patients indicated that fear of people with mental illness influenced re-integration of female patients with mental illness into the society to a great extent as indicate by the mean of 3.596.

Table 4: Community awareness and re-integration of females with mental illness

	1	2	3	4	5	Mean	Std. Deviation
Knowledge on mental illness	3.9	6.1	8.3	42.5	39.2	4.071	1.032
Fear of people with mental illness	7.7	11.0	22.7	30.9	27.6	3.596	1.219
Rejection by the public	2.8	4.4	11.6	50.8	30.4	4.016	.921
Social isolation and segregation	2.8	3.9	8.8	53.0	31.5	4.066	.898

The key informants were asked to indicate how community awareness on mental illness influence re-integration of female patients with mental illness into the society. From the findings, the medical superintendents and the personal assistants indicated that when the community understand the causes and management of the mental illness, it changes or improves the stigma

and this helps the patients to feel appreciated and this increases their wellbeing and gives them confidence to better their life generally and even boost their morale. The also indicated that the public should be education on what mental illness is and talks about inductivity help patient recover fully.

State policies and programs and Re-integration of women with mental illness

The doctors and nurses were asked to indicate their level of agreement with various statements on effect of existing state policies and programs governing admission and discharge of female inmates of mental institutions. A likert scale was used where 5 represented strong agree, 4 represented agree, 3 represented neutral, 2 represented agree, 1 represented strongly agree. From the findings, the doctors and nurses agreed with a mean of 3.812 that mentally ill people who voluntarily submit themselves to treatment for mental disorder are received as a voluntary patient into a mental hospital. They also agreed that mentally ill patients can be involuntarily be admitted to mental hospitals as shown by a mean of 3.812. In addition, the doctors and nurses agreed that the police as well administrative officers have power to take person suffering from mental disorder into custody as shown by a mean of 3.729. Further, the doctors and nurses agreed with a mean of 3.635 that the board of mental health hospitals have powers of discharge mentally ill patients.

Table 5: Existing State policies and programs governing admission and discharge of female with mental illness

	1	2	3	4	5	Mean	Std. Deviation
Mentally ill people who voluntarily submit themselves to treatment for mental disorder are received as a voluntary patient into a mental hospital	4.2	5.2	27.1	32.3	31.3	3.812	1.069
Mentally ill patients can be involuntarily be admitted to mental hospitals	5.2	6.3	16.7	45.8	26.0	3.812	1.059
The board of mental health hospitals have powers of discharge mentally ill patients	4.2	7.3	38.5	20.8	29.2	3.635	1.106
The police as well administrative officers have power to take person suffering from mental disorder into custody	4.2	6.3	25.0	41.7	22.9	3.729	1.020

The visitors of the female patients were asked to indicate the extent to which various state policies and programs governing reintegration of mentally challenged females discharged from institutions influence re-integration of female patients with mental illness into the society. A likert scale was used where 5 represented very great extent, 4 represented great extent, 3 represented moderate extent, 2 represented low extent, 1 represented no extent at all. From the findings, the visitors of the female patients indicated that voluntary admission of mentally ill individuals governed reintegration of mentally challenged females discharged from institution as indicated by a mean of 4.182. Article 29 of the Mental Health Bill, 2014 indicates that a person who presents himself or herself voluntary voluntarily to a mental health care facility for treatment or admission' admission shall be entitled to receive appropriate care and treatment or to be referred to an appropriate mental health care facility. They also agreed that emergency admission of mentally ill individuals governed reintegration of mentally challenged females

discharged from institution as indicated by a mean of 4.071. However, the visitors of the female patients were neutral that involuntary admission of mentally ill individuals governed reintegration of mentally challenged females discharged from institution as indicated by the mean of 3.486. They were also neutral that board's powers of discharge patients governed reintegration of mentally challenged females discharged from institution as indicated by a mean of 3.055. Further, the visitors of the female patients disagreed with the statement that power to take person suffering from mental disorder into custody influenced reintegration of mentally challenged females discharged from institution as indicated by the mean of 2.309.

Table 6: State policies and programs and re-integration of females with mental illness

	1	**2**	**3**	**4**	**5**	**Mean**	**Std. Deviation**
Voluntary admission of mentally ill individuals	4.4	4.4	13.3	24.3	53.6	4.182	1.102
Involuntary admission of mentally ill individuals	5.5	14.9	21.5	41.4	16.6	3.486	1.103
Emergency admission of mentally ill individuals	2.2	2.2	9.4	58.6	27.6	4.071	.809
Power to take person suffering from mental disorder into custody	25.4	44.8	8.3	16.6	5.0	2.309	1.165
Board's powers of discharge patients	1.1	9.4	76.8	8.3	4.4	3.055	.630

The key informants were asked to indicate the state policies and programs that govern the re-integration of female patients with mental illness into the society. From the findings, the medical superintendents and personal assistants indicated that hospital fee waivers due to in/out of the hospital frequently, community psychiatry to educate community play a key role in the re-integration process. This is done through community clinics so that it reduces the hospital visits as they can be followed through these clinics.

Re-integration of women with mental illness into the society

The doctors and nurses were asked to rate various measures of re-integration of women with mental illness into the society. A Likert scale was used where 5 represented excellent, 4 represented good, 3 represented moderate, 2 represented bad, and 1 represented poor. From the findings, the doctors and nurses rated the relapse of mental illness as moderate as indicated by a mean of 3.260. They also rated emotional and social as bad, as indicated by the mean of 2.416. Mandiberg (2012) had earlier indicated that individuals with a mental illness who live in the non–mental health community can be isolated, and moving them away from their mental health community may isolate them further. The doctors and nurses also rated getting of employment as bad as indicated by a mean of 1.947.With a mean of 1.760 the doctors and nurses rated consistent taking of the drugs as bad.

Table 7: Re-integration of women with mental illness into the society

	1	2	3	4	5	Mean	Std. Deviation
Consistent taking of the drugs	57.3	26.0	5.2	6.3	5.2	1.760	1.140
Relapse of mental illness	3.1	8.3	54.2	28.1	6.3	3.260	.823
Getting of employment	49.0	27.1	10.4	7.3	6.3	1.947	1.208
Emotional and social support	8.3	64.6	10.4	10.4	6.3	2.416	1.001

From the key informant interviews, the medical superintendent and the personal assistants indicated that the society has not really fully accepted mental patients and due to a lot of stigma associated with the illness they are not welcomed back fairly but with some myths which make the patients feel that they are discriminated.

> *Re-integration of women with mental illness into the society is far from being enacted fully and embraced, so I would give it 40% but we are on the right track* KI01

The social workers indicated that the process of re-integration involved contacting the patients, health talk and address any psychosocial issues that maybe present, review their status when they come back for follow-up clinics and if they have not improved they refer them back to the health facilities.

> *If the next of kin agree to come, we give a health talk and address any psychosocial issues that maybe present. If they do not come, with the assistance of the patient, we repatriate them home using information from the patient (this implies if the contacts do not go through). We later do reviews, mainly when they come back for follow-up clinics. Where they don't, and if they hail far away from one hospital, they are referred to the nearest government hospital at the medical social work department for follow-up* CHW1

Conclusion

The study concludes that economic factors affect the reintegration of females with mental health challenges into society in Nairobi County. Employment status and income levels have a positive influence on re-integration of female patients with mental illness. The employed female patients had better chances of being reintegrated into the society as compared to the unemployed female patients. In addition, the income levels of the patients' families had an influence on re-integration of female patients with mental illness.

The study also concludes that while traditions, beliefs and community values influence re-integration of female patients with mental illness, ethnicity and religion had no significant influence. As a result of traditional beliefs and norms patients will feel discriminated therefore affecting them socially, spiritually, physically, mentally even psychologically more so eventually they feel useless and not of any benefit to the society and this worsen their illness. The idea that religion and psychiatry have always been in conflict is still very prevalent. Today, most people believe that in the medieval ages most mental disorders were considered as witchcraft or demonic possession.

The study further concludes that community awareness about the need for reintegration of females with mental health challenges into society in Nairobi County was low. The study found that community members have not understood the importance of re-integration of individuals

with mental illness and hence have not fully learnt to accept people with mental illness. As result the cases of social isolation of people with mental illness in rural areas are quite rampant. When the community understand the causes and management of the mental illness, it changes or improves the stigma and this helps the patients to feel appreciated and this increases their wellbeing and gives them confidence to better their life generally and even boost their morale.

Lastly, the study concludes that there are relevant existing state policies and programs governing admission and discharge of female inmates of mental institutions in Kenya. Existing state policies and programs regarding admission and discharge of female inmates of mental institutions in Kenya focus on voluntary admission of mentally ill individuals, involuntary admission of mentally ill individuals, emergency admission of mentally ill individuals, power to take person suffering from mental disorder into custody and board's powers of discharge patients.

Recommendations

The study therefore recommends that;

- The government of Kenya as well as mental health facilities should provide skills to female patients to help them get jobs or start small business so as to improve their income levels after the leave health facilities.

- Community leaders including chiefs and sub-chiefs as well as political leaders should help female patients with mental illness to get jobs in their communities.

- The County governments should come-up with programmes to help female patients with mental illness to get jobs or start small business so as to reduce their dependency of the community and family members.

- The government of Kenya should develop programmes and campaigns aimed at improving communities' knowledge on the causes and treatment of mental illness. This can be done through radio campaigns or road shows.

- The government of Kenya should also carry out campaigns to improve the knowledge of community members throughout the country on the curability of mental illness and hence reduce stigma associated with it.

- The government of Kenya should come up with policies and programmes to ensure that people with mental illness are fully integrated into the society after they are discharged from health facilities.

Suggestions for Future Research

This study was limited to socio-economic constraints influencing re-integration of female patients with mental illness into the society by focusing on Mathari national teaching and referral hospital. Therefore the findings of this study cannot be generalized to the male patients. This study therefore recommends that a similar study should be done in male patients with mental illness patients. In addition, further studies should be conducted on the impact of mental illnesses on community development or on the national economy.

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