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**PATHWAYS TO MENTAL HEALTH CARE
IN
KWAZULU-NATAL PROVINCE
SOUTH AFRICA**

A DISSERTATION SUBMITTED TO THE:

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**MASTERS IN NURSING:
MENTAL HEALTH NURSING**

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DEDICATION

This work is dedicated to my late grandmothers, Evelyn Mgoboli and Sannah Mbangeni and also to my late parents, Raymond and Phillipina Mbangeni. Thank you for your unconditional love, support, understanding and encouragement.

This is for you.

DECLARATION

This study represents original work by the author and has not been submitted in any form to another University. The research described in this dissertation was carried out at TownHill Hospital, Pietermaritzburg and the School of Nursing, University of Natal –Durban, under the supervision of Professor L.R. Uys.

Except for referenced citations in the text, this is the researcher's original work.

Signature..... Date.....

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ABSTRACT

The understanding of the pathways that clients take prior to admission to a mental health institution, is a vital factor in planning to reduce delays in seeking treatment. Studying the pathways may also help in the identification of sources of delays in the receiving of care and suggest possible improvements.

Although western medicine plays an important role in the control of disease, traditional medicine continues to play an important role in the health care of black African communities. They, therefore possess unique attitudes, values and beliefs, about health and illness, which integrally influence their health behaviour.

This study aims to increase the understanding by health professionals of pathways to care taken by clients before they are admitted to a mental health institution, so as to enhance health service planning. It also aims to determine the socio-cultural and economic factors, as well as satisfaction with different service providers.

The sample in this study consisted of 15 clients, who were between the ages of ten and fifty-nine years. These clients were males and females who were admitted for the first time in a mental health institution (MHI) (TownHill Hospital, Pietermaritzburg). The interview questionnaire, was administered, by the researcher.

This study has demonstrated that, Africans still believe in traditional and faith healers as their first port of call when they are mentally ill. Their help seeking behaviour is determined by their cultural beliefs and values. The study also demonstrated the high involvement of the South African Police Services (SAPS) in the pathway to mental health institution by intervening to protect family or public and also transporting the client to a mental health institution. The Primary Health Care (PHC) is very seldom used

Economic factors like unemployment strongly influence the mental health of people and also affect their social functioning, as it is shown by the high levels of unemployment in the sample. Some of these clients resort to living on the streets, because they cannot find employment and are homeless.

The study has also shown the importance of education and training of health professionals in PHC, in identifying the first signs of mental illness when clients present themselves and making available the psychotropic drugs at the PHCC as this is the first port of call for clients.

Psycho education of traditional healers, spiritual healers, SAPS and community should be implemented on when and how to refer clients, how to handle mentally ill clients.

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CHAPTER ONE

INTRODUCTION

1. PROBLEM STATEMENT

The understanding of the pathways that clients take prior to admission to a mental health institution is a vital factor in planning to reduce delays in seeking treatment. Studying the pathways may also help in the identification of sources of delays in the receiving of care, and suggest possible improvements. Pathways to mental health care reflect the nature of health services, affordability, accessibility and availability of mental health professionals (psychiatrists, psychiatric nurses, psychologists, social workers and occupational therapists). The study of pathways to mental health care is important in elucidating popular beliefs about mental illness (Gureje, Acha, and Odejide, 1995).

The pathways which patients take are likely to be influenced by conventions governing referral by relationships which exist between mental health services, other sources of help and also by the availability of mental health and other helping agencies. Access to mental health care (MHC) continues to be a problem to the aged, the poor and rural Black population because of its financial affordability, location of services and transport costs to reach the required service (Gater, De Almeida, Sousa, Barrientos, Caraveo, Chandrashekar, Dhadphale, Goldberg, Al Kathiri, Mubbashar, Silhan, Thong, Torres-Gonzales and Sartorius, 1991).

It has been observed that episodes of mental disorders are fairly common in the population, but mental health professionals will see only minority. Furthermore, a

sizable proportion of those with psychological problems are not identified but remain undetected in the community (Casey, 1990). The majority of people consult their doctors, although they often do so for associated physical symptoms that are causing them distress (Goldberg and Huxley, 1992).

The personal characteristics such as race as well as socio- demographic variations affect help seeking behaviour with regard to mental health (Gallo, Marino, Ford and Anthony, 1995). The importance of socio-demographic factors may emerge as exerting an influence on this complex process in the sense that women have more contact with their family doctors than males. The social class status may also have an influence on consultation rates especially the lonely individuals than the ones in close relationships (Casey, 1990). The race characteristics refer for example to the Africans where in their culture are told specifically that when they marry they marry even the problems of that particular family. When one is married especially the women, they are supposed to sit on the new family problems (*hlala phezu kwezinkinga zomuzi*) do not share with anyone outside the family. Socio-demographic variations refer to the ability of the individual to pay for the services that he/she seeks.

What is also important is the person's experience of illness and distress, as it is this experience which will determine how the person behaves, the treatment sought, and the response to treatment. The approach to understanding mental illness cross-culturally, defining the codes used when talking about it, and different ways of expressing it can help to understand mental illness universally. No human activity is free from cultural

influence, for example a doctor may believe that the client has a brain tumor (disease), but the client may believe that bewitchment is at work (illness) (Swartz, 1998).

A study of pathways to mental health care is an important topic that might clarify understanding and yield insight into the working of the mental health care system in South Africa. Knowing where the delays occur in the pathway to mental health care will also help to improve and develop a plan that will speed up the early detection and prompt seeking of professional help when the first symptom of mental illness occurs. The identification of cultural differences at basic levels is of importance in connection with the creation and transformation of mental health services in the new South Africa (Swartz, 1998; Patel, 1995). A Pubmed search using, "*Pathways to mental health care in South Africa*", revealed no list of studies, hence this study.

1.2 RESEARCH GOAL

The aim of the study is to increase the understanding by health professionals of pathways to care taken by clients before they are admitted to a mental health institution, to enhance health service planning.

1.3 OBJECTIVES

1.3.1 To determine pathways of care the clients with mental illness take which ultimately lead to the mental health institution (MHI).

1.3.2 To determine the effects of socio-cultural and economic factors on pathways to mental health care.

1.3.3 To determine satisfaction with different service providers.

1.4 RESEARCH QUESTIONS

- 1.4.1 Who is the first provider of care used by clients in the community?
- 1.4.2 What are the pathways to care that have been used by clients from the first provider to the time of admission to the MHI?
- 1.4.3 Who makes the decision on the choice of the provider or service?
- 1.4.4 Are the clients satisfied with mental health care received?
- 1.4.5 Who is the preferred health care provider?
- 1.4.6 How are the pathways influenced by demographic factors?

1.5 THE CONCEPTUAL FRAMEWORK

This study, will be guided by the five levels and four filters model designed by Goldberg and Huxley (1992:4). They postulated that the majority of mental illnesses seen on community surveys have not been seen by mental health care services. They have concluded that there is a filtering process in operation between the community and the wards of the psychiatric hospital which is selectively permeable to those with more severe disorders.

According to these researchers, most clients are referred to the mental health care services by other professionals which concludes that there is also another filter between the community and the referring professionals as well as between the professional and the mental health services.

There is a problem with the first level and the first filter because some people do not go to PHC for the identification of their mental problems, but go straight to the general practitioners, teachers, pastors, spiritual and traditional healers. Others do not go

beyond the first filter, they are delayed or filter through when serious or inappropriate behaviour occurs.

Ngubane (1977) used the category of *ukufa kwabantu*, which indicates that not only the disease, or their symptoms, are associated with African people, but that their interpretation is bound up with African ways of viewing health and disease. According to Africans, concept of illness is viewed in terms of natural, moral and magical etiologies. The filtering system in this category does not seem to be in operation.

This model consists of five levels which each one corresponds to a stage on the pathway to mental health care. There are also four filters between five levels. This appears in (Appendix 1).

LEVEL ONE: THE COMMUNITY

GENERAL ILLNESS

1ST FILTER: THE IDENTIFICATION OF ILLNESS

Where all mental illnesses like depressive illnesses, anxiety-related disorders, organic mental disorders, schizophrenia and bipolar affective disorders are encountered. These mental illnesses cause enormous suffering, are chronic and cause severe disability.

The first filter, which deals with identification of illness, is present in the community but some clients do not pass this level and filter because they do not consult or they attend traditional/spiritual healers. Casey (1990) emphasize the fact that symptom severity is one factor which prompt consultation and who to consult although many others are involved.

LEVEL TWO: TOTAL MENTAL MORBIDITY- ATTENDERS IN PHC

2ND FILTER: ABILITY TO IDENTIFY DISORDER

In this level clients go to PHC and it is where the mental health professionals are able to detect psychological distress or mental illness. It is also in this level and filter where most of the clients are never filtered through because of their physical symptomatology presentation. One example is that of a lady who was frequenting the hospital with different physical ailments on each visit. All tests and diagnostic procedures were conducted and all yielded negative. One day a new registrar was consulted by the same lady, the registrar was overwhelmed by the thick file and all the tests that were done, the lady was referred to a clinical psychologist. The clinical psychologist was shocked about the tests that had been done for this lady and concluded to no tangible diagnosis. She then asked the lady, "Ma'am, what's your problem?" The client started crying and said, "This is my first time ever since I have been visiting hospital, to be asked about my problem." This was the beginning of the client's pathway to mental health care. Presently she is doing well on antidepressants coping well with life generally. This example highlights the delays at the second level and filter experienced by clients to proper mental health care.

The other aspect on this level is the mental health service use and the socio-demographic factors. In African society, when people feel sick, they report this to those around them. They observe the symptoms whether they are minor ailments that can be treated at home or a serious illness that needs the attention of an expert. The severity of illness is assessed by the behaviour of the person. If a sick person is sick but

continues to work, she/he is sick but goes with it "*uhamba nakho*". If she/he lies down, "*ulele phansi*", the illness is considered serious to those around him/her (Ngubane, 1977). The financial status of the client also plays a major role in determining the seeking of relevant help and the availability of the desired mental health service.

The decision to contact a western doctor or a traditional/spiritual healer is influenced by factors such as the seriousness of the illness, availability of health services, financial implications and the person responsible for the decision. It is important to note that there may be delays in consultation since the head of the family especially in African community is usually away from home, for example he may be a migrant labourer in another city. Casey (1990) states that it is undoubtedly true that symptom severity is one factor, which prompts consultation although many others are also involved.

This study is to determine whether there are any delays in this level, which seems to be the crucial filter for the next level that deals with conspicuous mental illness.

LEVEL THREE: MENTAL DISORDERS IDENTIFIED BY DOCTORS (CONSPICUOUS PSYCHIATRIC MORBIDITY)

3RD FILTER: REFERRAL TO MENTAL ILLNESS SERVICE.

At this level the clients are mentally ill, are therefore seeking help, treatment and admission.

LEVEL FOUR: TOTAL MORBIDITY- MENTAL ILLNESS SERVICE.

4TH FILTER: ADMISSION TO PSYCHIATRIC BEDS.

In this level the client passes through level three and is admitted in a mental health institution.

LEVEL FIVE: PSYCHIATRIC – IN – PATIENTS

These are the clients that have filtered and passed through all levels and are admitted in a mental health institution for a period of time.

1.6 DEFINITION OF TERMS

1.6.1 PATHWAY TO MENTAL HEALTH CARE

According to the World Book Dictionary (1988:1526), pathway means a way for foot passengers, a track or a course of actions or conduct. In this context pathway of care refers to the health care providers consulted by clients from the time the first symptom of mental disorder occurs until admission.

1.6.2 MENTAL ILLNESS

Mental illness is a clinically significant behavioural or psychological syndrome or pattern that occurs within a person that is associated with distress and disability. It is not an expected response to a particular event or experience (Uys and Middleton, 1997).

Mental disorders which are encountered in the community and whose occurrence signals a breakdown in normal functioning. These conditions are schizophrenia, major depression, post traumatic stress disorder, substance abuse organic brain disorders and mental retardation (Diagnostic and Statistical Manual of Mental Disorders, 1994).

1.6.3 SOCIO- CULTURAL AND ECONOMIC FACTORS

1.6.3.1 Socio - cultural factors

Social factors, refers to social interactions among human beings through explicit and implicit cultural guideline that are transmitted from generation to generation (World Book Dictionary, 1988:1984).

1.6.3.2 Socio – economic factors

Factors, that refer to the social standing and the financial status of an individual in his society (World Book Dictionary 1988: 1984).

1.6.4 CLIENTS

World Book Dictionary (1988) refers to clients as persons who receive assistance from a social service agency or similar organization – in this context, the mental health service.

1.6.5 PROVIDER OF CARE

Provide refers to supply, furnish, to give what is needed or arrange means of support (World Book Dictionary, 1988: 1675). In this study, provider of care refers to the supply of mental health care and means of support as needed to the clients.

1.6.6 PREFERRED PROVIDER OF CARE

Preferred means first choice or to like better (World Book Dictionary 1988: 1675). In this study the preferred provider of care refers to the clients first best choice of the provider he/she prefers to consult when the first symptom of illness occurs.

1.7 SIGNIFICANCE OF THE STUDY

The study of pathways to mental health care is an important topic that might clarify understanding and yield insight into the working of the mental health care system in South Africa especially KwaZulu – Natal province. Knowledge gained will help facilitate the identification and early detection of first signs and symptoms of mental illness through psycho- education of clients, families and the other mental health care providers. The study will also increase understanding of how levels and filters of pathways to mental health care operate in order to enhance the planning of mental health services.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This is a review of the existing literature on various areas associated with the study. The literature review focuses more on utilization of mental health services, pathways to mental health care and the cultural influences on health especially mental health.

2.2 UTILIZATION OF MENTAL HEALTH SERVICES

The health system of South Africa is unique in many respects because its development and its structure, has been strongly influenced by a unique political ideology of racial separation that is the apartheid system. The racial segregation of the health system has led to discrimination and fragmentation in health services as well as large disparities in health services between different population groups (Pillay, 1993).

The relationship between health and apartheid has negatively affected black population groups especially the Africans in several ways. Pillay, (1993) cited De Beer, (1984) as stating that the inequalities and discriminations have led to severe social problems, such as, poverty, unemployment, overcrowding, poor education and inadequate housing which naturally adversely affect the mental health status of black communities.

The disruption of family life through migrant labour and influx control have increased vulnerability to illness and disease especially when a decision has to be taken when

mental illness has occurred in the family. The inequalities and discriminations in health system have also promoted and maintained negative health behaviour and delays in help seeking behaviour.

Pillay,(1993) states that there is gross lack of adequate mental health services and health facilities for black South' Africans especially in rural areas. The term health facility refers to the range and quality of care provided by the facility, the quantity, accessibility, affordability and acceptability by the community it serves. The lack of mental services, undoubtedly restrict the appropriate health seeking action of the people and the traditional or spiritual healers' help is sort which causes delays in proper health care.

Nevin (2000), states that about 90% of the African population prefer to consult traditional healer first and if that does not work they try western medicine. There is a need to bridge the two healing fields. Traditional/ spiritual healers also known as *izangoma* or *abathandazeli* respectively have been administering health for centuries to the majority of South Africans. Instead of using the antibiotics or other substances, they use fruits of the earth, gathering plants in the mountains and rivers of the country. Traditional/spiritual healers are the first port of call and frontline service provider of health services because they live within the communities. They serve a greater number of clients than the western doctors, especially in rural areas (Hess, 1998).

With South Africa's new health dispensation necessitating the working together of both the traditional/ indigenous/ spiritual healer and the formal health worker, It is important

to know the mental disorders normally taken by the clients to the traditional healers (Shai – Mahoko, 1996:31).

Heagert (1996) cited deJong in her research into health seeking behaviour by Cape – Tonians as describing three functions of any health care system:

First, to give meaning to suffering; second the healing per se and thirdly, communication during the healing process. Westernized people look at symptoms – the commonest reaction was: “when my body feels different”. Many “listened to what their body was saying”. Non westernized Africans went by dreams or experiences, feeling something moving in or eating that part of the body that was thought to be sick for example in the stomach or back. One interviewer concluded that, “Nobody can tell anybody that they are sick. It is very personal. They are in their own ways responsible for their health” (Heagert, 1996:82).

Gallo, et al (1995:1149) conducted a study on comparing health service use by individuals with different socio- demographic characteristics, accounting for the first time occurrence of psychiatric disorder, over the course of one year. In their study, they were concerned with self- reported ethnicity, gender, and age with adjustment for differences. Due to other covariates, selected a *priori* thought to be associated with health care use such as socio - economic status, past contact with mental health services, availability of an usual source of medical care and importantly coincident psychiatric disorders.

The data gathered through an investigation about health and mental health services use by adults with and without newly incident mental disorders helped Marino, Gallo, Ford,

and Anthony (1995) to study the behaviour of persons with the first occurrence of psychiatric disorders. They hypothesized that in the United States, the general medical sector is a major pathway to mental health care for persons with an incident mental disorder. Even accounting existing variables such as gender and the existence of the “ American By – Pass” which allows clients to seek specialist care independent of general practitioners.

The National Health Plan adopted by the ANC (1994), developed a mental health policy aimed at ensuring the psychological, physical, spiritual and emotional wellbeing of all South Africans through elimination of fragmented services and ensuring comprehensive and integrated mental health. The health plan also supports the development of non-governmental community based mental health care services and emphasizes the cooperation, networking and collaboration amongst the various mental health care providers including traditional healers.

2.3 PATHWAYS TO MENTAL HEALTH CARE SERVICES

It is reported that in South Africa, 80% of clients consult a traditional healer before going to a professional nurse or a medical doctor. Some 60% of all babies born in the country are delivered not by those trained in western schools but by traditional birth attendants. The distinction between natural and supernatural causes of illnesses was found to influence an individual’s choice or pathway on whether to consult a traditional healer or a biomedical service. Traditional healing methods play an important role in the treatment of illnesses perceived to be of supernatural origin (Nevin 2000).

There is evidence that clients visit traditional healers before they come to the PHC or even the hospital. Nemeč (1980,) as quoted by Shai – Mahoko (1996) states that two thirds of the people in the world today depend on the healing methods used by their ancestors and in some areas it is the only type of health care available and with which people feel comfortable. Nevin (2000) supports the fact that traditional healers throughout the continent have long applied these treatments and undoubtedly there is power in these ancient processes of healing and there is need for further learning to be done.

Swartz (1998) emphasized the importance of the person's experience of illness and distress as it is this experience which will determine how the person behaves, the treatment sought and the reaction to treatment. In trying to understand the meaning of illness experiences of the client, a full picture is possible from the client's family, community and spiritual background.

Balestrieri, Bon, Rodriguez-Sacristan and Tansella, (1994) compared the pathways to psychiatric care with the others described in other countries using the method of the WHO cross-cultural study of pathways in psychiatric care. The first port of call for 92% of clients was the doctor, whilst more than one third arrived at the community psychiatric service directly, not filtered by other careers. " We are therefore able to study the effects of various levels of provisions of service on the delays which occur in seeking care. As well as to document the relationship between delays on the pathways to care and both clinical and demographic factors in a wide range of settings" (Gater, et al 1991:762).

Professor Smith as quoted by Nevin (2000) states that education of the traditional healers is important especially in the concept of infectious diseases and the need to take medicine. This statement is in line with the mental health principles of the National Health Plan (1994) of liaison, opening channels of communication and cooperation with the traditional healers.

The studies conducted by Davies, Thorncroft, Leese, Higginbotham and Phelan (1986) and Koffman, Fulop, Pashley and Coleman (1997), that compared ethnic differences in risk of compulsory psychiatric admission, expose clearly, the compulsory pathway, taken by Black Afro Caribbean people which, is under section 2 and 3 of the Mental Health Act 1983, and involves the police and forensic services. These Afro Caribbean young men are usually diagnosed as schizophrenic, that their white counterparts, will be located in locked wards and not be registered with a General Practitioner (GP).

Previous studies have founded that in London independent of diagnosis and socio-demographic differences patients of African and Caribbean origin are more likely to be detained compulsorily under the Mental Health Act than white patients (Davies et al 1996; Koffman et al 1997).

Compulsory admission was found to be strongly associated with the absence of GP involvement and or with the absence of help seeking by a friend or relative. This study also demonstrates an association between admission rates for psychotic illness and indices of social deprivation, such as unemployment, overcrowding and lone – parent

families. The study of first onset patients may enable us to understand the relationship, between ethnicity socio-demographic factors and pathways to care in the context of first engagement with psychiatric services (Burnett, Mallett, Bhugra, Hutchinson, Der and Leff 1999).

Burnett et al (1999) postulated that an understanding of how socio-demographic factors' impact on the pathways to care for psychiatric patients is central to the evaluation of mental health services.

Cole, Leavey, King, Johnson- Sabine and Hoar (1995) and Pillay (1993) support the notion of ethnicity as the determinant choice of the type of pathway into care for the patients with a first onset psychosis. This distinction is important as the patients experience of their first pathway to care, may determine future compliance with care. The latter author also identifies the financial costs, lack of community support, lack of transport and the location and quality of the health service as the trigger factors of pathway to be taken.

2.4 CULTURAL INFLUENCES ON HEALTH

Cultural determinants are an important part in maintaining a sense of good health. Cultural values, norms and expectations influence and shape beliefs, lifestyles, family interactions, roles, social organization and institutions. Pillay (1993), cited Berkanovic and Reeder (1974), stating that cultural influences affect not only perspectives on health, illness and disease such as patterns of diseases, but also a variety of health related behaviours such as the utilization of services, seeking of medical care, response to pain, responses to symptoms and the use of traditional healers.

According to Patel (1995), the influence of culture on mental illness is of interest for several reasons: Firstly, it promotes the understanding of how clients from different ethnic groups experience and express mental distress, sheds light on aetiological factors and lastly plays an important role in the development of psychiatric theory.

According to black Africans, the concept of illness is viewed in terms of natural, moral and magical aetiologies. The natural causes refer to those natural illnesses that just happen for example flu *umkhuhlane* or *ufuzo* which is certain mental illnesses that run in families (Ngubane, 1977). The moral illnesses are caused by failure to prevent imbalance between persons and their environment. The environment may be polluted by bad tracks (*imikhondo emibi*) only but by things discarded during traditional healing of someone as well as noxious substances placed by sorcerers. The balance between the person and the environment is achieved by the use of "strengthening medicine" (Ngubane, 1977). The magical illnesses are caused by African disease (*ukufa kwabantu*), due to vulnerability to misfortune and diseases. The vulnerability is due to a long stretch of time between the treatments and the newcomers to the territory for example infants and strangers. The misfortune may occur when ancestors are believed to be "facing away from the people" "abaphansi basifulathele". The ancestors may be annoyed by lack of peace at home or the non-fulfillment of marital duties (Ngubane, 1977).

A study on conversion disorders in Zulu patients conducted by Edwards, Jainarain, Randeree, Rzadkowolski and Wessels (1982), discovered that cultural factors,

operationally defined as traditional beliefs and or consultation of traditional practitioners were present in 78% of the sample; a higher incidence among rural than urban patients. This study also provided evidence that is significant of culture on the evidence and clinical manifestations of hysteria reactions. The patient's, attributed their disorder to traditional beliefs, sorcery in a variety of forms and was regarded as the most common cause.

On the one hand, western medicine permeates the entire social structure and serves all population groups and on the other hand, traditional or tribal medicine is still well established and is relatively popular among the African black population (van Rensburg, 1982:179). Van Rensburg (1982) further explains the traditional approach to health care as emphasizing the supernatural nature and cause of disease. Consequently the entire organization of traditional medicine is surrounded by a typical magic- religious aura, centered on the figure of the so- called witch doctor (*isangoma / igqira*) or spiritual healer (*umthandazeli*).

The pathway to psychiatric care of Africans will be chosen according to the Manganyi Classification as specified by van Rensburg (1982) which is as follows: A group of traditionalists - the smallest group who will utilize only traditional medical services. A second group who, will use western services, to the exclusion of all else. A third group - probably the largest – who will resort to a combination of Western and traditional services.

According to Kruger (1974) in his paper, he emphasized the fact that understanding the work of the traditional healer (*Igqira*) in Western natural scientific terms is virtually

impossible. The traditional healer lives in an undivided world in which ancestor, dream, plant and body all belong together. If he/she is informed in a vision or in a dream, that a certain plant is to be used for a patient who will visit him/her on the next day. He finds it unnecessary to enquire why this specific plant should have the property of curing this particular person. The very fact that he fails to ask this last question discredits the whole procedure in the eyes of the western scientists.

Kruger (1974), reports that west has set itself up as a standard in every aspect of life for the rest of the world. Western medicine is regarded as being advanced and the traditional Xhosa approach to illness and malady, unsupported as it is by any anatomy, physiology or technology must then be regarded as primitive, retarded or underdeveloped. The Xhosa diviner is seen as a sort of primitive doctor/priest/psychologist. Some primitive healers have used plants, which have the same properties as reserpine or LSD, in the treatment of psychosis – which is appreciated by the Western science as a move to development.

Daynes and Msengi (1979) concluded that patients not only have to be treated for their illnesses but also have to be told why they are ill. If these explanations are not given, they will go to tribal diviners to obtain the information. Practitioners who explain the causes of illness will have a greater number of satisfied patients. In their study, they found out that patients consulting practitioners of Western medicine in Transkei expect answers to the questions:

“Why am I ill?”

“Who made me ill?”

The tribal diviners do not only tell their patients why they are ill, they also tell them who made them ill. Although, the Western philosophy of life and approach to illness differs very considerably from those of Blacks, their frame of reference is so broad that certain Western ideas can be incorporated into it without upset and these new concepts, can become relevant for them. Those practitioners who wish to practice relevant psychiatry in Africa, should not only provide their patients with therapy but also with explanations as to why they are ill and who made them ill. In other words practitioners should not only try to understand the cause of the condition but like the diviners, they should pass this understanding to their patients.

Traditional or tribal medicine universally displays strong magic – religious qualities, with little differentiation between religious, medical and magical aspects. This also applies to the tribal medicine still enjoying widespread support among South African Blacks particularly those forms characterized by strong elements of ancestral worship and witchcraft. Blacks with strong tribal ties have little scientific knowledge of the process of diseases and its natural causes and consequently, numerous concepts of western medicine, are completely foreign to traditional thinking (van Rensburg & Mans (1982:185).

Cheetham and Rzadkowolski (1980) recognized that any culture influences mental disorder in a variety of ways. Specific culture – dependent stresses may precipitate disorders, mould personalities and create vulnerability or resistance. Culture also shapes symptomatology, according to group expectation and given clues.

They also claim that attitudes to mental illness are culture dependent, for example in their containment of mental illness. Pastoral societies are more tolerant of psychotics and have fewer illness taboos than do industrial cultures. The course and prognosis of the illness are also dependant, upon specific cultural clues, directly and indirectly through symptomatology and the attitudes displayed by the community. Culture also accounts for the prevailing concepts of mental illness, including beliefs relevant to causation.

They also emphasize that preliterate society understand causation of mental illness in terms relating to primary process thinking, moral and ethical issues being important and supernatural influences of ancestors and familiars firmly believed in as well as magic, witchcraft and sorcery, although heredity and contagion are also observed. Mental illness is viewed in the light of a threat to social order rather than as a cognitive malfunction (Cheetham & Rzadkowski 1980:323).

Buhrmann, (1981) in her study of lifestyle and disease identifies two mental states occurring in Black people namely: *Thwasa* and bewitchment, which are different from schizophrenia and catatonic schizophrenia. The aetiology is seen as arising from the relationship of the afflicted individual to his ancestors, which may be either positive or negative. Van Rensburg & Mans (1982) support the fact that the traditional healers ascribe causes of disease to angry spirit either ancestral or seeking vengeance for disrespect or disregard of a traditional norm. Disease can also be ascribed to witchcraft brought by evil spirit.

Thwasa means an emergence of something new like a new moon or the ancestors are calling the individual to have treatment and training and thus enter their service – to become a sangoma or igqira in Xhosa. A *sangoma* or *igqira* is one who understands the messages of the, ancestors which are conveyed in dreams, visions, illness and misfortunes of all kinds. He or she is able to interpret these to the sick and troubled people who seek advice and help. Bewitchment is a state which the ancestors have withdrawn their protection from the person.

Uys (1986), in her study focused on collecting information about the sick role and illness behaviour. This included the view of the responsibilities and privileges of clients and their interpretation of symptoms treatment practices including prevention, self-treatment, aftercare, use of both traditional and western healers and expectations from these systems. A further view is that of connectedness of life in that the individual is connected not only to the living people around him, but also to the ancestors, events and to people. Even the inanimate environment is, connected by magical thinking to people and events.

According to Uys (1986), after care is something that is foreign to the African and may be attributed to an absence of future directness in their thinking so that planning for the future is impossible. Le Roux (1973) also supports this view of Africans having culturally- bound thought system whereas the whites have rational attitudes respecting demonism and supernaturalism in general. He also says that the Africans have not experienced such a transitional phase.

Burnett et al (1999) also supports this poor follow up care, by Blacks over one year. The relationship between the Black patients and carers in the psychiatric services deteriorates overtime, initiating a cycle of avoidance, non-compliance with treatment and increase rates, of compulsory detention.

Buhrmann (1977) advocates that a real understanding of Black Xhosa culture, customs, beliefs and philosophy of life is very important. The difficulties of the western-trained psychiatrist in dealing with African patients are three-fold namely: the language and intricate of its usage, the cultural beliefs, customs and rituals and the applicability of the western psychiatric model to people of a different culture. This background knowledge is very important for psychiatric assessment. Swartz (1998) and Patel (1995) support what Buhrmann is saying and also emphasize the understanding of the psychological, social, cultural meaning of the other person's verbal and non-verbal messages for the correct interpretation of the problem.

Malello (1997) believes that mental health workers can assume a leading function in bridging cultural differences because their work involves development at the political, social, cultural and psychological levels. She also recommends that as far as professional training in the field of mental health is concerned, students from other races are to accept the challenge of learning not only one African language, but also become familiar with its cultural background, the teaching of which, could be part of their professional education. This is where true bridging could start on a basis of reciprocity.

Knowing cultural diversity in South African society has necessitated the inclusion of cultural influence on health in the curriculum of nursing to enable graduates to render congruent cultural nursing care. Leininger's nursing theory emphasizes the relationship between culture and health, perceptions of health and sickness and sickness behaviour, including pathways to health and treatment strategies (de Villiers and van de Wal, 1995: 58).

Giger and Davidhizar (1990) emphasize the fact that a new generation, of nurses with different cultural insights have a deeper appreciation of human life and values in developing, a sensitivity for cultural appropriate individualized care. A practical easy to understand assessment model has been developed. It provides a systematic approach to evaluating six essential cultural phenomena evidenced among all culture groups namely: communication, space, social organization, time, environmental control and biological variations, bio-psychosocial factors.

"The key to culturally sensitive care lies in enabling nurses to examine their own prejudices towards and stereotypes about the poor as a prelude to identifying factors that contribute to dehumanized care" (McGee,1994:790).

In conclusion it is not clear where exactly the pathways to psychiatric care begin. Do they begin with the family, friends, or the client himself or herself? Do they really end with the psychiatrist or mental health institution? Pathways to psychiatric care are not static events or strategies, but an ongoing process in search of an ideal care-giver. It is a process, dependant on a wide range of bio-psychosocial factors which need to be understood individually.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this section of the study a description of the research design, setting, population sampling, measurement instrument and data collection procedure will be discussed. In this qualitative research the researcher sought to use a semi- structured individual interview schedule or guide to collect data from fifteen clients in the pre-discharge units of MHI.

3.2 RESEARCH DESIGN

An exploratory survey research design was used to explore and analyze the pathways to mental health care taken by clients, seeking help before being admitted to a MHI. It is an exploratory survey because Wilson, (1985) defines survey research design as a method of studying populations or universes based on the data gathered from a sample drawn from them. Survey is also generally known to serve the purpose of describing characteristics, opinions, attitudes or behaviours as they exist in a population, in this study the first port of call till the admission to the MHI.

Wilson (1985) also refers to survey as a means of collecting information from a variety of clients who resemble the total population on the characteristic of interest to the researcher, which in this study is the pathways to care to MHI. The data has been gathered through semi- structured interviews.

3.3 SETTING

The target population for the study was the first time admissions to TownHill hospital (THH) in Pietermaritzburg, excluding those clients with dementia. The targeted population was the male and female clients from the pre-discharge units of the hospital. The pre-discharge units have been targeted because the clients are no longer psychotic and aggressive, they can relate well to the researcher. Since this group is their first admission to a mental hospital, it is hoped that they will be able to trace their pathways from the time of the onset of mental illness to the time of admission to a MHI.

3.4 SAMPLE

A purposive sample of fifteen clients were selected to participate in the study. Burns & Grove (1987) states that purposive sample is the selection of participants as judged by the researcher to have the necessary knowledge and experience to contribute meaningful data to the study. It is assumed that this sample would be adequate information to identify major trends in help seeking behaviour when first signs and symptoms of mental illness occurs. It is also hoped that their memories are intact to be able to relate their choices and decisions made during the course of their mental illness. It is also important to note that this sample may be a difficult group of clients to interview, and therefore a large sample cannot be planned.

The client selection depended on those that were in both female and male pre-discharge units on the third and fourth weekends of October 2001 and the first weekend of November 2001. These were the weekends that were utilized to collect data for the study.

3.5 INSTRUMENT

The instrument for this research consisted of the initial demographic data about the client, which helped the researcher to gain more knowledge about the clients' background (Appendix II Section A).

Throw away questions were used to develop trust and rapport with the client for example asking about the weather. This instrument used a semi-structured interview guide developed to explore and find out about the pathways clients take to mental health care services (Appendix II Section B). The semi-structured interview is a method of obtaining information by asking open-ended questions, beginning with broad and general to specific questions that are not preset in an attempt to understand complex behaviour from a certain sample of population of society.

The study used interview schedule written in English and translated into Zulu language for user friendly to some of the clients. The instrument consisted of four questions which are related to the levels and filters of the conceptual framework adopted from Goldberg and Huxley (1992) (Appendix I).

The first question: How did you realize you were sick you, family or others? addresses the first level as well as the filter of the conceptual framework which deals with the general illness as found in the community, the identification of illness and the decision to consult. When the mental illness has been identified, whether and who to consult depends on the individual, family and how the illness is perceived. Cultural background of the client seemed to be determining the pathway to take whether western or traditional origin. Who was the first provider consulted if ever.

The second and third questions deal with the first contact with the health professionals in PHC clinics and the general practitioners rooms where the mental disorder has been identified that is second level and the filter. The period the client has to wait before being referred to the next level and the filter where there is conspicuous mental illness. Who was the provider, what treatment was he/she given and was she / he satisfied or not. Who was the decision maker in all the consultations that were done and ultimately the admission to the MHI.

This interview schedule has been chosen because of its suitability and effectiveness in getting at clients' complex feelings or perceptions. Probing questions were used to gather more information and explanations. Open-ended questions were asked to ensure that the clients are encouraged to give more information for example: "Tell me about getting help...." Tracking was used which allowed the client to tell his/her story in his/her own way while the researcher shows interest and understanding of the conversation.

Wording of questions were in simple language either in Zulu or English as preferred by the client. Double barrel questions were avoided as much as possible. Too long and complicated questions were avoided because the client may remember only part of the question and respond to that. The researcher provided a reflective summary where she would repeat in her own words, ideas, opinions and feelings of the client and make sure that the researcher understood the clients correctly for example: " In other words, you feel that....."

Fourth and fifth levels deal with the clients that are mentally ill and admitted to the MHI.

3.6 PILOT STUDY OF THE INSTRUMENT

A pilot study was conducted on one client from Peace Haven unit in TownHill hospital. This client was chosen by the same procedure, which was intended for the main sample. No major difficulties were met except rephrasing the first question in the Zulu translated questionnaire to read thus, " *Waqala nini ukugula'* when did you become mentally ill. The instrument was, understood by the participating client because she was able to explain her pathway to mental health care. This client was not included in the sample.

3.7 DATA COLLECTION

Permission was requested and obtained from the Senior Nursing Service Manager and the Chief Medical Superintendent of THH. There was a delay of approximately a month in responding to my request because the hospital was under going accreditation inspection from the department of health. Fortunately the hospital was rated highly in its performance in rendering quality care to its clients.

Data collection was started on the third weekend of October 2001. The last clients were interviewed on the first weekend of November 2001. On obtaining the permission, the zonal matrons informed the chief professional nurses manning the pre- discharge units, the researcher then contacted the appropriate clients to set up appointments through the nursing staff on duty those particular days. Weekends were chosen so as not to interfere with the daily routine and the running of the units. Collection of data was started on the 20/10/2001.

The researcher had to introduce herself, and the research topic to the nursing staff in the units so as to gain cooperation and support. The staff working in the units were,

willing to identify the first admission clients and briefly explained their mental state at the time.

The researcher read the files of those that were selected for the interviews. More background information was obtained from the files and jotted down. The interviews were conducted in a doctor's room within the unit. The initial introduction between the client and the researcher was done.

The client was informed about the research, its purpose, confidentiality and the client's right to refuse to participate if he/she so desires. The client was asked to sign a written consent to agree to participate (Appendix III B). Permission was sought from the client to use a tape recorder and to take notes during the course of the interview to ensure that no collateral information is lost. Pseudonym was used to protect the client's identity and confidentiality was maintained all the time.

3.8 ETHICAL CONSIDERATIONS

Permission to conduct the study was obtained from the Chief Medical Superintendent and the Chief Nursing Service Manager of the THH (Appendix IV). A verbal approval was also obtained from the matron on duty and the chief professional nurses in charge of the pre-discharge units during weekends of data collection. Clients were provided with essential information for informed consent and a choice to refuse or terminate their participation at any time of the study (Appendix III A). Respect and confidentiality was maintained at all times. Pseudonym was used to protect the client's identity. The informed consent was given to clients to read and sign when accepting to participate (Appendix III B). Permission was obtained from the clients to take notes and to use the tape recorder during the interview.

3.9 DATA ANALYSIS

Data analysis has been done through transcribing recorded interviews and reviewing the notes taken during interviews so as to ensure that no information is lost. The information gained has been used to answer the research questions and to match these responses to the five levels and four filters of the conceptual framework of the study. Major trends have emerged as to who is the first provider, why was he/she the first provider to be consulted.

3.10 CONCLUSION

The instrument designed for this study has proved to be collecting the desired information about the pathways to mental health care. The pilot study has proved that clients take different pathways when mental illness strikes.

CHAPTER FOUR
DESCRIPTION OF THE FINDINGS

4.1 INTRODUCTION

This section deals with the description of the findings of the study. The research questions are going to be used as the template to describe the findings. The first part deals with the characteristics of the sample and then the responses to research questions. The pathways are described both in diagrammatic form and anecdotally.

4.2 SAMPLE CHARACTERISTICS

GENDER

The sample size was fifteen (15), consisting of eight (8) females, and seven (7) males. These clients were present in both the male and the female pre-discharge units of the MHI during the weekends of 20, 21 & 27/10/01 and 03/11/2001.

TABLE I: GENDER DISTRIBUTION

UNITS	FEMALE	MALE	TOTAL
Uitsig G & H	0	7	7
Peace Haven	8	0	8
Total	8	7	15

AGE DISTRIBUTION

The age distribution of the sample appears in Table II and shows it to be between 10 and 59 years. Females were evenly distributed amongst all age groups. There was a preponderance of males in the 20-29 age group.

TABLE II: AGE DISTRIBUTION

AGE	FEMALE	MALE	TOTAL
10-19	2	1	3
20-29	2	5	7
30-39	2	1	3
40-49	1	0	1
50-59	1	0	1
TOTAL	8	7	15

MARITAL STATUS

Table III shows that thirteen clients were single and two clients both females were married.

TABLE III: MARITAL STATUS

CLIENTS	FEMALES	MALES	TOTAL
Single	6	7	13
Married	2	0	2
Total	8	7	15

EDUCATION

All clients had primary and secondary education, none were illiterate nor had tertiary education (TableIV).

TABLE IV: EDUCATION DISTRIBUTION

EDUCATIONAL LEVEL	FEMALES	MALES	TOTAL
Primary	5	1	6
Secondary	3	6	9
Total	8	7	15

OCCUPATION

All clients were unemployed except for one who was employed as a domestic worker. None were self-employed. Two females were receiving disability grant (Table V).

TABLE V: OCCUPATION

OCCUPATION	FEMALES	MALES	TOTAL
Employed	1	0	1
Unemployed	5	7	12
On disability grant	2	0	2
Total	8	7	15

LANGUAGE

Thirteen clients in the sample were African and Zulu speaking, and two were English speaking which were, one white and one Indian. There were no Afrikaans speakers (Table VI). The referencing of participants will by number example Client 1 up to Client 15.

TABLE VI: LANGUAGE

LANGUAGE	FEMALES	MALES	TOTAL
English	1	1	2
Zulu	7	6	13
Total	8	7	15

RACE

The results show that there was one White, one Indian and thirteen Africans clients.

4.3 FIRST PROVIDER OF CARE

The results, show that for three clients the first provider of care were faith healers (FH), three were seen by traditional healers (TDH), one was seen at the PHCC, five were seen by a general practitioner (GP) and three clients were provided with care at the district hospital (DH) (Table VII).

TABLE VII: FIRST PROVIDER

FH	TDH	PHCC	GP	DH	TOTAL
3	3	1	5	3	15

4.4 PATHWAYS TO CARE FROM THE FIRST PROVIDER TO ADMISSION AND DELAY BETWEEN RECOGNITION AND ADMISSION

The pathway deals with the steps or consultations taken by the client before being admitted to MHI.

The bold line represents the first pathway and the broken line presents the subsequent pathway taken by the client to MHI. The double lined boxes indicate the decision-maker, who decided the choice of provider and service to be consulted.

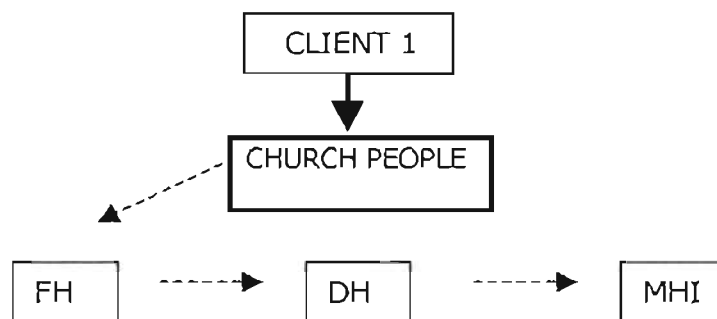


FIGURE 1: PATHWAY OF CLIENT 1

This client started praying continuously at church. She was, taken to a faith healer by the church people but did not get any better. She was then taken to the district hospital, where she was referred to the MHI. The delay between recognition of mental illness and admission to hospital was approximately six months.

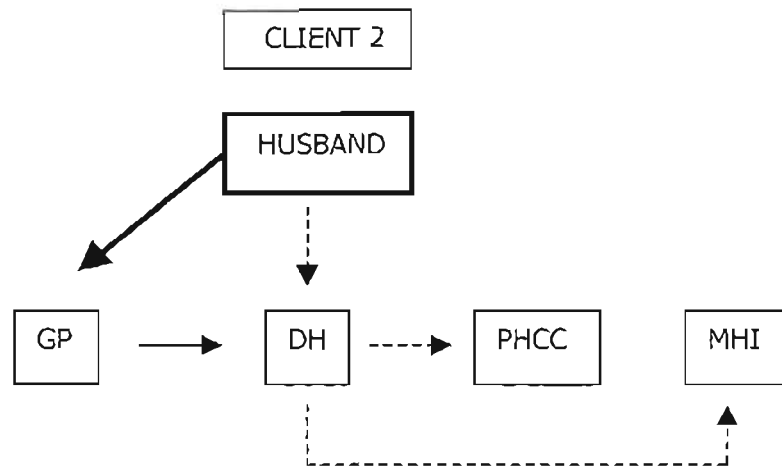


FIGURE 2: PATHWAY OF CLIENT 2

With this client mental illness started when she heard of her fathers' death. Her husband noticed odd behaviour and took her to a GP. The GP referred her to DH for further management. The client has been attending PHCC, until she defaulted, treatment in July 2001. She relapsed in August 2001 and was admitted to a DH and then transferred to MHI. The delay between recognition of mental illness and admission to hospital was 10 years.

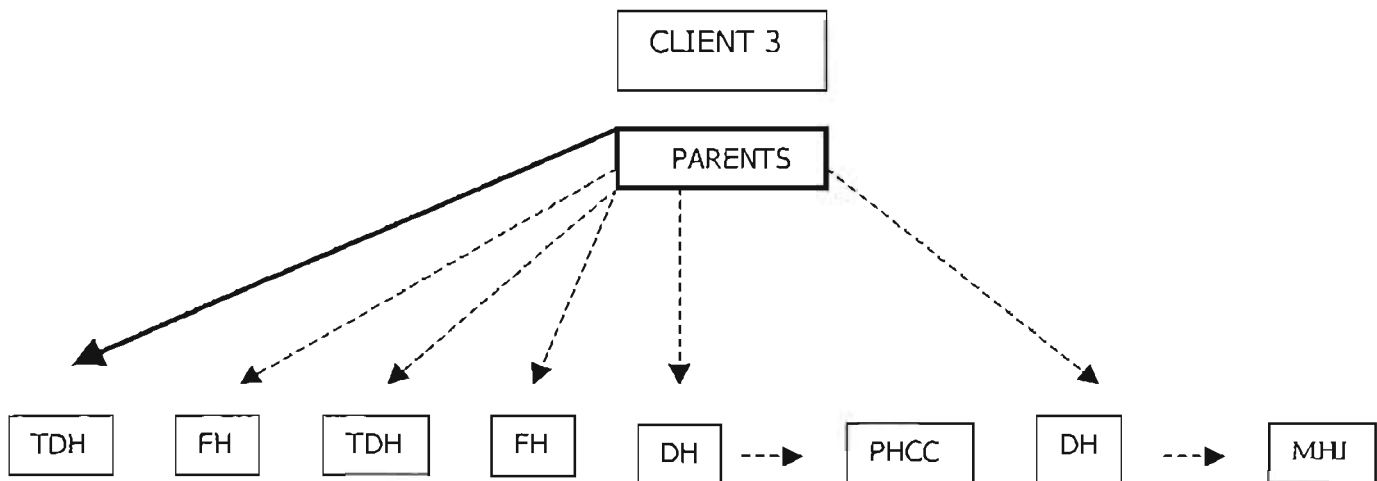


FIGURE 3: PATHWAY OF CLIENT 3

The first signs of mental illness in this client were noticed when she was sixteen years old. She believes that she was bewitched by her grandmother. She was taken by her parents to a TDH, FH, TDH, FH with no improvement. She was taken to DH where treatment was ordered and referred to PHCC for further management. She defaulted, treatment in August 2001 and was transferred to MHI. The delay between recognition of mental illness and admission to hospital was approximately nine years.

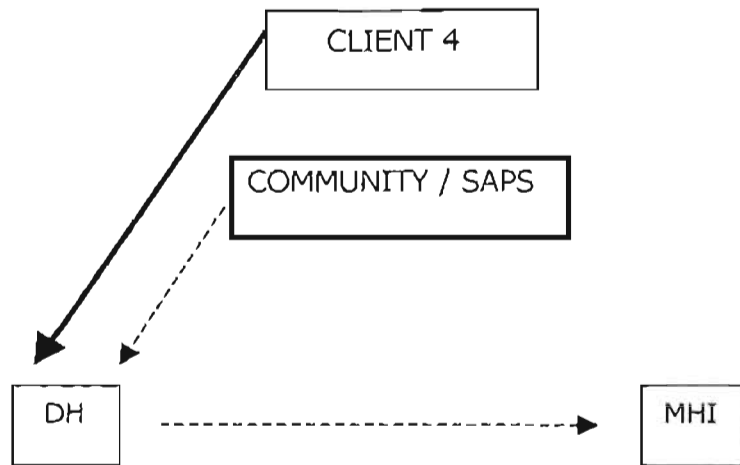


FIGURE 4: PATHWAY OF CLIENT 4

This client became mental ill, when her mother passed away. She went to Pietermaritzburg to look for work but auditory and visual hallucinations were troubling her. She fell pregnant and went to DH for delivery. She was diagnosed as having post partum psychosis. She was discharged to a home and her baby was taken by social services. She ran away from the home to the streets. She was violent and disruptive, the community called the police and was admitted into a DH, where further transferred to MHI. The delay between recognition of mental illness and admission to hospital was approximately fourteen months.

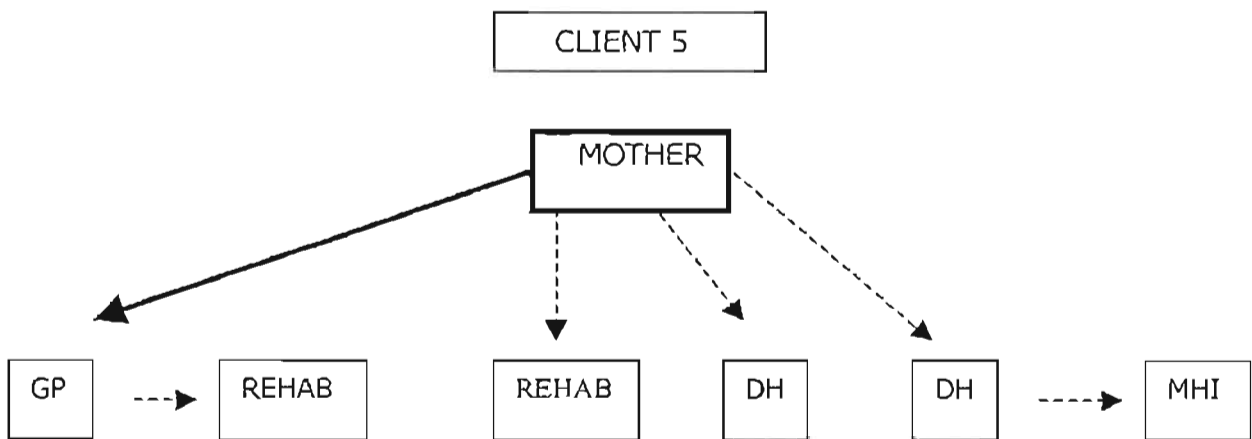


FIGURE 5: PATHWAY OF CLIENT 5

This client started abusing alcohol, dagga and mandrax at the age of ten years old. His father passed away when he was nine years old. Mother took him to a GP, who then referred him to a rehabilitation centre. There was no improvement and was sent to another rehabilitation centre then to DH and discharged home. He was admitted to a DH, which further transferred him to MHI, because of his depressive episode and suicidal ideation. The delay between recognition of mental illness and admission to hospital was approximately four years, eight months.

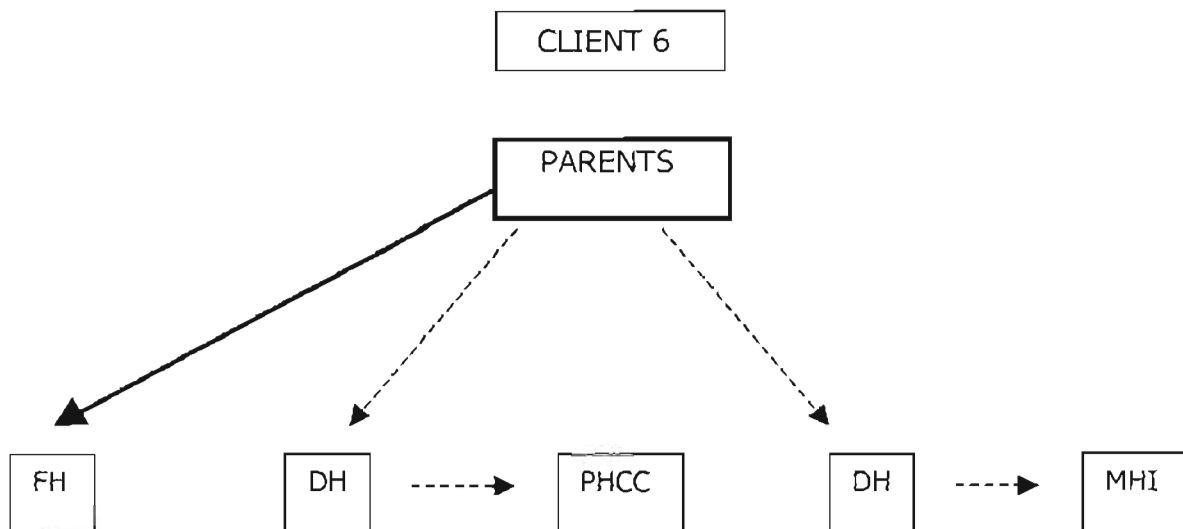


FIGURE 6: PATHWAY OF CLIENT 6

This client became mentally ill in 1996. She was talking to herself, undressing and not sleeping well. Her parents took her to a FH where she felt better using holy water (*isiwasho*). Her parents took her to a DH and treatment was ordered and discharged to attend PHCC. She defaulted treatment in February 2001 and relapsed in September 2001. She was admitted to a DH and was further transferred to MHI. The delay between recognition of mental illness and admission to hospital was approximately four years and eight months.

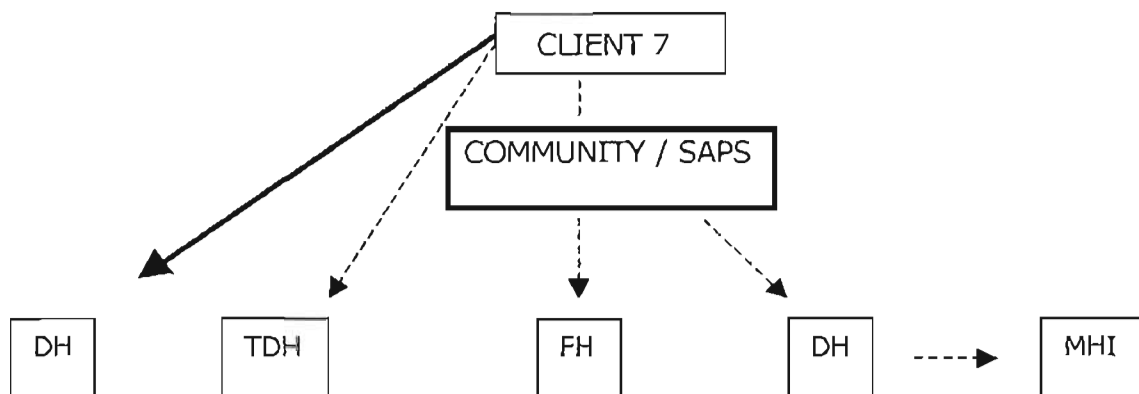


FIGURE 7: PATHWAYS OF CLIENT 7

This client was admitted in 1999 into a DH for delivery. She became psychotic after delivery and was diagnosed as having post partum psychosis. She was discharged home. She went to a TDH and then to a FH. She was symptom free for the whole of 2000. She became confused, undressed herself and seeing visions. The community called the police and was taken to a DH, where she was certified to MHI, for further management. Her journey to MHI took her twenty months

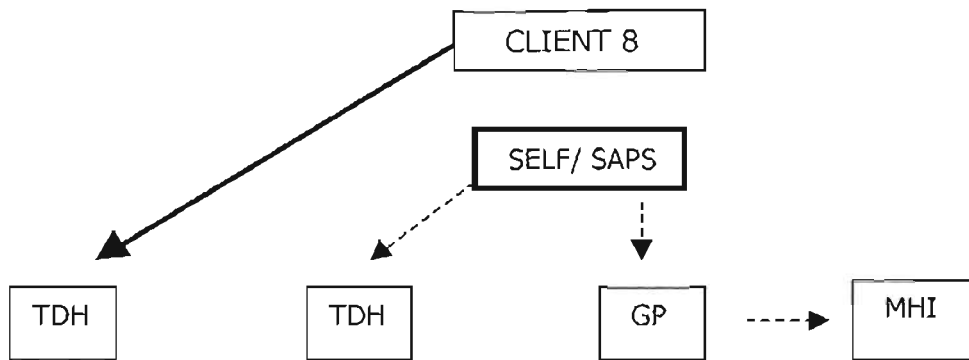


FIGURE 8: PATHWAY OF CLIENT 8

This client started behaving abnormally since 1995 but family never cared. He is an illegitimate child, who was brought up by his grandmother and uncles. He went to a TDH because he thought he was to become a *Thwasa* initiate. He went through a number of rituals as a *Thwasa* initiate. He had this vision of another TDH that could help him in his quest to be a Sangoma. When he got there, voices told him that it's not worth living, he must end his life. He attempted to drown himself. Police were called and was taken to a GP, who further referred him to MHI. His mental illness has taken him sixteen years before admitted to a MHI.

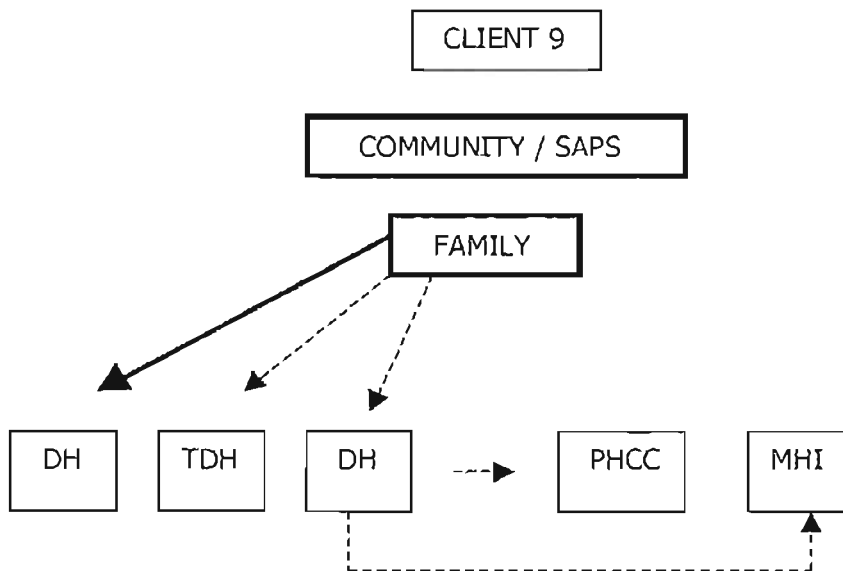


FIGURE 9: PATHWAY OF CLIENT 9

This client started undressing himself and smashing cars in 1995. The community called the police who took him to the police station. He was taken to DH for further management. On discharge his family took him to a TDH. He defaulted treatment and relapsed and admitted to DH, where he put on treatment and referred to PHCC. He defaulted treatment again and was admitted to DH, where he was certified to a MHI. The delay between recognition of mental illness and admission to hospital was five years and five months.

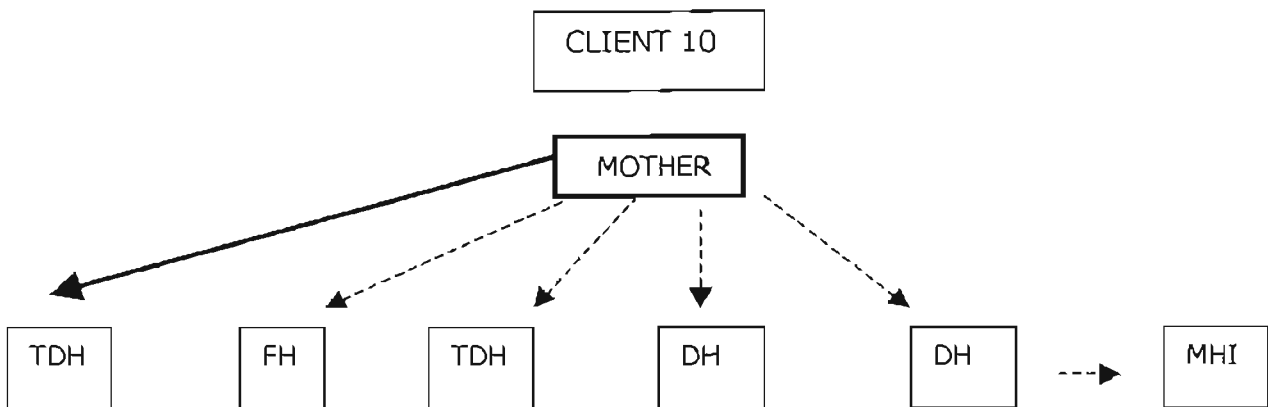


FIGURE 10: PATHWAY OF CLIENT 10

Mental illness for this client started in 1990 when he displayed bouts of aggressive and violent behaviour. His mother took him to a TDH, because he had auditory and visual hallucinations. From the TDH he was taken to a FH, and then back to a TDH. He was admitted to a DH, no follow up treatment then back to DH. He defaulted treatment, he relapsed and physically hurt his grandmother. The police were called and took him to a DH, where he was transferred to MHI. It took him eleven years to be admitted to a MHI.

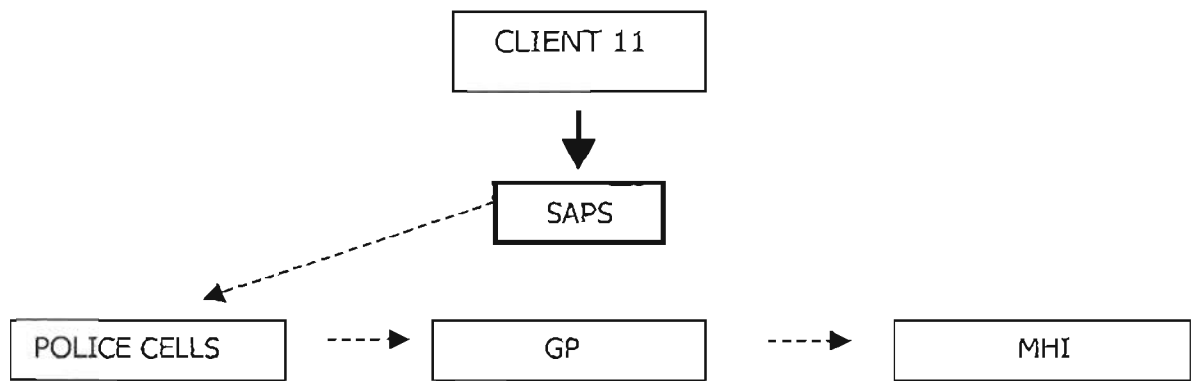


FIGURE 11: PATHWAY OF CLIENT 11

This client started having auditory and visual hallucinations for the first time at the end of September 2001. He walked from home to the next district, where the community there called the SAPS, because of his violent state. He was taken to the police station and was seen by a GP. The following day the GP transferred him to a MHI. He experienced a delay of one month in his pathway to mental health care.

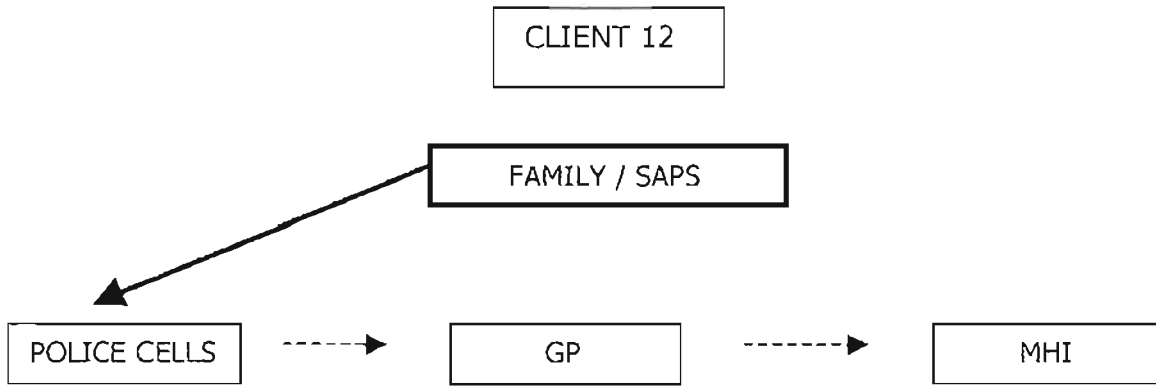


FIGURE 12: PATHWAY OF CLIENT 12

This client started swearing at people, praying loudly and accusing neighbours of being sorcerers (*abathakath*) on the 24th September 2001, following his cousin sister's death whom she believed was bewitched. She admits to have been religious since January 2001. Her family and the SAPS were involved in taking her to the GP, who certified her to MHI. Her journey to MHI was about ten months.

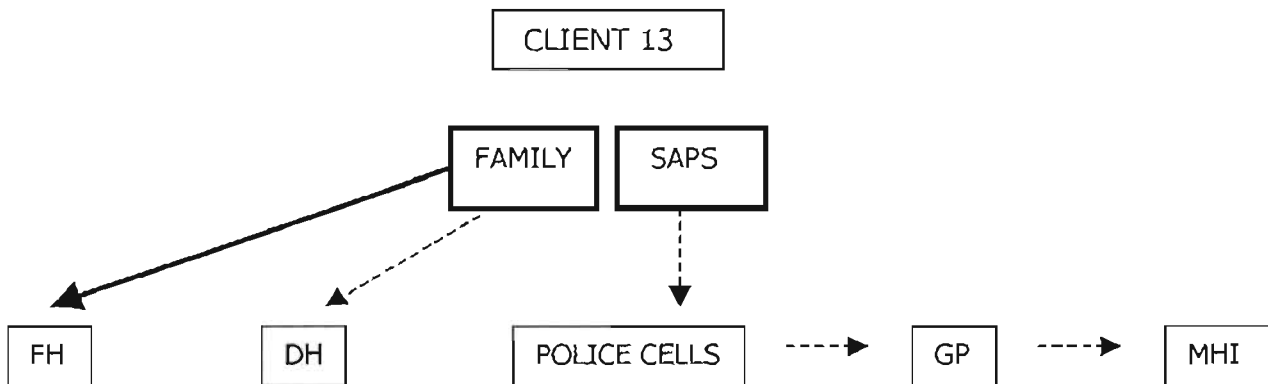


FIGURE 13: PATHWAY OF CLIENT 13

This client visited a FH in 1995, who prophesied that she will be mentally ill in the near future. In 1997, she had tactile and auditory hallucinations, undressed herself and ran away from home. Family took her to a FH, there was no improvement noted and was admitted to a DH. Discharge on follow up treatment. Defaulted treatment in April 2001. In September 2001 she was involved in stealing live chickens. Police were called and was taken to police cells. GP saw her three days later and was certified to MHI. It took her four years and eight month to be admitted to a MHI.

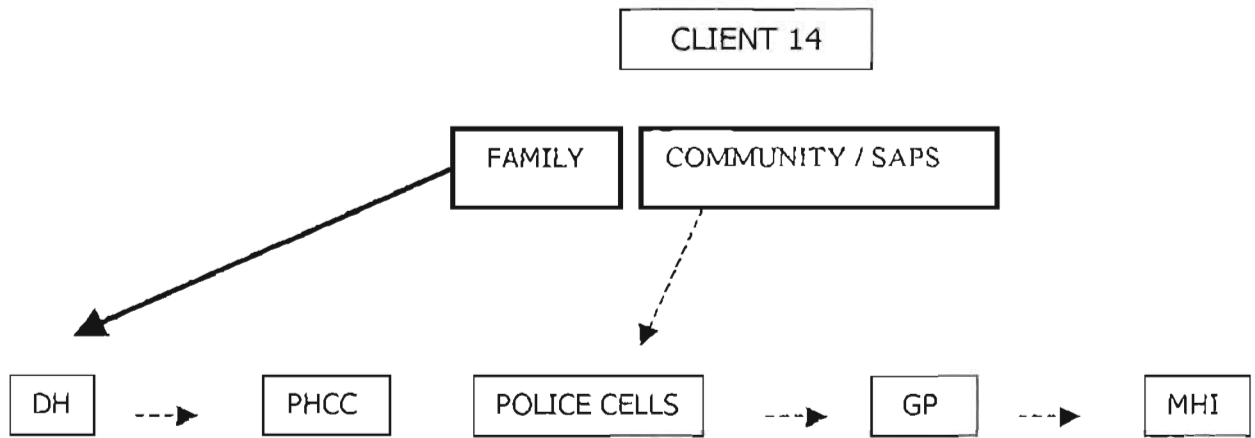


FIGURE 14: PATHWAY OF CLIENT 14

This client was mentally ill for the first time in 1998. He had auditory and visual hallucinations as well as delusions. Family took him to a DH, where follow up treatment was ordered and referred to PHCC. He defaulted treatment because of financial reasons and ran away from home to the streets. He relapsed, exposing himself and becoming a danger to the community. The community called the police, who took him to a police station. He was seen by a GP the following day and certified to MHI. It took him three years and eight months to be admitted to MHI.

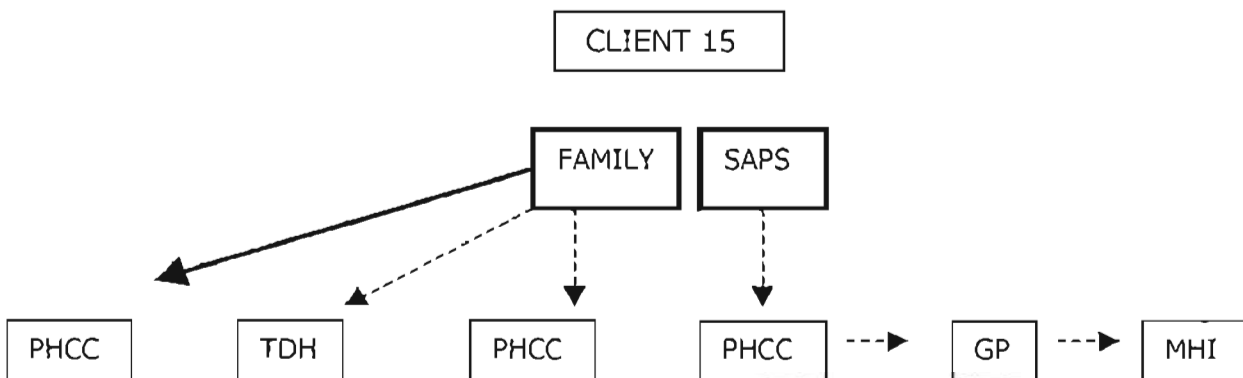


FIGURE 15: PATHWAY OF CLIENT 15

This client's mental illness started in 1996. He was aggressive, violent and abusing dagga and alcohol. He was, taken by his family, to PHCC, where he was seen by a doctor who ordered treatment for him. He attended PHCC until 1998, when he was taken to a TDH in Gauteng. He relapsed and was taken to a PHCC in Gauteng and was given treatment. He refused treatment in September 2001, because of side effects from the injection. He relapsed, destroyed property at home and police were called, who took him to PHCC. He was seen by a GP and certified to MHI. It has taken him five years and nine months before he was admitted to MHI.

4.5 THE DECISION MAKING ON THE PROVIDER OR SERVICE

This appears in Table VIII and shows that close family member like parents, husband and brother made the decision on choice of the provider for the seven clients.

Community members were involved in choosing for the two clients. The South African Police Services were also involved in bringing some of the clients to the health care providers to be consulted. Two clients decided on their own which provider to consult.

TABLE VIII: DECISION-MAKERS

CLOSE FAMILY	SELF	COMMUNITY	SAPS	TOTAL
7	2	2	4	15

4.6 SATISFACTION WITH HEALTH CARE AND PREFERRED HEALTH PROVIDER

Figure 16 shows that one client was satisfied with the TDH's care, who organized his admission to MHI (client 8). Client 6 was satisfied with FH, because she felt better after treatment. Client 15 was satisfied with PHCC, because he had his freedom unlike in the hospital where he is locked up behind bars. No client was satisfied with the GP because there is no examination or consultation with the client, except to fill the forms. Four clients were satisfied with DH care and eight clients were satisfied with MHI care because symptoms started disappearing.

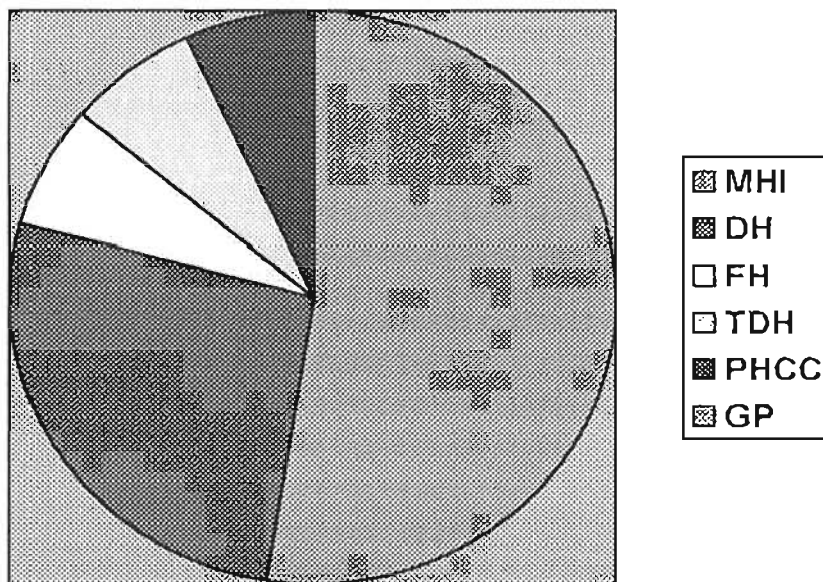


FIGURE 16: SATISFACTION WITH CARE

4.7 TIME DELAYS

The results appear in Table IX and show, that there are delays in seeking relevant and proper mental health care. In about eight (8) clients the delay was more than two and a half years. For some clients, the delay was approximately less than six months, and others a year to more than one year.

TABLE IX: TIME DELAYS BEFORE FORMAL CONTACT

MONTHS	CLIENT
0 - 6	3
7 - 12	1
13 -18	1
19 -24	1
25 -30	1
31 >	8
TOTAL	15

4.8 CONCLUSION

The results show that the African clients use the TDH and FH as their first port of call. These results also show the time delays experienced by these events, before admission to MHI. Cultural beliefs and values of clients determine their perception of illness and the subsequent pathway that will be taken.

CHAPTER FIVE

DISCUSSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This study despite its limitations provides an interesting picture of the pathways to mental health care. There are no studies in this country which can be used as a basis for comparison of current findings except for studies in other countries.

5.2 DISCUSSION OF SAMPLE

GENDER

Males and females were equally represented in the sample, 7 and 8 respectively.

Commander et al (1997) states that men were readily filtered through filters 4 and 5 than women.

AGE DISTRIBUTION

About seven of the clients in this study were between 20 to 29 years old, followed by 10 to 19 and 30 to 39 years at two clients each (Table II). This phenomenon is probably related to the fact that younger adults especially males, are more exposed and involved in substance abuse that lead to mental illness. This finding is in keeping with the study by Commander et al (1997), where the majority of admissions were young Black men with psychosis.

MARITAL STATUS

At the time of data collection, all the clients were unmarried except for two females that were married. Single women had shorter intervals in their pathways to mental health

care than women who live with their husbands or presence of children at home (Table III). These findings are in keeping with previous studies by Gater & Goldberg, 1991 & Pillay, 1993 who observed that isolated people lacking social support use the services more readily. Commander et al (1997) states that single men were more permeable through filters 4 and 5 than those that were married, that's indicative of the study because all males were single.

EDUCATION

The higher percentage of secondary education and six clients had primary education. No tertiary education or illiteracy was observed in the sample. The reason for this may be due to the fact that more educated persons earn better and are on a medical aid scheme and make use of private facilities. Those clients that make use of the state hospital are generally those that cannot afford private facilities (Pillay, 1993).

OCCUPATION

The results show that unemployment is very high (12 clients) in this study and is a determining factor in help seeking behaviour of people. According to Commander et al (1997) morbidity rates were highest for those that were economically inactive and were least likely to consult. This again is in keeping with the view that those who cannot afford private medical health facilities or who do not have medical aid would most likely use the state health care facilities.

Pillay (1993) cited Radford and Leeb (1986) in his study that unemployment has a negative impact on an individual's health. They further state that dismissal from work correlates with anxiety and distress after six months without work and is associated with

helplessness and despondency. Commander et al (1997) observed the highest permeability through 4th and 5th filters for the unemployed clients.

LANGUAGE

Table VI shows that the majority of clients are Zulu speaking. The reason is that Zulu is the most common ethnic group in Kwazulu Natal, the number of clients who are Zulu reflect the demographic composition of the community in that area.

5.3 PATHWAYS

5.3.1 FIRST PROVIDER OF CARE

The finding indicates that the first provider of care consulted depended on family support, location of provider of care, financial implications, how the family has interpreted the mental illness and the seriousness of the presenting symptoms. This is in keeping with the findings by Gater et al (1991), recognized that most referral pathways were from the indigenous healers especially in Rawalpindi and Bangalow districts. Some clients verbalized that if the family cared and had financial means, proper consultation would have been initiated. "*Kade ngaqala ukugula kodwa abasekhaya benganakile.*" (I have been mentally ill for a long time but my family took no notice of this). (client 8 & 10)

The findings also show that, if mental illness is interpreted as bewitchment *ukuthakatha* then a traditional or faith healer, is the first provider of care to be consulted, because of their expertise in dealing with African magic or "*Ukufa kwabantu*" (Ngubane, 1977 & Buhrmann,1982). The TDH and FH are living in the same community as the client and have reputation of healing completely certain illnesses including mental illness "*Umah*

wangisa kwiSangoma esalapha omunye umfana owayegula njengam!" (My mother took me to a TDH who had succeeded in curing a guy who was mentally ill like me).

(client10). Peu et al (2001), state that people in communities consult TDH and FH, because of shortage of equipment in health care centres, lack of transport, inadequate information about what health care services are available, and TDH and FH are respected, acceptable, accessible and available for continuity of care.

For this study, the first port of call is the TDH and FH which is not in line with the findings by Balestrieri et al (1994), Gater et al (1991), Burnett et al (1999) which found that GP was the most common mode of referral to mental health care. This difference is due to the difference in the demographic characteristics of the two samples. Five clients in this study were seen by GP through the involvement of the South African Police Services (SAPS) because of violent and aggressive behaviour.

According to the 1st level and 1st filter of the conceptual framework adopted from Goldberg and Huxley (1992), the identification of mental illness in the community depends on how the individual and family perceive mental illness, the beliefs and values as well as the cultural background of the individual. If bewitchment or *ukufa kwabantu* is suspected there will be delays to seek relevant mental health care (Ngubane 1977).

5.3.2 PATHWAYS TO CARE FROM THE FIRST PROVIDER TO THE TIME OF ADMISSION

The results show short and long pathways to mental health care (Table VIII). Some of the short pathways are attributed to the severity of the first signs of psychotic features that the client presented. Aggressive violent disruptive and undressing behaviours are the ones that prompted relatives and the public to seek appropriate mental health help

(Casey, 1990). Although filter 1 is most permissible given the high rates of psychiatric morbidity in the general population, it is clear that a substantial number of clients failed to seek assistance. The clients that had short pathways to mental health care were those that were a danger to themselves and to the public and also undressing themselves. Most of these clients, were brought by the SAPS, to GP's or MHI for admission. (Burnett et al. 1999)

Marino et al (1995) talk about an "American By Pass" which occurs when a person with an incident mental disorder is seen by a specialist in a mental health without being seen by a general medical doctor. This study is in line with this By Pass because of those clients that required urgent psychiatric assessment and treatment due to their serious psychotic features. Gater and Goldberg (1991) & Balestrieri et al (1994) associated the shortest total delays with appearance of psychotic symptoms, disturbed behaviour and self-harm.

The results also show that clients with insidious onset of mental illness like the ones who pray non stop are never recognize in time as mentally ill, as well as those that are abusing alcohol and drugs. These results, are also observed by Gater and Goldberg (1991), who claim that alcohol and drug related problems have a long interval, before seeking care and consequently have the longest total intervals.

5.3.3 THE DECISION - MAKER ON THE CHOICE OF THE PROVIDER OR SERVICE

The results in Table IX show that family members are the ones that make the decision as to who to see and where to take the client for consultation In seven clients. In keeping with other research studies emphasis is on the family or friends support as the

major guide and support for the client or even determining the compulsory admissions in MHI, involving the police (Davies et al, 1996, Koffman et al 1999, Cole et al,1995). In four clients of the sample had the SAPS involved in bringing them to mental health services for professional help. Burnett, et al (1999) define police involvement as when the client that was taken into care by the police either from a public place or following a request from the clients family. Koffman et al (1997), Cole et al (1995), Davies et al (1996) and Gater and Goldberg (1991) all agree that police involvement shorten the clients journey to mental health care because of presenting violent and self-harm psychotic behaviour as well as the absence of family or friend support system.

5.3.4 SATISFACTION WITH CARE AND PREFERRED HEALTH PROVIDER

The results in Figure II show that most clients were satisfied with the care given to them especially in district hospitals and MHI, because this is where proper treatment was ordered and given. All clients attributed their satisfaction to the fact that they can think clearly and getting better everyday. "*Uwele-wele womsindo ebengiwuzwa ezindlebeni awusekho*" (The ringing and cluttering of noises I used to hear is no longer there). (client 11) "*Ngiyalala manje, ngiyadla kahle futhi ngiyageza*" (I can now sleep, eat and bath myself). (client 4). All the worrying symptoms like auditory hallucinations, sleepless nights are over, poor appetite and poor hygiene is no longer there.

5.3.5 HOW ARE THE PATHWAYS INFLUENCED BY DEMOGRAPHIC FACTORS

The findings in Table VII show that most of the African clients (13) consulted with faith and traditional healers in these results are in line, with those of referral pathways from indigenous healers, as observed by Gater et al (1991). The results also show that the

White and the Indian clients (2) consulted a GP as their first port of call when the first signs of psychotic features appeared. The belief system of bewitchment/sorcery or *ubuthakathi* as identified by Ngubane (1977) and Buhrman (1982), is still entrenched in the way of thinking and lifestyle of the African people thus, long periods of delay are experienced. The lack of social and family support as well as poverty and unemployment results in people wandering away from their familiar surroundings and ending up in streets as mentally ill homeless clients. The study confirms the fact that FH and TDH are still popular, respected and enjoy a good status in the rural communities. They are living with clients in the communities, accessible 24 hours and reasonable in price than western biomedical staff especially in rural and disadvantaged areas. This is supported by Gater et al (1991), Nevin (2000) and Peu et al (2001), who advocate education, integration and working with the FH and TDH in the recognition and referral of the mentally ill clients. Poverty and unemployment of most clients seem to be a problem to consult their GP and have access to mental health services because of financial constraints (Commander et al 1997).

5.3.6 DELAYS ALONG THE PATHWAY TO MENTAL HEALTH CARE

The delays to get proper mental health care is evident and supported by the high number of clients (8), (Table IX) which shows how entrenched the belief system of bewitchment / sorcery / *ukuthakatha* is amongst Africans (Edward et al 1982, Swartz, 1998, Daynes & Msengi 1979). Ngubane (1977), Gumede(1990) and Shai-Moloko (1996) have stated that 80% of African population still consult their FH and TDH for their illnesses. It is also important to understand culture and mental health and to remember that human activity is not free from cultural influence (Swartz 1998). Pillay (1993),

observed a 5.8 weeks over a year in attendance when clients first suspected that they were ill, which depended on the nature of illness unlike with mental illness especially when the onset is insidious. This delay of Africans coming late to the health service for assistance is also supported by Uys (1986) and Koffman et al (1997), where they all agree that these clients do not present early with mental health problems until it is too late to prevent admission to a MHI. "*Ngayekelwa ngaba kithi, manje ngila esibedlela*" (My family ignored my mental illness, now I am here in hospital). (client 8).

The clients that had the shortest delays of less than six months had presented with self harm and aggressive behaviours. Police involvement was the only alternative to use to help them. This police involvement is in keeping with the studies of Davies et al, (1996), Cole et al, (1995) & Burnett et al, (1999), who observed that African Caribbean clients who lived alone with no family or friend support system are likely to be candidates for compulsory admissions.

Gater et al (1991) reported that the delay between first developing symptoms and first seeking care varied from 32 – 1 week in all the centres that the surveys were done. For this study the lowest delay was six months for three clients in the sample and the longest delay was sixteen years, which is (8) clients. The delays at the main health providers, which are the FH, TDH, PHCC, GP, DH and MHI, are depicted in Table IX.

This study shows that the highest delays in clients seeking proper mental health care is amongst the FH and TDH. This is supported by the changing of FH and TDH, due to lack of improvement in their illness and dissatisfaction with the treatment which in turn results in delays of many years.

According to this study the clients passed through filter 1 – identification of mental illness in level one, which is the community. A few clients moved to the second level and

were filtered through the second filter, where either the family members or community had the ability to detect the mental disorders. Those that were detected managed to be referred to the third level and filter, where they were seen at the DH or even transferred to the MHI.

There are eight clients that delayed and did not filter through because they never consulted the health professionals but were first seen by FH and TDH.

This study has also shown that client defaulted treatment after having been stabilized in DH and were attributing this default to economic factors. The study shows that 80% of clients were unemployed and single, which makes them more permeable to fourth and fifth filters (Commander et al, 1997). One client defaulted treatment because his siblings kept on referring to his treatment "*Phuza amaphilisi akho okuhlanya.*" (Take your tablets for madness). This remark is in keeping with what Cole et al, 1995 cited Harrison et al, 1989, stating that mental illness carries more stigma in black communities, which when combined with other factors like unemployment and poverty, might explain the delays in reaching services and an increased likelihood of adverse pathways.

5.4 RECOMMENDATIONS

In the light of the findings and problems identified in this study, the researcher makes the following recommendations:

COMMUNITY BASED MENTAL HEALTH SERVICES

- Cooperation, support and liaison with community based mental health care services and good working relations between health care providers, including faith and traditional healers, needs to be pursued and implemented, and is in keeping with the National Health Plan (1994).
- Making psychotropic drugs available at all levels of health care in order to provide first line treatment thus preventing relapse, reduce disability and shorten the course of many disorders.
- Giving care in the community to improve the quality of life, of individuals with chronic disorders. Community based services can help in early detection and intervention, aiming at limiting the stigma of taking treatment.
- Providing rehabilitation services along with availability of crisis support, protected housing and sheltered employment.

PSYCHO-EDUCATION

- Nursing curriculum in South Africa should be designed in terms of transcultural principles so as to enable graduates to render congruent cultural nursing care.
- Detailed information should be given to health professionals about the possible pathways to care that clients might take as to encourage acceptance, understanding and appreciation of where they come from in their health seeking behaviour.

- Health professionals should embark on educating traditional and faith healers in the concepts of mental illness, the need to take medicines and follow up care and recognition of signs for referral to health professionals, thus shortening the clients mental journeys to proper health.
- Community/public education and awareness campaigns on mental health should be launched in order to reduce stigma and discrimination, increase the use of mental health services and bring mental and physical health care closer to each other.
- Educate the SAPS about how to respect and handle mentally ill patients and so as to avoid them treating the clients like common criminals.

CLINICAL NURSING

- More attention should be given on psycho education of the client, the family and the community about mental illness.
- Support groups should be organized for relatives and carers of mentally ill clients, to maintain the protective buffer they provide.
- The importance of primary care in the detection and management of severe mental illness in disadvantaged communities
- Psychiatric units within the general hospitals so that people can be treated in their own communities

RESEARCH

The findings of this study suggest that further research is needed that will take the following points into consideration:

- Increasing the sample size.
- Interviewing of family members, friends and other relevant people who have been in contact with the client under study for collateral information.
- Period of data collection should be approximately six months to have a broader view of the study.
- The pathways of care and satisfaction of those clients who never reach the MHI.

5.5 LIMITATIONS

The research was limited to the first admissions in pre-discharge units of the Mental Health Institution, which was Town Hill Hospital. The sample size was small and therefore cannot be generalized to other studies.

- Families, friends or other people who have been in contact with clients were not interviewed for collateral information.
- This study would have benefited from more detailed examination of how separate services, especially faith and traditional healers, general practitioners and district hospitals managed individual clients.

5.6 CONCLUSION

The study has provided useful information about the pathways taken by clients to mental health care. It highlighted the delays within the faith and traditional healers.

Delays with the client and his or her family in recognizing first signs of mental illness and seeking appropriate professional help. Cultural background of an individual and how mental illness is interpreted, according to his or her value system determines who and where to go for help. The study indicated the need for integration of faith and traditional healers into the health system, so as to prevent delays.

Involvement of family members and neighbours in the care of mentally ill clients in order to lessen, the stigma attached to mental illness.

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FACULTY OF COMMUNITY & DEVELOPMENT DISCIPLINES

COURSEWORK MASTER'S RESEARCH PROPOSAL

NAME: L.P. Mkize Student No.

SCHOOL AND PROGRAMME School of Nursing
M. Nursing

Credit points allocated to Research Project: 48C

SUPERVISOR	CO-SUPERVISOR
NAME: <u>L.R. Uys</u>	NAME:
SCHOOL: <u>Nursing</u> ✓	SCHOOL:
DISCIPLINE: <u>Mental Health Nursing</u>	DISCIPLINE:
UNIVERSITY: <u>UND</u> ✓	UNIVERSITY:

PROVISIONAL TITLE:

Pathways to mental health care

I confirm that I have discussed this project with my supervisor and am satisfied with the proposed outline and practicality of the project.

Applicant's signature: [Signature]

Date: 12/09/01

I am satisfied with the merit and practicability of this project

Supervisor's signature: [Signature] Date: 31/8/2001

Approved by the School Board: Signature: [Signature] Date: 31.8/2000

Verified by the Faculty Post Graduate Committee:

Signature: [Signature]

Date: 13.9.2001



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RESEARCH ETHICS COMMITTEE

Student: LP MKIZE

Research Title: PATHWAYS TO MENTAL HEALTH CARE

A. The proposal meets the professional code of ethics of the Researcher:

YES NO

B. The proposal also meets the following ethical requirements:

	YES	NO
1. Provision has been made to obtain informed consent of the participants.	X	
2. Potential psychological and physical risks have been considered and minimised.	X	
3. Provision has been made to avoid undue intrusion with regard to participants and community.	X	
4. Rights of participants will be safe-guarded in relation to:		
4.1 Measures for the protection of anonymity and the maintenance of confidentiality.	X	
4.2 Access to research information and findings.	X	
4.3 Termination of Involvement without compromise.	X	
4.4 Misleading promises regarding benefits of the research.	X	

Signature of Student: [Signature] Date: 12/09/01

Signature of Supervisor: [Signature] Date: 31/8/2001

Signature of Head of School: [Signature] Date: 31/8/2001

Signature of Chairperson of the Committee: [Signature] Date: 11.9.2001
 (Professor S P Henzi)

APPENDIX I
CONCEPTUAL FRAMEWORK
FIVE LEVELS AND FOUR FILTERS

Level 1	The Community	GENERAL ILLNESS
	1 st Filter identification of illness
Level 2	Total mental morbidity – attenders in PHC	
	2 nd Filter Ability to identify disorder
Level 3	Mental illness identified by doctors (conspicuous psychiatric morbidity).	
	3 rd Filter Referral to mental illness services.
Level 4	Total morbidity – mental illness	
	4 th filter Admission to psychiatric beds.
Level 5	Psychiatric in – patients	

(Adapted from Goldberg and Huxley, 1992)

APPENDIX II
SECTION A
DEMOGRAPHIC DATA

Pseudonym.....

Age

Gender Male

Female

Marital status Married

Divorced

Single

Separated

Co-habiting

Education Illiterate

Primary

Secondary

Tertiary

Occupation Employed

Self employed

Unemployed

Language: English

Zulu

Afrikaans

SECTION B

PATHWAYS QUESTIONNAIRE

Questions	Probes
1. How did you first realize you were	You / family
Sick?	Others
2. How were you admitted to hospital?	Tell me your story of how you were Admitted
	How long before you were admitted?
	Who made the decision?
	Were you satisfied with the help given?
3. What happened after the consultation	Where did you go after the first Consultation?
	Were you given treatment?
	Were you admitted to hospital?
4. Which provider gave you the most satisfaction?	Why?

APPENDIX III
CONSENT TO PARTICIPATE

School of Nursing
University of Natal
Durban

Dear Sir/ Madam,

I am currently registered with the University of Natal(Durban) for a Masters degree in Mental Health Nursing. I am doing a study on:

PATHWAYS TO MENTAL HEALTH CARE IN KWAZULU-NATAL PROVINCE
SOUTH AFRICA.

The results of the study will be used to improve the mental health services through understanding of pathways of care taken by clients in order to minimize the delays as well as the disability caused by chronic mental illness.

You are requested to complete the questionnaire on personal data and to answer the questions given by the researcher to you. Notes and tape recording will be done during the interview.

Anonymity and confidentiality will be maintained at all times. Completion of this questionnaire is voluntary and you are free to terminate your participation at any time.

It also means that you have given consent to be part of the study.

Your cooperation in this matter is highly appreciated,

Yours faithfully,

L.P. Mkize (Mrs.)

.....

200275731

APPENDIX IV

PARTICIPANT SIGNED CONSENT

I..... agree to participate in the research of PATHWAYS TO MENTAL
HEALTH CARE IN KWAZULU-NATAL PROVINCE SOUTH AFRICA. I promise to answer all
questions as accurately as possible. I also

understand that the information I give, will be kept in confidence and be only used for
research purposes. I also understand that I can stop participating at any moment.

Thank you,

The Participant.

Sign.....

APPENDIX V

P.O. Box 313
Plessislaer 3216
17th September 2001

Mental Health Department
Private Bag
Pietermaritzburg
Dear Sir/Madam,

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH STUDY AT YOUR
INSTITUTION

I hereby apply for permission to conduct a research study at your institution. I am conducting the study for the fulfillment of the requirement for the Masters Degree in Mental Health Nursing Coursework and I need your assistance and cooperation. My research topic is:

PATHWAYS TO MENTAL HEALTH CARE IN KWAZULU-NATAL PROVINCE SOUTH AFRICA.

This study of pathways to mental health care is an important topic that might clarify understanding and yield insight into the working of mental health care system in South Africa.

Knowledge gained will help increase understanding of levels and filters of pathways to care in order to enhance the planning of mental health services.

Anonymity and confidentiality will be maintained and all the information will be held in strict confidence. Research proposal enclosed.

Hoping that my request will reach your most favourable attention,

Yours Faithfully,
Mkize LP (Mrs.).

Sign.....

Student No: 200275731

P.O. Box 313
Plessislaer 3216
17th September 2001

The Chief Medical Superintendent
Townhill Hospital
P.O. Box 400
Pietermaritzburg

Attention: Dr J Walker

Dear Sir,

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH STUDY AT YOUR
INSTITUTION.

I hereby apply for permission to conduct a research study at your Institution. I am conducting this study for the fulfillment of the requirement for the Masters Degree in Mental Health Nursing Coursework and I need your assistance and cooperation. My research topic is:

PATHWAYS TO MENTAL HEALTH CARE IN KWAZULU-NATAL PROVINCE SOUTH
AFRICA.

The study of pathways to mental health care is an important topic that might clarify understanding and yield insight into the working of mental health care system in KwaZulu Natal in particular and South Africa in general. Knowledge gained will help increase understanding of levels and filters of pathways to care in order to enhance the planing of mental health services.

Anonymity and confidentiality will be maintained and all the information will be held in strict confidence. The research will be done only during weekends and/ or public holidays so as not to interfere with the running of the units.

I enclose the research proposal.

I hope my request will reach your most favourable consideration,

Yours faithfully,

Mkize LP (Mrs.)

Sign.....

Stud No 200275731

P.O. Box 313
Plessislaer 3216
17th September, 2001

The Chief Nursing Service Manager
TownHill Hospital
P.O.Box 400
Pietermaritzburg

Attention: Mrs V. Ngubane

Dear Madam,

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH STUDY AT YOUR HOSPITAL.

I hereby apply for permission to conduct research at your hospital. I am conducting this study for the fulfillment of the requirement for the Masters Degree in Mental Health Nursing Coursework. I need your assistance and cooperation. My topic is:

PATHWAYS TO MENTAL HEALTH CARE IN KWAZULU-NATAL PROVINCE SOUTH AFRICA.

This study of pathways to mental health care is an important topic that might clarify understanding and yield insight into the working of mental health care system in KwaZulu Natal in particular and South Africa in general. Knowledge gained will help increase understanding of levels and filters of pathways to care in order to enhance the planning of mental health services.

Anonymity and confidentiality will be maintained and all the information will be held in strict confidence. The research will be done only during weekends and/ or public holidays so as not to interfere with the running of the units. I enclose the research proposal.

Hoping that my request will reach your most favourable attention,

Yours faithfully,
Mkize LP (Mrs.)

Sign.....
Stud No 200275731

MIDLANDS HOSPITAL COMPLEX

(Fort Napier Hospital/Town Hill Hospital/Umgeni C & R Centre)

Tel. No. : 033-3428741

Fax. No. : 033-3421553

E-mail : H993763@DOHKO.KZNTL.GOV.ZA

P.O. Box : 400

Isikhwama Sepost : Pietermaritzburg

Privaatsak : 3200

Enquiries :	Date :	Reference :
Imbuso : J G Walker/mn	Usuku : 17 October 2001	Imkomba :
Navrae :	Datum :	Verwysing :

Mrs L P Mkize
P O Box 313
PLESSISLAER
3216

Dear Madam

APPLICATION TO CONDUCT RESEARCH AT TOWN HILL HOSPITAL

Your letter of 17th September 2001 has reference.

Approval is hereby given for you to undertake your research – "Pathways to Mental Health Care" – at Town Hill Hospital, on condition that:

1. The collection of data is done by yourself, and does not interfere in the treatment and/or care of the patients.
2. You report to the Matron-on-duty.
3. You obtain written consent from the patients, as I am not sure whether the "consent to participate" (appendix III) is sufficient for this purpose.
4. You submit your final research report to myself on completion of the research.

While I believe the research proposal is worthwhile, and could be of value in the planning and development of mental health services, there are certain points I would like to make regarding the proposed research:

1. Is your sample group of 10-15 patients too small for it to be statistically significant ?
2. What about patients who have not had to be admitted to a psychiatric hospital, but have been successfully treated at community or district level ?

I do apologise for only replying now, but the chairperson of our Research and Ethics Committee had resigned and no new chairperson had yet been appointed. The hospital has just been through the accreditation process and this has further extended an already full timetable.

I wish you therefore everything of the best and look forward to the results obtained.

Yours faithfully

A handwritten signature in black ink, appearing to read 'J. Walker', with a long horizontal flourish extending to the right.

CHIEF MEDICAL SUPERINTENDENT

APPENDIX II
SECTION A
DEMOGRAPHIC DATA

Igama ozinika lona.....

Ubudala

Ubulili

Owesilisa

Owesifazane

Ushadile

Uhlukene

Awushadile

Uhlala ngokhlukana

Ukipitile

Imfundo

Awuyanga esikoleni

Imfundo ephansi

Imfundo ephakathi

Imfundo ephakeme

Usebenza phi?

Uqashiwe

Uyazisebenza

Awusebenzi

Ulimi olukhulumayo

Isingisi

IsiZulu
Isibhunu



SECTION B
PATHWAYS QUESTIONNAIRE

1. Waqala nini ukugula?
 - Wazibona wena?
 - Wabonwa abomndeni wakho?
 - Wabonwa abanye abantu?
2. Ngitshele waluthola kanjani usizo?
 - Wahlala isikhathi esingakanani phambi koba uze la esibhedlela?
 - Ubani owenza isinqumo sokuthi ulale esibhedlela?
 - Waya kuphi ngemuva kokubonwa abezempilo?
 - Lwakwanelisa yini usizo abakunika lona?
3. Kwenzakalani emva kosizo owalutholayo?
 - Wanikezwa imithi kumbe olunye isizo?
 - Walaliswa esibhedlela?
4. Ikuphi lapho wathola khona usizo olugculisa okudlula lonke usizo owaluthola?
 - Kungani usho njalo?

APPENDIX III
CONSENT TO CLIENTS

School of Nursing
University of Natal
Durban

Mhlonitshwa /Mhlonishwakazi,

Okwamanje ngingumfundi e University of Natal eThekwini, ngenza I Masters Degree, kumkhakha wokuvikela nokulapha izifo zengqondo.

Ngizama ukucwaninga ngezindlela abantu abazihambayo baze bafikelele ekutheni balaliswe esibhedlela saba gula ngengqondo.

Imiphumela yalezi zifundo izosetshenziselwa ukuthuthukisa imikhakha yezempilo kwezengqondo ngokuciphisa ukubambezela nokukhubazeka okudalwa ukugula ngengqondo isikhathi eside.

Uyacelwa ukuthi uphendule ngendlela imibuzo ozoyibuzwa. Imibuzo ozobuzwa iphathelele nawe nobuwena. Izimpendulo zakho ziyo bhalwa phansi noma ziqoshwe yilowo oyobe uxoxisana naye.

Okukhulumile kuyo gcinwa kuyimfihlo ephakathi kwenu nobabili. Uma uzwa ukuthi awuthandi ukuqhubeka nokuphendula imibuzo, ungasho noma ucele ukuma, lokhu kuligunya lakho. Ngokuvuma ukuphendula usunike imvume yokuxoxisana nalowo ozobe ekubuza imibuzo.

Ngingajabula uma singazwana futhi sizimisele ukuze konke kuqhubeke kahle.

Yimi ozithobayo,

.....
L.P.Mkize (MRS). 200275731

APPENDIX IV

ISIVUMELWANO ESISAYINIWE

Mina..... Ngiyavuma ukubandakanyeka kucwaningo lwezindlela abantu abazihambayo befuna usizo baze bafikelele ekutheni balaliswe esibhedlela sabagula ngengqondo.

Ngiyethembisa ukuphendula yonke imibuzo. Ngiyaqonda ukuthi engikukhulumile kuyimfihlo yami nalowo engixoxisana naye. Ngiyazi futhi ukuthi uma ngizwa ngingasathandl ukuqhubeka nokuphendula imibuzo, ngosho noma ngicele ukuma ngoba kuyilungelo lami.

Ngiyabonga.

Sign.....

APPENDIX VI

LIST OF ABBREVIATIONS USED

MHI	Mental Health Institution
SAPS	South African Police Services
PHC	Primary Health care
PHCC	Primary Health Care Clinic
MHC	Mental Health Care
TDH	Traditional Healer
FH	Faith Healer
GP	General Practitioner
DH	District Hospital
THH	TownHill Hospital
REHAB	Rehabilitation Centre