EFFECT OF HEALTH EDUCATION ON COMMUNITY REINTEGRATION AMONG DISCHARGED PSYCHIATRIC PATIENTS IN AGBOR ANDWARRI CENTRAL HOSPITALS, DELTA STATE

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Abstract
The study investigated the effect of health education on community reintegration among discharged psychiatric patients in Aghor and Warri Central Hospitals in Delta State. The study targeted at using health education as an intervention to mitigate stigma, misconception and rejection against mentally ill persons and promote their acceptance, recovery and successful community reintegration. Three (3) research questions were raised and three (3) hypotheses were formulated and tested at 0.05 alpha level. The study adopted the quasi-experimental research design of the pretest, posttest and control group. The sample of the study consisted of 21 adults (12 males and 9 females) of the Agbor and Warri Central Hospitals. The instrument for data collection was a self-structured scale with a reliability index of 0.66. The intervention lasted six (6) weeks. Differential statistics was used to answer the stated three (3) research questions, while the t-test was used to test the stated three (3) hypotheses at alpha level of 0.05. Among the three(3) stated hypotheses, 2 were rejected only one was retained. The analyzed result findings revealed that, there was significant improvement on their mental health recovery, acceptance and adequate community reintegration after the intervention. Based on the findings, it was recommended among others that professional health educators, health education instruction and community reintegration training should be combined with the conventional hospital discharged programme/procedure for a better community reintegration.

Introduction
Psychiatric disorder across the world is perceived as a stigmatized condition associated with humiliation and social exclusion. Individuals with psychiatric illness are frequently degraded and discriminated against. Stigma may emanate from misconceptions and judgmental attitude faced by discharged psychiatric patients returning home after a protracted hospitalization to the community. These negative attitudes subsequently result to social exclusion, lack of self-esteem, dejection and poor meaningful life for discharged psychiatric patients back to the community. Psychiatric illness is a mental health condition that has to do with changes in emotion, personality, behaviour, thought process or a combination of all in an individual. Psychiatric illnesses are often connected and associated with distress, difficulties functioning in personal, social, work, family or community activities (American Psychiatric Association, 2021). Mental health is an essential and integral component of health as reflected in Mosher andCumming (2024) definition of health as: "The extent of an individual's continuing physical, emotional, mental and social ability to cope and deal with challenges of daily life and relate well with others and the environment. A very salient implication of this definition is that mental health is beyond just the absence

of psychiatric impairments of an individual, but entails the total physical and social well-being and adjustment. Hence, World Health Organization (2022) conceptualized mental health as a state of well-being in which a person is able to achieve his or her own potentialities, able to deal with challenges and stress of daily life activities, learn, relate well with others and contribute meaningfully to community and involve in productive work.

Mental health is the foundation for personality emotions, thought process, communication, learning, resilience and effective coping and functioning in daily activities such as work, school, caregiving, decision making and coping abilities (American Psychiatric Association, 2021). Thus, for any behavior, habit or attitude to qualify as metal illness, it must be capable of disrupting the ability to be resilient, self-aware, productivity and also constitute the individual a nuisance to community. Mental illness has both spiritual and socio economic dimensions. There is a rising mental and emotional ill-health burden all over the world with astonishing statistics '.specially in developing nations. In Nigeria, psychiatric morbidity in the community spans from 16% to 43% of individuals utilizing general medical practice. The most prevalent psychiatric disorder include depression 5-20%, generalized anxiety disorder 4-15%, harmful alcohol use and dependence 5-15% and somatization disorder 5-11% (Onyeji, 2018). Onyiji added that in Nigeria with a population of over 200 million, more than 60 million Nigerians are suffering from psychiatric illness, while the availability of care is grossly neglected and poor. Although, there is preponderance of alternative care especially spiritual homes and traditional healers. There is a common opinion that there is actually no family without one person with a mental health challenge. This shows how rampant these disorders have become in our contemporary community.In advanced nations, there have been great paradign shifts of prolonged psychiatric patients care from hospitals and institutions to the family and community, and from just only recovery to rehabilitation and reintegration. Family and community play a great role in the successful rehabilitation and reintegration of treated and discharged psychiatric patients (DPPS) from the hospitals back to the community. Rehabilitation and social reintegration are both essential and integral part of the same process (Chakrabortiet al, 2015). Reintegration in psychiatry is a restorative process of returning the mind to a unified whole state again following an experience of derangement by psychosis through therapy and education.Chakrabortiet a! (2015) postulated that the goals of reintegration are categorized into three (3) perspectives to achieve an acceptable, purposeful, meaningful, and responsible engagement in daily activities. The authors stressed that the above objectives could be realized through; the provision of gainful employment, which provides means of economic power and support to daily life, provision of the individual with accommodation of his or her own (place of abode) and carry out task and life activities independently, and enabling the individual to function and interrelate proficiently with family, and friends within the community and the community at large.

Homelessness experienced by the discharged psychiatric patients (DPPs) could be described as not having a home (accommodation), no acceptance, not meaningfully engaged, vagrancy, wandering, roaming mentally ill person. In Nigeria, they are eye sores seen on the streets of our villages and towns in dejected poor conditions under bridges, uncompleted houses, around motor parks, vulnerably exposed to the harsh weather

conditions and lots of health hazards without any form of lawful, social, family or community support provided for them (Nwaopara *et al*, 2016).Recovery perspectives are intimately related and often influence each other in complex processes. Thus, treatment and support for people with severe mental illnesses should normally pay attention to all perspectives of recovery, and should be structured to a person's individual needs. Rehabilitation intervention thus, should focus on patient's personal goals and wishes regarding daily life and community recovery (Bitter *et al*, 2020).Psychiatric patient's rehabilitation begins in the hospital, but continues after discharge to the family and community. Family and community play salient functions in the successful reintegration of DPPs from the hospitals back to the community. Family acceptance and support can assist deal with issues connected to self-esteem and self-identity post discharge of psychiatric patients from the hospitals back to the community, positive attitude and reinforcement from family, friends and community members promote recovery. Family and community involvement, flexibility and open communication break many hindrances and discrimination connected to discharged psychiatric patients. Families and communities who inspire hope facilitate good adjustment, confidence and self-esteem on the mentally ill persons (https://www.hopkins medicine.org/health, 2022). Williams (2020) emphasized that stigmatic attitude can result to different health challenges such as depression, low self-worth, social exclusion and suicidal thoughts. The authority stated further that many recovery mental healthcare and others who would have sought for access deprive themselves of utilizing these services for fear of stigma related to psychiatric illnesses. Subsequently, this affects their fundamental human rights, opportunity and equal access to care leading to social exclusion, maladjustment and poor quality of life, Loch (2014) noted that this stigmatic attitude towards DPPs is not only seen among the general population but also among government, care givers, healthcare providers, friends, family members and institutions.

The rational for this study anchors on the experiences of rejection, neglect and negative attitude against mentally ill persons from family members, friends, colleagues, and the community. They are barely shown love and care during treatment and after discharge from the hospitals, they are scarcely accepted and reintegrated back to the community. Consequently, they go depressed; withdrawn and some serious cases commit suicide. All of these negative attitude emanates from the community's judgmental behavior, beliefs and misconceptions about psychiatric illnesses that the condition is not curable, caused by the evil deeds of the person, as repercussion from the gods and can be contracted through physical contact, hand shake or sharing o cutleries. This has made even some family members of psychiatric ill persons to refuse to eat or stay under the same roof with them. Nevertheless, Health education intervention measures through family and community information, teaching and exposition on the true fundamental position of mentalillnesses will foster the acceptance, recovery and successful reintegration of psychiatric ill persons back to their family and the community.

Ademola (2018) conceptualized health education as a multidimensional tool which is entrenched in education and the healthcare system which may be utilized at every phase of prevention and control of disease with the main fundamental core value held by the statement that the health of individuals and consequently the community they both belong

to is significantly conditioned by the behavior of a person. Therefore, health education can be seen as a health intervention strategy which can assist us to eradicate stigma, rejection and misconceptions about psychiatric illness and enhance acceptance and social reintegration of DDPs back to the community. Thus, discharged psychiatric patients can live a normal life free from discrimination, shame, depression and exclusion.The focus of the study is on the variable of this study which is personal recovery: involving individuals own experience and is about hope, empowerment, good quality of life, self-determination and regaining the identity of a person who lives a meaningful life despite the presence of symptoms; The instrument of change is the Health Education Instruction Content (knowledge, attitude and practice) on mental health and community integration of DPPs.

A psychiatric person has need, concern, and right like other "normal" persons in the community. Psychiatric- illness stigma, misconceptions, discrimination and rejection in Nigeria is widespread, pervading and harmful. A large proportion of the community show that persons with psychiatric illnesses are subjected to rejection, job denial, school expulsion, exclusion, neglects, loss of self-respect, feelings of shame, suicidal thoughts, lack of access to care, affection, care and support, loss of family, property, financial restriction and so on. These negative attitude towards persons with psychiatric illness take place at different levels such as family level, community level and institutional level such as healthcare facility or hospital, school, media, work place and even in the government domain. This negative attitude of the community affects the recovery health of the discharged psychiatric patients. At times some do relapse into the early mental state.

A number of programmes such as the Mental Awareness Initiative and National Alliance on Mental Illness against psychiatric illness on stigma, rejection and community's negative attitude towards them have been done in Nigeria. However, notwithstanding these programmes, the rejection and negative attitude of community towards them still continue and on the increase. The problem thus, is: would Health Education Intervention measure effect, or succeed in bringing down stigmatization, rejection and negative community attitude towards discharged psychiatric patients? Would Health Education intervention increase the acceptance of discharged psychiatric patients, and encourage them back into the community?

Hypotheses

The following hypotheses were tested:

1. There is no significant difference in the behavioural outcome in the pretest experimental group and the pretest control group in their levels of community reintegration before health education intervention in personal recovery instruction among discharged psychiatric patients Agbor and Warri Central hospitals in Delta State.
2. There is no significant difference in the behavioural outcome in the pretest and posttest of the experimental group in their levels of community reintegration among treated and discharged psychiatric patients in health education personal recovery instruction among discharged psychiatric patients in Agbor and Warri Central Hospitals in Delta State.

4. There is no significant difference in the behavioural outcome in the posttest of the experimental group and the Post-test of the Control group in their levels of community reintegration following health education intervention in Personal Recovery instruction among discharged psychiatric patients in Agbor and Warri Central hospitals in Delta State.

Methodology

This study adopted pretest, posttest control group Quasi-experimental research design of the. The study population consisted of discharged psychiatric patients (DPPs) from the psychiatric Units of Agbor and Warri Central Hospitals in Delta State, discharged but still attending the Central Hospitals Psychiatric Out Patients Department (OPD) for follow up treatment/ management appointments. Respondents for both Agbor and Warri Central Hospital included 21 adults of both gender (male 12 and female 9). The Control group Agbor Central Hospital Psychiatric Unit, 8 adults (5 males and 3 females), while the Experimental group Warri Central Hospital Psychiatric Unit, 13 adults (7 males and 6 females). A self-structured scale tagged "Discharged Psychiatric Patients' Community Reintegration Achievement Test" (DPPCRAT) with a reliability co-efficent of 0.66 was used for collecting data. The researcher briefed two (2) research assistants before the administration of the research test instrument. With the help of the research assistants, the researcher administered the instrument (test) across the two (2) central hospitals psychiatric units, Agbor and Warn to the DPPS and their care giver at the same time. Before the researcher and the assistants administered the test questions to the DPPS and their care givers in each of the central Hospital, they first obtained the consent of the DPPS, care givers and that of the psychiatric units doctor-in-charge through the head of Hospital administration board, who helped organized the DPPS during the periods to ensure they were available for their Out Patient Department (OPD) clinic days for the teaching and co-operation during the experimental process.

The researcher spent time with the Respondents in the Agbor and Warri Central Hospitals which included 21 adults (12 males and 9 females). Agbor Central Hospital Psychiatric Unit was the Control group, 8 adults (5 males and 3 females), while Warn was the experimental group, 13 adults (7 males and 6 females). The researcher clarified the purpose of the research exercise and encouraged the Respondents to be sincere in the provision of their responses that all responses will be kept confidential and will only be used for academic purposes in other to achieve the research objectives. Thereafter, the pre-test was administered to both the experimental and control groups, the participants were requested to respond to the test items indicating with a dash "(-)" against or directly below the options of their choice from Option A to D. completed copies of the instrument (test) were collected on the spot from the respondents by the researcher and assistants to avoid loss of some copies and then answers were marked and scores were obtained from both groups.

The experimental groups were taught and instructed on Psychiatric illness and related stigma, misconceptions, recovery in mental health, rehabilitation and community reintegration through the hospitals OPD Psychiatric Units on the Health Education Intervention Manual.Lesson plan was prepared to teach the study participants in the experimental group, Warri Central Hospital on Psychiatric illness, its causes, misconceptions, stigma, and management, recovery in mental health, rehabilitation and community reintegration. At the end of the teaching duration of six (6) weeks, the Section B of the instrument (test) "DPPCRAT" was then re-administered to the experimental group in Warn and the Central group in Agbor Central Hospitals. The completed copies of the test questions were collected from both the experimental and the control groups from the Agbor and Warri Central Hospitals, after which the answer were marked and scored.

After marking and scoring of the completed copies of the test questions, the collected marked and scored copies of the test questions were grouped into community recovery, personal recovery and rehabilitation. The scores were then subjected to analysis to measure the general impact, success or failure of the programme (Health Education Intervention) on community reintegration of participants).

Results

Hypothesis 1: There is no significant difference in the behavioural outcome in the pre-test experimental group and pre-test control group in their levels of community reintegration before health education intervention in personal recovery instruction among discharged psychiatric patients in Agbor and Warri Central Hospitals in Delta State.

Table 1: Independent sample t-test analysis in the behavioural outcome in the pre-test experimental group and pre-test control group in their levels of their levels of community reintegration in personal recovery instruction among discharged patients

Groups	N	Mean	SD	Df	t	Sig
Pre-test Experimental Group	13	2.62	1.04			
Pre-test Control Group	8	1.88	1.23	19	1.53	0.14

The result in table 1, showed the t - value of 1.53 and p - value of 0.14. Testing the null hypothesis at an alpha level of 0.05, the p - value of 0.14 was greater than the alpha level of 0.05. Therefore, the null hypothesis was retained. This indicated that there is no significant difference in the behavioural outcome in the pre - test experiment group and the pre-test control group in their levels of community reintegration before health education intervention in personal recovery among discharged psychiatric patients in Agbor and Warri Central Hospitals in Delta State.

Hypothesis 2: There is no significant difference in the behavioural outcome in the pre-test and post-test experimental groups in their levels of community reintegration in personal recovery among discharged psychiatric patients in Agbor and Warri Central Hospitals in Delta State.

Table 2: Independent sample t-test analysis in the behavioural outcome in the pre-test and post-test experimental groups in their levels of community reintegration in personal recovery among discharged psychiatric patients

Groups	N	Mean	SD	Df	t	Sig (2 tailed)
Pre-test Experimental Group	13	1.92	0.76			
Pre-test Control Group	13	2.77	1.01	24	2.41	0.02

Table 2, indicated the t - value of 2.41 and a p - value of 0.02. Testing the null hypothesis at an alpha level of 0.05, the p-value of 0.02 was less than the alpha level of 0.05. Therefore, the null hypothesis was rejected. This showed that there was significant difference in the behavioural outcome in the pre-test experimental group and post-test experimental group in their levels of community reintegration before health education intervention in personal recovery among discharged psychiatric patients in Agbor and Warri Central Hospitals in Delta State.

Hypothesis 3: There is no significant difference in the behavioural outcome in the post-test experimental group in their levels of community reintegration before health education intervention in personal recovery instruction among discharged psychiatric patients in Agbor and Warri Central Hospitals in Delta State.

Table 3: Independent sample t - test analysis in the behavioural outcome in the post-test experimental group in their levels of community reintegration before health education intervention in personal recovery instruction among discharged psychiatric patients in Agbor and Warri Central Hospitals in Delta State

Groups	N	Mean	SD	Df	t	Sig (2 tailed)
Pre-test Experimental Group	13	3.08	0.76			
Pre-test Control Group	8	2.00	0.76	19	3.16	0.01

Table 3, indicated the t - value of 3.16 and a p - value of 0.01. Testing the null hypothesis at an alpha level of 0.05, the p-value of 0.01 was less than the alpha level of 0.05. However, the null hypothesis was rejected. This revealed that there was significant difference in the behavioural outcome in post-test experimental group and post control group in their levels of community reintegration before health education intervention in personal recovery instruction among discharged psychiatric patients in Agbor and Warri Central Hospitals in Delta State.

Discussion of results

The result in hypothesis 1, showed that there was no significant difference in the behavioural outcome in the pre-test experimental group and pre-test control group in their levels of community reintegration following health education intervention in personal recovery instruction among discharged psychiatric patients. The finding concurs with Thomas (2022) submission which substantiated that behavioural change only occured with the application of an intervention in interventional studies. The finding of this study identified no noticeable

personal recovery behavioural outcome in the pre-test experimental group and the pre-test control group because both groups entered the study at relatively the same levels of community reintegration understanding before health education intervention in personal recovery instruction among discharged patients.

The finding in hypothesis 2, revealed that there was significant difference in the behavioural outcome in the pre-test and post-test experimental groups in their levels of community reintegration following health education intervention in personal recovery instruction among discharged psychiatric patients. The finding in this study revealed remarkable personal recovery improvement in discharged patients as reflected in their ability to understand and regain their identity, build self-worth, confidence and maintain relationships. This finding was in tandem with the guideline of the Department of Health and Aged Care (2022) in their study on National Framework for Recovery-Oriented Mental Health Services: Guide for practitioners and providers, which affirmed that health education programme in personal recovery instruction helps discharged patients in redefining their personal recovery goals, maintaining hope and finding meaning to life. This study finding identified that both discharged patients and their caregiver benefited from the health education outcome as they were both exposed to the protocol.

The finding in hypothesis 3, revealed a significant difference in the behavioural outcome in the post-test experimental group and post-test control group in their levels of community reintegration following health education intervention in personal recovery instruction among discharged psychiatric patients. This finding in this study established a notable personal recovery behavioural improvement in discharged patients as shown in their ability to recognize and accept their selves, appreciated their self-worth, assertiveness, maintaining relationships and demonstrating the right perception and attitude towards self at the end of the 6 weeks intervention programme. The health education programme was applied to both patients and their caregivers. The finding of this study also tally with the study of Lin *et al* (2022) on the effects of rehabilitation models of self-stigma among persons with mental illness, which pinpointed personal recovery instruction as an antidote to self-stigma and negative attitude towards self which are barriers to successful community reintegration of discharged psychiatric patients.

Conclusion

This study concluded that community's behavior towards the mentally ill persons is that of rejection, stigmatization, lack of care, affection and support which affects the recovery health of discharged psychiatric patients and sometimes relapses and fall back into the early mental state. However, health education intervention contributed significantly to changing these negative behavioral trends, by promoting their mental health recovery, acceptance and successful reintegration back to the community.The following recommendations were made based on the findings of the study;

1. Government should engage more health education programmes at schools, hospitals and community levels concurrently and consecutively in order to yield more effective and sustainable change in the knowledge, attitude and actions of community towards individuals with psychiatric illness and other related disease.

2. Government should make health education a compulsory subject at all levels of education and health education teachers should be employed to handle the subject. Likewise, professional health educators should be employed into the health care delivery system should handle health education talk in the hospitals.

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