THE TRAJECTORY OF PATIENTS THROUGH THE WOMEN'S ADMISSIONS UNIT AT VALKENBERG HOSPITAL: THE FACTORS INVOLVED.

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ABSTRACT

Mental health services in South Africa have had a long history of segregation under the Apartheid regime. This situation came under the spotlight as the country prepared for the arrival of the new dispensation. Efforts towards the integrating of institutions highlighted, amongst many other things, the issue of equal accessibility to these services. In particular the issue of accessibility to health care as regards the language of patients was an issue.

This research investigates the factors that influence the trajectory of female psychotic patients through the admissions unit at Valkenberg hospital. In particular it explores the role of language and race in the management of patients. This research had two parts; a quantitative archival study of the data and a qualitative study. The first part of the study investigated archival material in patient folders in the registry at Valkenberg hospital (N=118). Female patients who had been admitted between January 2001 and March 2001, and who met the inclusion criteria were studied. The data was statistically analysed to establish if there is a relationship between race and language and the management of patients. The results from the first part of the study prompted the next part of the study, in that there was a contradiction in what the archival material revealed to what seemed to be the perceptions of nursing staff at the time. In the second part of the research, semi-structured interviews were conducted with six members of nursing staff, to explore their experiences regarding the role that race and language play in the management and transfer of patients. Data analysis involved thematic analysis of the interview transcripts.

The results from the archival data suggest that there is no relationship between the race and language of patients and their management in the unit. The results from the interviews with nursing staff suggest that in their experience, language plays a great role in the management of patients, but not all nursing staff agreed that it influenced the transfer of patients. Race was found to be of no great significance in the management of patients. The nursing staff reported that there were many factors that influenced the management and transfer of patients, as well as problems they encountered in the admission process.

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CHAPTER ONE: INTRODUCTION

This dissertation explores the factors that are involved in the trajectory of patients admitted to the women's admissions unit, through Valkenberg Hospital.

The South African health care system has had to undergo a significant amount of transformation, since the end of the era of apartheid. The health care system was previously racially segregated under the policy of apartheid, and has had to go through a challenging period of desegregation. This segregation was said to have been "one of the most visible manifestations of apartheid practices in health." (Chapman & Rubenstein, 1998).

In the late 1970s, the World Health Organisation (WHO) reported 'gross inequalities' in mental health in South Africa (WHO, 1983). The American Psychiatric Association conducted an inspection of the then segregated facilities, run by Smith Mitchell. The report from this found that the general conditions for blacks were inferior, to that of whites, in these institutions (Torkington, 2000). Since then, the desegregation of health services has happened, but the services and conditions in institutions might still not be equal due to entrenched political and ideological structures, and the immense amount of work needed to reverse past inequalities.

There is a growing body of literature addressing the role of language in the integrated mental health services, and difficulties of studying the role language plays within institutions without looking deeper into issues of ethnicity, culture and identity (Drennan, 1999; Swartz, 1998; Swartz et. al, 1997).

This research will try to follow up on the desegregation of the mental health services, and attempt to illuminate the present status of patients and care-givers. The focus in particular will be what factors have an effect on the transfer of patients from ward to ward. Firstly, the research will attempt to identify if there is a direct correlation between the race and language of a patient, and their management within the hospital. Secondly, it will shed some light on the experiences of the staff, in particular to ascertain what their

experience regarding the race and language of patients has been, and if they have experienced it as a determinant of patients' treatment in hospital.

1.1 Background and motivation for the study:

The women's admissions unit at Valkenberg hospital, which is called the Women's Mental Health Unit, is divided into three wards. The first is ward 14, which is a closed ward, designed specifically for the containment of behaviourally disturbed patients. Patients are admitted here when they first present for admission. Here they are managed until they are contained sufficiently to move to the next ward. The next ward is ward 5, a closed ward for the less behaviourally disturbed patient. Here patients stay until they are able to move to ward 3, where patients are being prepared for discharge. This is an open ward, where patients participate in occupational therapy, group therapy and individual therapy. This ward would not be suitable for actively psychotic patients. As patients' conditions improve, the policy of the unit is for them to be moved to the appropriate wards, in order to make space for patients being admitted. Therefore, to look at the trajectory of the patients, is to look at the exact path of improvement they follow from admission until their discharge from the unit.

Each ward has a staff component that consists of two psychiatric consultants, who are in charge of the unit; four psychiatric registrars, who complete a six month placement working in all three wards; two professional nurses and two nurse assistants per shift, in each of the three wards; one permanent social worker, one permanent clinical psychologist; one permanent occupational therapist; and one intern clinical psychologist, who is on the unit for a four month placement. Up until end of 2001, there was a part-time interpreter based only in ward 14 for approximately two years. The psychiatric consultants, registrars, social worker, occupational therapist, clinical psychologist and intern clinical psychologist are based in all three wards. The nursing staff is spread across the three wards. Other than the nursing staff and the interpreter, each of the staff is expected to be a case manager, for a certain number of patients. Although the unit is primarily a multi-disciplinary team, each case manager is responsible for their individual patients' admission process, and follows them through to their discharge.

The hospital serves the population groups represented in the Western Cape, and the languages represented, reflect the specific population groups. The languages are English, Afrikaans and Xhosa, with other languages increasingly represented by the immigrant population coming from other parts of South Africa. Within the staff component these languages are widely represented amongst the nursing staff, with limited representation among the therapeutic staff. There are limited resources in terms of the availability of an interpreter, who was based in ward 14, and worked for four hours of the day.

In particular, the need arises for interpretation among Afrikaans and Xhosa speaking patients, from the admission interview, to the subsequent therapies offered on the unit, until the patients' discharge. For most of the group therapies offered, English is the main language of communication. In the event that there is no interpreter amongst the staff or patients, there are problems in the management of patients, because of the effects of poor communication.

During my internship year as a Master's student in Clinical Psychology, I was based in the female psychotic admission unit, for a period of four months. It was while working in this unit that the idea for the following dissertation was born.

There were observations made, particularly by the nursing staff, of bias in the admission process of patients, towards those who were English speaking. The nursing staff felt certain patients, who were able to communicate with the case-manager, were admitted into more open and hence more comfortable wards, and by-passed the closed wards. This they felt resulted in patients having to be re-assessed at a later stage because of the initial assessment having been by-passed. This perception resulted in many discussions in ward rounds, some of which included recommendations from the nursing staff on how to eliminate the element of bias from the management of patients. In particular, nursing staff recommended that all patients, regardless of their presentation, should be admitted in the ward for the behaviourally disturbed, for a 24 hour observation period. This was not acceptable to the other members of staff, as it was felt that this practice could harm less

behaviourally disturbed patients. It is here that I feel I must mention that I am a Black woman who speaks Sesotho and English. My role as an intern in a transitional and temporary position, may have made it easier for the nursing staff to be open about their experiences with me. The additional fact that I am Black may have also made me accessible to speak to informally in the unit, as there would certainly be an assumption that I would be empathetic to the race and language issue.

It was through the discussions that took place in the ward rounds, as well as informally in the wards that the question of whether patients' race and language had an effect on their trajectory through the hospital was raised. It was also after I had seen patients excluded from certain therapies, for example group therapy, due to their inability to speak English. My inability to speak both Afrikaans and Xhosa meant that their predicament could not be altered by my presence in the groups, and I wondered what the effects of this were on the patients' general admission process, and in the ward.

1.2 Research Objectives:

This study aims to ascertain the effects of language and race on the management of patients admitted to the female psychotic admission ward. Factors that will be looked at in this research will be:

1. To look at the length of stay of each patient in the unit.
2. The reasons for the patients' transfers from one ward to another.
3. The diagnosis of patients.
4. To investigate whether admission policies are affected by patients' languages and race.

The results of the above quantitative study prompted the final aim:

5. To do a qualitative exploration of staff's attitudes and impressions about the effect of race and language on the management of patients.

CHAPTER TWO: LITERATURE REVIEW

The following literature review will explore the area of language and race in mental health services in South Africa. The review will begin by discussing the historical perspective of mental health services, including the challenging process of integration in this country. The doctor-patient relationship will be reviewed both in psychiatric and medical settings. The focus will be on how it is affected by the language and race of both the patient and clinician. The literature review will then move to the decision-making process in psychiatry, which includes the treatment, transfer and discharge of patients, and the relationship of these to the race and language of the patient. This will include the issue of race-related and race-based diagnoses.

The theoretical perspective of transcultural psychiatry will be used as a framework within which the literature is viewed.

2.1 The historical perspective

South Africa's history is steeped in racial discrimination and segregation. In mental health the classification of patients along racial lines can be traced back to the 1860's, resulting consequently in the segregation of black and white "lunatics" in the 1890's (Foster & Swartz, 1997). It was along with this segregation, that specific differences in diagnostic and treatment practices along racial lines became commonplace (Swartz, 1995). In the early 1900s, efforts went into theorising the differences between black and white, in particular in experimenting and testing, and patients' statistics were reported along racial lines (Foster & Swartz, 1997). Many racist practices and segregation itself were supported by these theories, and as Swartz (1991) notes many of these inhumane practices were thought to be culturally sensitive and that primarily due to racial stereotypes and myths, those practicing them genuinely believed that they were in people's best interests. When the National Party came to power in 1948, apartheid policy

was introduced. This meant that along with others, health care was officially segregated along racial and geographical lines. White, Coloured, Indian and African people all had different and unequal health care facilities and services. The amount of funds allocated to whites in health care was significantly more than that allocated to blacks. According to the department of Health, in 1987 the per capita expenditure on health for a black person was R137 and for a white person it was R597 (Chapman & Rubenstein, 1998).

As a result of these inequalities, there were differences in life expectancy amongst the population. Health care services did not provide for the emotional and psychological suffering of black people (WHO report, 1981 in World Health Organisation, 1983). It is in mental health care particularly where gross human rights violations were reported during the apartheid era, with several reports written on the state of apartheid facilities finding that there were gross inequalities in all areas of psychiatric services. The number of outpatient services, the quality of treatment, as well as the ratio of personnel to population at risk, were found to have inequalities (WHO report, 1977, in Chapman & Rubenstein, 1998; WHO report, 1981 in World Health Organisation, 1983).

Black people were sometimes placed in privately run mental institutions which in the late 1970s, were investigated by the American Psychiatric Association. The result was a damaging report, that reflected deepening racial discrimination within the mental health services (Foster et. al., 1997). Some of the violations committed during this era were represented in the Health Sector Hearings conducted by the Truth and Reconciliation Commission in June 1997 (Chapman & Rubenstein, 1998). The apartheid policy also made Afrikaans and English the two 'official' national languages, effectively excluding the other indigenous languages. Policies in education gave white Afrikaans and English speakers the advantage over indigenous language speakers, in that they had access to higher education (Swartz, 1998). Swartz, et. al. (1997) point to the manner in which the language issue has been reflected in the power relations within mental health institutions. In particular those who do not speak English and Afrikaans have been marginalized.

It is usually professionals higher up on the hierarchy that are unable to speak indigenous languages, leaving the nursing staff in particular as the people with direct access to patient understanding.

In the 1980s, mental health practitioners began defying the many policies of the apartheid regime that forced inhumane treatment of patients. There were also those who worked actively to justify segregation policies (Foster & Swartz, 1997). In psychology for example, the 1980s were a time that psychologists rethought their role, within the context of a racist regime, and began looking seriously at the need to train black professionals, and paved the way for a 'new psychology' (Freeman, 1991; Swartz & Gibson, 2001).

In a review of transcultural psychiatry in South Africa, Swartz (1987) touches on the role that apartheid had played in the mental health of the oppressed, as well as its impact on mental health knowledge generated within apartheid. Part of this process involved the equally important issue of how black identity was being affected by the psychiatric system in South Africa (Swartz, 1991a). Alongside the rest of the country, mental health was going through a transformation in preparation for the new South Africa.

Under the new dispensation, a mental health and substance abuse committee was appointed in 1995, by the then Minister of Health in South Africa. The committee was to report on issues of the provision of mental health services (Chapman & Rubenstein, 1998). The committee reported the findings in the "Human Rights Violations and Alleged Malpractices in Psychiatric Institutions" and arrived at the conclusion that the violations and malpractices in mental institutions could be attributed to the legacy of the apartheid system. The report also pointed to inequalities in treatment and in the allocation of resources, and concluded that racism remained prevalent within South African psychiatric institutions (Torkington, 2000).

The American Psychiatric Association was also asked to send a delegation to investigate the state of South African mental health services in 1996. Although there was no direct reference to human rights violations, the delegation found that there were shortages of

personnel and resources, and most notably there was a sense of paralysis amongst white professionals about hopes for any change (Chapman & Rubenstein, 1998). This is a state that can be identified with by many care-givers in these institutions, as there are so many factors that are out of practitioners hands that interfere with the treatment of their patients, not least being the inheritance of apartheid-designed structures.

South Africa's mental health services have a deeply entrenched history of racial segregation and discrimination. Although the road towards desegregation was difficult given the legislated divisions, there emerged a new voice of resistance and politically sensitive thinking. This voice paved the way to equitable access and care in mental health for all South Africans. In the new dispensation, the difficulties of integration in respect to language lie in institutional and personal attitudes, that are ingrained and will require a psychological shift, amongst others, to change (Swartz & Drennan, 2000).

2.2 The integration of mental health services

In the late 80's transformation began taking place in the South African mental health services and desegregation accelerated in the early 1990's (Swartz, 1996). Mental health hospitals began the gradual work of integration, a process that was challenging and complex. Guiding principles for mental health workers and suggestions on policy, were formulated in different forums (Freeman, 1989; 1992). In the early 1990's literature on the effects of racialisation on diagnosis and treatment began to appear (Swartz, 1989), and the issues faced by previously black wards in the dynamics between patients, and both black and white professionals came to the foreground (Swartz, 1991a).

That racism existed in the structure of mental health services was clear (SAIRR, 1988: 792-812, cited in Swartz, 1991) but, in trying to address the issue of race and language within hospitals proved to be quite complex as many were uncomfortable talking about these issues (Roth & Swartz, 1992; Drennan, 1999). In the context of such new transformations and structural reviews, the staff was unable to adjust to thinking freely about language and race. In many ways the fear that one would be labeled racist or

reactionary, was prevalent in the avoidance of speaking about race in the process of integration (Swartz & Drennan, 2000). Perhaps this was a wish to look at the positive side of the integration process, and avoidance of the emotionally charged issues, such as language.

In a hospital study in the Western Cape, Drennan (1999) tried in interviews with the staff to interchange language and race labels, in an effort to avoid being explicit about racial discrimination. He found that evidence of problems within the hospital related to language, could be easily interpreted as evidence of racism, threatening the identity of the hospital as an institution. It is important to add that the other areas of discrimination; gender, class and age, are just as vital in the inequalities present in mental health services, and that they can all contribute to neglect and abuse (Foster & Swartz, 1997).

Integration in other countries, such as the United States of America, Australia and the United Kingdom, to name a few, has had its share of problems as well as successes. The issue of language and race as a problem in the management of patients is well documented in other settings, as well as the inequalities that continue to exist (Epstein & Ayanian, 2001; Gornick, et. al., 1996; Fernando, 1991;Fernando et. al., 1998). The differences that may exist between South Africa and other settings, may lie in the fact that the necessity for integration in other countries resulted from an immigrant population that is treated differently due to its 'foreign' culture and language (Fernando, et. al., 1998). This is a situation that is different to South Africa's historical context. The differences in language, values and beliefs have been used to explain the different experiences of groups, as regards health care.

The issue of racism in South African mental health will not be discussed fully as it is beyond the scope of this review. For a theoretical and historical view of racism in mental health see Swartz, 1991b. For a review of sociological perspectives on how race theory has developed over time, see Winant, 2000.

2.3 The doctor-patient relationship

Much has been written on the micro-politics and nuances that go into the doctor-patient relationship. The wider historical and social role of being a patient, in the doctor –patient relationship is such that one has to surrender one's body and independence in this relationship (Jones, 1991). The race, gender, and class of both patient and doctor, can greatly influence the effectiveness of communiçation between the two (Waitzkin, 1983, in Jones, 1991). In particular, race and ethnicity have been cited as barriers to effective communication in health care in studies conducted in the USA (Segal, et. al., 1996; Mull, 1993; in Cooper-Patrick et. al., 1999). Race difference can affect communication in general, and the result can be that the clinical aspect of the relationship is affected (Segal, et. al., 1996). For example, in a study conducted in the United States of America, black people rated their visits with physicians as less participatory than whites, and rated physicians of their own race as having a more participatory decision-making style (Cooper-Patrick et. al., 1999).

For a review of literature that investigates particular communication styles, from studies carried out in the Netherlands, USA, Mexico and UK, see Williams et. al., 1998. The studies found that establishing a good relationship and having less negative affect towards patients during consultations is related to patient satisfaction. There were contradictory results relating to how much information provision and seeking behaviours related to patient satisfaction, but higher patient-centredness and empathy were related to higher patient satisfaction (Williams, et. al., 1998). The attitudes of physicians in the United States towards less affluent and less educated people, was found to be more negative than with their other patients (van Ryn & Burke,2000). This is in a society where a high proportion of blacks patients are in these socioeconomic groups.

The process of assessment in psychiatry has numerous dimensions that require close and subtle interactions between patient and care-giver. In South Africa, where this relationship exists mostly in a multilingual context, few studies have looked at patient satisfaction within psychiatric services. Ensink & Robertson (1999) write that the

experiences of patients have hardly been explored. Swartz, (1991a) recognises that the clinicians' attitudes and beliefs about difference needs to be monitored in order to see how they are played out in the clinical arena.

2.4 The language issue in South Africa

With eleven official languages in South Africa, the issue of language services in mental health has been of great importance. Studies have looked at the use of the Present State Examination, a standard psychiatric instrument, and its shortcomings when used on Xhosa-speaking patients (Gills et. al., 1982). The findings were related to the difficulties amongst others, of translating English psychiatric words like "depression" and "pseudo-hallucinations". In addition "various interpretive factors relating to cultural beliefs may affect assessment" (Swartz, 1987). Therefore, there are more than just language problems in psychiatric assessment. There is also the question of whether the instrument used is culturally appropriate (Swartz, 1989).

Drennan's (1996, 1999) study of the language services provided in a psychiatric hospital in the Western Cape, demonstrated the complexities of implementing these. He found that there were shortages in resources, and that language issues presented the main cause of inequality in accessing the services. In addition as had been noted by Swartz (1989, 1991a) he found that the issue of language has enormous emotional implications for staff that affect even patient care. There is a very thin line between studying language issues and looking at race.

Implementing language policy within mental health, and conceptually laying down the issues involved, has been described as of low priority in mental health (Swartz, et. al., 1997). This situation was brought about by the low status that language in mental health has been given internationally, the history of language use in the country and the politics of who is in power within the mental health system (Swartz, et. al., 1997). They suggest that policy be geared towards improving the climate, training, language services and practice for equitable health. In a study conducted in the Orange Free State for example,

on the reduction of discrepancies in the services provided for black and white patients, there was no mention of equal service and access, in terms of the languages of the patient population (Freeman, et. al., 1994).

Swartz & Drennan, (2000) write about the slow progress of change in the access of mental health services on the basis of language. They point out that there are still stumbling blocks when it comes to implementing knowledge of an indigenous language, amongst white English speakers. In addition there is the fact that training in South Africa still equips students for working abroad rather than locally, and the teaching of second-languages is not well developed in schools. Swartz & Drennan (2000) argue that another reason that could contribute to resistance to learning an indigenous language is possibly an attempt to avoid the emotional exposure. They add that a complicating factor is the power politics involved between those who can, and those who cannot speak an indigenous language.

One cannot talk about language issues in mental health without touching on the subject of interpreting. Literature on interpreting in South Africa (Swartz, 1989, 1991b, 1998; Crawford, 1994; Swartz, et. al., 1997; Drennan, 1996a, 1999; Muller, 1994) has highlighted amongst other things how under resourced mental health institutions, have had to deal with the poor communication between clinicians and patients and how this can affect clinical practice.

Drennan (1996a) looked at the effect of the state not having official interpreters' posts, but rather relying on family members and other unqualified staff members, noting the negative impact it had on delivery of service. He found that the remuneration of employed interpreters, severely under-represented the role and skills required to interpret. This perhaps further emphases how low a priority the interpreter role is in mental health. The technical aspects of interpreting will not be entered into here. For a detailed theoretical review, see Swartz, 1998.

2.5 The language issue in other settings

In the USA, the need for interpreting in mental health has been promoted as a means of increasing diagnostic precision (Rack, 1982; Mezzich et. al., 1996), and models for working with interpreters have been put forward as necessary steps towards working in a multilingual environment (Westermeyer, 1990; Westermeyer & Janca, 1997). Studies have been conducted for advanced plans of implementing remote-simultaneous interpretation, which involves the doctor and patient wearing headsets that are linked to an interpreter who is not physically in the room (Hornberger, et. al., 1996). This is with the recognition that language discordance between the doctor and patient, can prevent cost-effective patient care.

2.6 Diagnosis

Literature on this subject has also been divided into three areas; those that find ethnicity as a basis for differences in psychiatric diagnoses; those that find ethnicity is not a basis for psychiatric diagnoses; and those that find the evidence to be inconclusive, deciding that no real judgment can be reached (Flaskerud & Hu, 1992).

Research has been conducted in psychiatric institutions on the effects of race on the diagnosis of patients and the history of racism in psychiatry (Fernando, 1988, as cited by Fernando, 1998). The literature shows that in the United States of America and the United Kingdom, an excessive number of black patients are being diagnosed with schizophrenia or a psychotic disorder, regardless of the colour of the doctor concerned. (Harrison, et. al., 1997, in Fernando, et. al., 1998; King et. al., 1994, in Fernando et. al., 1998). On the basis of these studies, the use of schizophrenia as a valid diagnosis, has been challenged by Fernando, et. al., (1998).

In reviewing the concept of schizophrenia, from both a historical and transcultural perspective, he aims to show the invalidity of the diagnosis, especially in a multi-cultural context in which the 'judgments' are arrived at from a different cultural point (Fernando, et. al., 1998). Given how often this diagnosis is attached to many African and Asian patients in psychiatric institutions, there is a need for sensitivity towards potential racism in diagnosis, given psychiatry does not operate in a socio-political vacuum (Fernando, et. al., 1998).

The diagnosis most debated is that of schizophrenia, with studies reporting higher rates in prevalence amongst African-Americans as compared to their white counterparts (Baskin et. al., 1981, in Flaskerud & Hu, 1992), including amongst elderly patients admitted to an acute-care unit (Mulsant et. al., 1993, in Fabrega et. al., 1994).
Various confounding variables were found in the studies. These included age, gender, education and therapist ethnicity (Flaskerud & Hu, 1992). However in a study where these variables were statistically controlled, psychotic diagnoses were higher in the African- American group (Fabrega, 1994). Flaskerud & Hu (1992) write that other factors that have contributed to ethnic differences in diagnoses have been found to be; misdiagnosis, attribution of symptoms of one disorder to that of another, stereotyping, bias in diagnostic tools against certain groups, failure for some groups to use mental health services until their illnesses are severe, difficulties in expression of psychopathology and misdiagnosis of cultural phenomena as illness.

2.7 Diagnosis in South Africa

Earlier studies looked at the use of standard psychiatric instruments on Coloureds (Ben-Arie et. al., 1983, 1987; Elk & Nash, 1985) and Xhosa-speakers (Gillis et. al., 1982). The result of the study on Xhosa-speakers, found that the Present State Examination (PSE) was an appropriate instrument to use on Xhosa-speakers, but also found limitations using the PSE. It was found that the difficulties in translations of English words such as depression, interpretations based on cultural beliefs, as well as other factors that affected assessment, all affected the use of the PSE. Swartz (1991b) wrote that the conclusion

arrived at by Gillis et. al., of the universalism of psychiatric illnesses, wass based on problematic evidence. Swartz (1989) looked at the studies available on diagnoses and its relation to the different race groups. He discusses the widely held prejudice at that time, that depression was an uncommon phenomenon amongst Blacks, pointing to the emerging studies locally and abroad that probed the question of depression in culture. In conclusion he finds that from study to study the "psychiatric 'caseness' differs so substantially... that it is impossible to talk of an overall picture" (Swartz, 1989).

Swartz (1989) writes that in general, the language issue made it easier to assess mental disorder in coloureds and whites than in blacks, concluding that the question of race and diagnoses remained open. Due to poor or lack of communication in assessment, Swartz (1991b) describes the management of patients as "veterinary", saying that in diagnosis the patient's reality is not engaged with, for their existence and discourse do not slot into neat diagnostic systems.

2.8 Treatment, transfers and discharge of patients

The literature on the racial disparities has generally been from the United States of America. Literature on racial differences in the provision of health care has been substantial (Epstein et. al., 2000; Bach et. al., 1999; Ayanian et. al., 1999).

In psychiatry, a study by Way & Banks (2001), found that in order of importance, the clinical factors that are said to influence the decisions surrounding admission and discharge of patients in psychiatric emergencies are:

1. The level of danger to self.
2. The severity of psychosis.
3. The ability to take care of self.
4. Impulse control.
5. Severity of depression.

Prescription practices studied in psychiatric emergency services, revealed an increased tendency for black patients to receive oral doses and injections of anti psychotic

medication (Segal et. al., 1996). This is an indication that black patients fit the factors that influence the decision to admit, but also have the diagnosis of a psychotic disorder more often. The same authors found that when the clinicians made an effort to engage the patient, the tendency to over-medicate black patients was lowered (Segal, et. al., 1996). In a study to examine if there were racial differences in treatment of an inpatient psychiatric unit, the results showed that non-psychotic black patients had shorter stays than non-psychotic white patients (Chung et. al,, 1995). In addition, they found that white patients were more likely to get a one-to-one observational status. The level at which the clinician will engage with a patient will be influenced by their attitude towards the patient and the extent to which she can understand the patient. It is surprising given the monolingual nature of American society, that these disparities still exist, but this also points to the inherent racism present within these institutions.

2.9 Conclusion

Health care in South Africa has gone through many changes in the past, many more of which are happening currently. The official policies of apartheid are a thing of the past. Nevertheless the complexities associated with the process of desegregation in health care continue to be tackled. Part of the legacy of apartheid is the inheritance of the structures that made that policy work, but that have to be dismantled in the new dispensation. It has not been easy in mental health, especially given the lack of resources, and a long history of violating patients' human rights. Things however continue to change.

The integration process has resulted in more work being done on the need for language services and increasingly issues of race and discrimination, conscious or not, are being raised. The discomfort of raising such emotionally charged issues, will hopefully make way to openness, tolerance and acceptance of diversity within mental health.

CHAPTER THREE: METHODOLOGY

3.1 RESEARCH DESIGN

This part of the dissertation aims to set out the research design and the analysis used on the data collected. This is a limited and tightly focused study, reporting on some aspects of the management of patients in the women's admissions unit at Valkenberg hospital. The research was carried out using archival material and interviews conducted with members of staff.

The research is divided into two parts. The first part, a quantitative investigation was done using records to ascertain the admission and transfer from ward to ward, using a sample taken over a period of three months in 2001. This period was chosen because this was when the perceptions of the nursing staff were raised. It was during this period that I worked in the unit, and the aim was to establish if the nurses' perceptions had any foundation. The surprising nature of the results from the first part of the study prompted the subsequent investigation. In the second part, a qualitative investigation, undertaken on a relatively small scale, was used as a means of clarifying the results from the initial part. Combining both quantitative and qualitative approaches in research fills the gaps that data, derived from an individual approach, might ordinarily lose (Silverman, 2001).

Permission was sought from the Valkenberg Management Committee[1], to gain access to patients' records, and this was granted[2]. The first part of the research required archival extraction of the data on patient trajectory in the unit. The second part of the research was a qualitative study, which looked at the experiences of staff regarding the role that language and race have played in the management of patients in the unit. This was carried out by conducting interviews with six members of staff that work in the unit.

[1] See Appendix 1 for letter requesting permission from the Management Committee.

3.2 ARCHIVAL MATERIAL

Part 1 of the study was conducted using archival material from the registry at Valkenberg hospital. It was important that all information be present in the folders, as all the variables were vital in the analysis of the research. Some of the problems with the excluded folders were missing clinical notes for particular admissions, including folders that were devoid of any clinical notes altogether.

The population in the study was female patients in the women's admissions unit, which includes ward 14, ward 5 and ward 3. A period of three months was selected in 2001, this started January 1st, to March 31st. A total of 149 folders were extracted, with only 118 meeting the criterion set above and therefore included in the sample. The ages of the subjects ranged between 19 and 64 years of age, and they were from the three prominent population groups represented in the Western Cape. The following racial categories were used for the purpose of this study, Black, Coloured and White, and no other racial groups were represented in the sample. The language groups were also put into three category groups that are represented in the Western Cape; Xhosa, Afrikaans and English. There were no other languages represented in the sample.

3.3 DATA COLLECTION

3.3.1 Folders

Firstly, computer records that summarized the admissions and discharges of female patients from January to March 2001, were retrieved from the registry computer[3]. The individual patients folders were retrieved from the registry and from these, the patients' age, language, race, the trajectory within the unit, the length of stay in each ward and the discharge date were retrieved. The clinical notes and summaries were consulted for the diagnosis of the patients, as well as nursing notes that record the movement of the

[2] See Appendix 2 for letter granting permission for study from the Management Committee.
[3] See Appendix 3 for the data retrieved from the registry.

patients from ward to ward. The data was then placed in columns with the variables put into categories. The categories were coded, in order to make the data accessible to analysis. The advantages of coding that make the process of analysis efficient and least time consuming have been established (Swift, 1996).

The interview part of the research was carried out with nursing members of the unit who were working in September 2002. Although they describe current conditions in the unit and the quantitative data reflects patient data from the previous year, no major policy or staffing changes have affected patient management. The exception to this is that during the January-March 2001 period, a part-time interpreter was available to the staff in ward 14. The effects are discussed fully in chapter 5, page 50. The experiences of the nursing staff were sought to shed further light on the meaning of the quantitative data. Themes that emerged from the interviews were used to amplify and interrogate the quantitative data. The experiences of the staff were thus taken into consideration in the forming of any opinions about the data, in order to give a holistic view of the research results. This part of the research involved interviews with six nursing staff members who work in the unit. Interviews were set up with 2 members of nursing staff in each ward, by setting up an appointment with the sister in charge in each ward. In all three wards the sister in charge was interviewed and the choice of nurse assistant was the one on duty at the time of the interview and who was free to participate.

It is essential to mention the racial make-up of the sample, as the research highlights issues of race. It would be important to understand the person interviewed from a view of how their own race may influence their perception of issues relating to race in the unit. Of the 6 participants in the study, there was a Coloured professional nurse who speaks English, a Coloured professional nurse who speaks Afrikaans, a Black professional nurse who speaks Xhosa, a White nurse assistant who speaks Afrikaans, and two Coloured nurse assistants who speak Afrikaans.

3.3.2 Interviews

The interviews were intended to supplement the quantitative data, and so they were kept relatively short in length of time. Each interview was estimated to be between 10 and 15

minutes. When setting up the interviews, the topic of research was explained briefly to the sisters and nurses, as well as that the identity and information of the nursing staff would be treated as confidential.

The interview schedule[4] involved five semi-structured questions that were asked in the same order, and the responses were taped. Where appropriate the interviewees were probed with further questions for clarification. The interview schedule had questions that would attempt to gain nurses' perceptions and experiences of the factors that influence patient transfer and management of patients, problems experienced, the effect they perceive race and language to have on the transfer of patients and lastly recommendations that they may have to alleviate these problems.

The interview itself began with an introduction that involved setting out the topic of the research and the nature of questions that I would be posing. The confidentiality of their identity and responses was assured and their permission to use the tape recorder was sought. To place interviewees at ease and to build rapport, the race and language questions were raised in the middle of the interview rather than early in the interview. As much as possible the interviewer did not try to vary from the questions asked, except to follow-up with a question that would clarify interviewees' responses. In this way the interviewer would not be perceived to have any biases on the matters being discussed. As Johnson, (1996) writes the researcher has a duty to report the view of participants and desist from attempting to modify these, as "those views and perceptions are data." When the interviews came to an end, the interviewees tended to continue talking informally about the issues raised. This part of the interview was used to end the interview and thank the participants for their time.

3.4 DATA ANALYSIS

3.4.1 Part 1

The analysis used was different for the two different parts of the data. For the first part of the research, the data collected from the folders, such as the length of stay in the unit

amongst the different language and race groups was tabulated. The second stage involved quantitative data analysis using the statistical package SPSS.

The first stage involved the categorizing of the different variables that were to be tested. This was to enable the development of a coding sheet[5], so as to understand the meaning of the data. This involved for example, the grouping of length of stay in terms of a 5 point scale ranging from 1 (less than 10 days) to 5 (more than 41 days). In this way the variable of length of stay can be coded as a single digit. The variables were then placed in rows and columns so as to make them accessible for the data capturer. The disadvantage of recoding the data into accessible categories, is that one is likely to lose some valuable information (Seale, 1998).

The second stage involved quantitative analysis of the data, by firstly looking at the frequencies of the different variables. Although this is one of the easiest ways of presenting data, it is beneficial in so far as it helps to see at a glance the numbers represented by each group (Sapsford, 1996). It gives an indication with each variable what the mean and median are, a concept that is called descriptive as no inferences are being made about the data at this stage (Calder, 1996).

The third stage in quantitative analysis of the data, was an attempt to find if there is an association between language and race, and the variables of trajectory and diagnosis (Calder, 1996). Using chi-square to determine the association between variables, produced contingency tables that depict the frequencies present in different cells of the table. The chi-square is used to test the null hypothesis, and in particular "the frequencies or proportions found in the cells of the contingency table are what you would expect to find if there was no association" (Calder, 1996). In particular the strength of a relationship is presented as a single figure. Problems that are associated with this method are that there maybe too few frequencies in the cells, making significance testing difficult (Bryman & Cramer, 1990; Seale, 1998; Howell, 1999). According to Howell (1999),

[4] See Appendix 4 for the interview schedule.
[5] See Appendix 5 for coding sheet.

when calculating chi-square, one should have at least 5 cases in 80% of the cells. This was the reason the data had to be reviewed, and new codes drawn up in an attempt to meet the requirement set out.

The fourth stage included the quantitative analysis that set out to ascertain the difference between race and language and the continuous variable of length of stay in the unit. The statistical test used was ANOVA (3x3 designs), and this is a test of difference of length of stay to ascertain if it is significant or not, depending on the subject's race and language.

3.4.2 Part 2

The second part of the research involved the analysis of the taped interviews. The tapes were transcribed and the data was thematically analysed to determine what the salient perceptions and experiences, the nursing staff interviewed had. The themes that emerged from the data, were then grouped and reported on, as the prevalent attitudes, perceptions and experiences of the nursing staff.

In conclusion, this was both a quantitative and qualitative study exploring the factors involved in the trajectory of patients in the women's admissions unit at Valkenberg. A period of three months from January 2001 to March 2001 was researched. The folders of 118 patients extracted from the registry, met the inclusion criteria to be part of the study. Data was collected from these folders and analysis involved the use of a statistical package. The second part of the study involved the administering of interviews to six nursing staff members currently in the unit. The transcribed data was descriptively analysed for prevalent perceptions and experiences of the interviewees.

CHAPTER FOUR: RESULTS

The results to be reported here will be the statistical data obtained from the patients' folders. The second part will be the results from the interviews conducted with the staff members of the women's mental health unit, at Valkenberg hospital. Together the two parts will be merged to clarify the results quantitatively and qualitatively.

4.1 Socio-Demographics

Of the 149 folders that were studied, 118 of them were suitable for inclusion in the research. All the data required for the research was available in the folders used, as well as on the registry computer.

Table 4.1 shows the age frequencies and the percentages of the ages according to age groups.[6] The minimum age was 18 and the maximum 64. The most patients, 26.3% were between the ages of 31 and 40 years. Diagram 4.1 shows the distribution and frequencies of the ages represented in the sample. The mean age of the patients was 38.95. Patients over 60 years were the least represented in the sample at 2.5%. Of patients below the age of 20, there were only 6.8% represented in the sample.

Table 4.1

Age group	Frequency	Percentage
1	8	6.8
2	29	24.6
3	31	26.3
4	30	25.4
5	17	14.4
6	3	2.5

[6] 1= -20, 2= 21-30, 3= 31-40, 4= 41-50, 5= 51-60, 6= +61

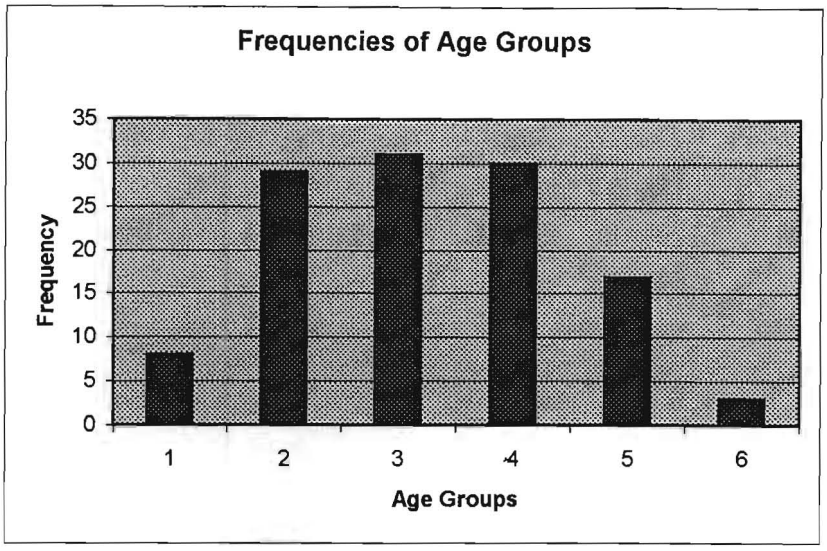
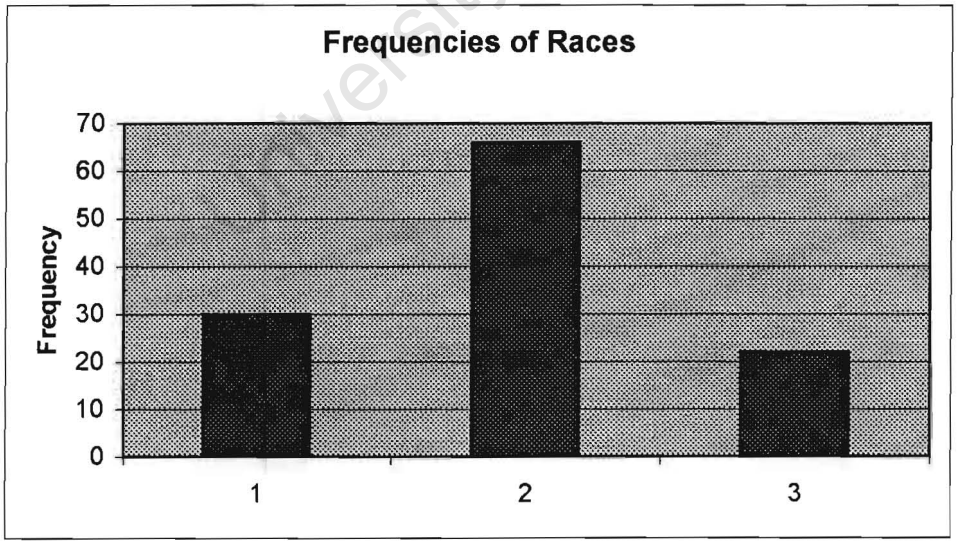


Diagram 4.1[7]

Diagram 4.2 shows the frequencies and distribution of the race groups represented in the sample.[8] The race of the patients was divided into the three categories represented in the Western Cape, these being Black, Coloured and White. During this admission period, 25.4% of the patients admitted were Black, 55.9% were Coloured and 18.6% were White. There were no other races represented in the sample.

Diagram 4.2[9]



[7] 1= -25, 2= 21-30, 3= 31-40, 4= 41-50, 5= 51-60, 6= +61
[8] See Appendix 5 for coding of race groups.
[9] 1= Black, 2= Coloured, 3= White

The languages represented in the sample, were also the three represented in the Western Cape. The sample consisted of 25.4% Xhosa speakers, 38.1% Afrikaans speakers and 36.4% English speakers. In the different race groups, all of the 30 Blacks spoke Xhosa, 22 of the Coloureds spoke English and 44 of the Coloureds spoke Afrikaans, and finally 21 of the Whites spoke English and only 1 spoke Afrikaans. Diagram 4.3 shows all the language groups represented in the sample and their frequencies and distribution.

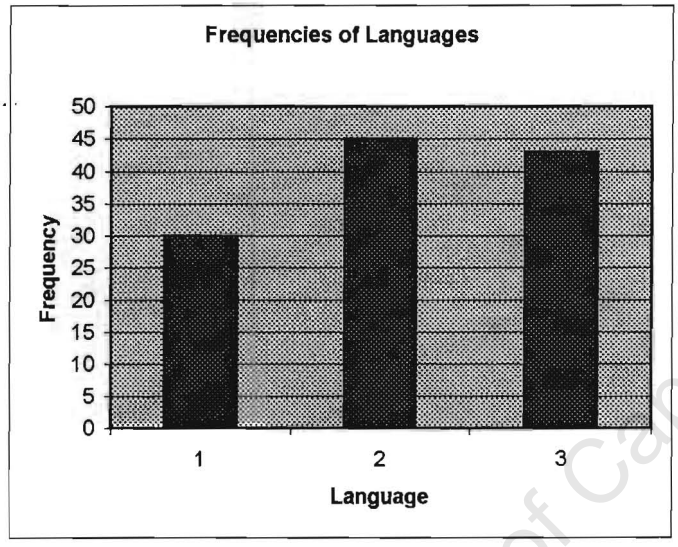


Diagram 4.3[10]

70.3% of the patients had less than 4 previous admissions, 11% had between 5 and 9 admissions, while 18.6% had more than 10 previous admissions.

4.2 DIAGNOSES

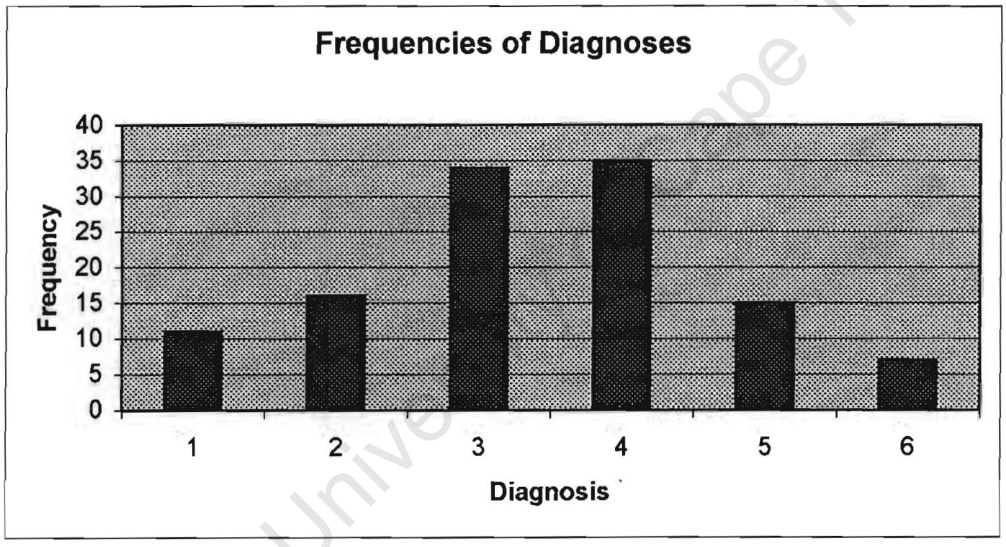
The diagnoses of the patients were coded into 6 categories of the different diagnostic groups. Diagram 4.4 shows the frequencies and distribution of diagnoses with the 6 categories. The categories were reduced to 4 categories, so that there could be sufficient frequencies present in the contingency table to enable testing for statistical significance.

[10] 1= Xhosa, 2= Afrikaans, 3= English.

The result shows that 9.3% of the patients were diagnosed Major Depressive Episode, with suicidal ideation, 13.6% were diagnosed Major Depressive Episode or Bipolar Affective Disorder, with psychotic features, 28.8% were diagnosed Bipolar Affective Disorder, manic episode, 29.7% schizophrenia, 12.7% psychotic episode and 2.5% were diagnosed with other disorders.

The psychotic episode diagnoses included drug and alcohol induced psychosis, postpartum psychosis and psychotic episode due to a general medical condition. The category of other included schizoaffective disorder, adjustment disorder and a possible diagnosis of dementia.

Diagram 4.4[11]



[11] 1= MDE/BPAD suicidal, 2= MDE/BPAD psychotic, 3= BPAD mania, 4= Schiz, 5= Psychotic, 6= Other.

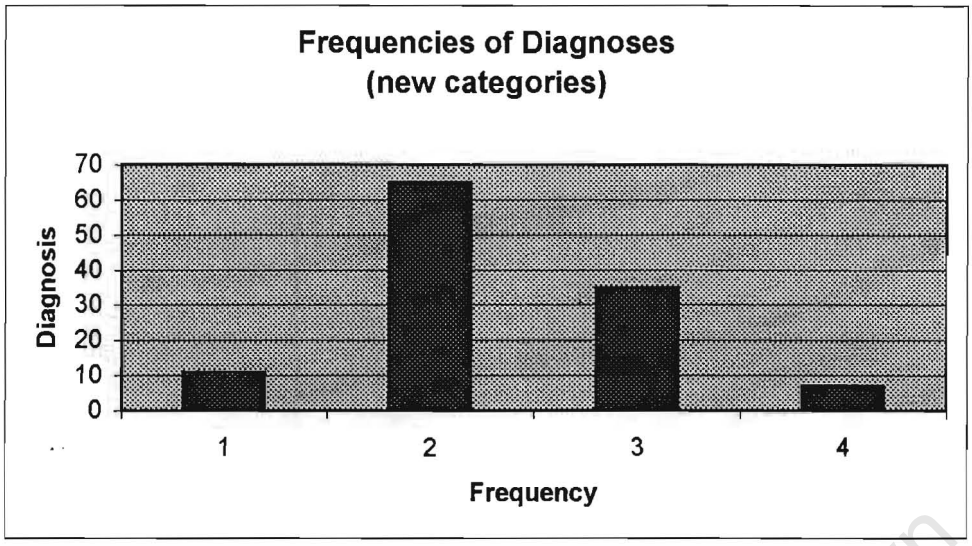


Diagram 4.5[12]

Diagram 4.5 shows the frequencies and distribution of the new categories of diagnoses.

4.2.1 Diagnoses and language

The association between language and diagnoses is shown in table 4.4. The table shows that language is grouped into 1 for Xhosa, 2 for Afrikaans and 3 for English. The diagnoses are grouped into 6 different groups. The table shows the total number of patients that were diagnosed in each category and the total number from each language group. The chi-square was performed on each test, to reveal whether there is any association between the two variables. The statistical significance of the results points to an insignificant association between the two variables, with chi-square (x^2 (10) = 10.089,

[12] 1= MDE/BPAD suicidal, 2= MDE/BPAD psychotic OR BPAD mania OR Psychotic
3= Schizophrenia, 4= Other.

p>0.433). Therefore there is no significance in the association between language and the different diagnoses.

Table 4.4

Language and Diagnosis

Frequencies

	Diagnosis	1		3	4	5	6	Total
Language	1(x)	4	2	10	9	4	1	30
	2(A)	3	8	9	12	8	5	45
	3(E)	4	6	15	14	3	1	43
	Total	11	16	34	35	15	7	118

Chi Square = 10,089 df = 10 p = .433 not significant

44,4% of cells expected cell count <5.

According to Howell (1999), when calculating chi-square there should be at least 5 cases in 80% of the cells of the contingency table. In an attempt to meet this statistical requirement, the categories for diagnoses were reduced to 4 categories and the process was repeated using the chi-square test. Table 4.5 shows the new categories, and the statistical results of the chi-square test ($x^2(6) = 4.459$, p >0.615) shows no significant association between the variables.

Table 4.5

Language and Diagnosis - new categories

Frequencies

	Diagnosis	1	2	3	4	Total
Language	1(x)	4	16	9	1	30
	2(A)	3	25	12	5	45
	3(E)	4	24	14	1	43
	Total	11	65	35	7	118

Chi Square = 4,459 df = 6 p = .615 not significant

50% of cells expected cell count <5.

4.2.2 Diagnoses and race

The association of race and the diagnoses is depicted in table 4.6. The table shows the different race groups, 1 being for Blacks, 2 for Coloureds and 3 for Whites. The different diagnoses are grouped into 6 categories. The chi-square test was performed to determine if there is an association between the race of patients and the diagnoses that they were given. The statistical result of the chi-square test (x^2 (10) = 12.975, p >0.225) calculates that there is no significant association between the race of patients and the diagnoses they are given.

Table 4.6

Race and Diagnosis

Frequencies

	Diagnosis	1	2	3	4	5	6	Total
***Race:*1(B)**		4	2	10	9	4	1	**30**
2(C)		5	12	13	20	10	6	**66**
3(W)		2	2	11	6	1		**22**
	Total	**11**	**16**	**34**	**35**	**15**	**7**	**118**

Chi Square = 12,975 df = 10 p= 0.225 not significant

Table 4.7 shows the new categories, as regards the three race groups, and the statistical results of the chi-square test (x^2(6) = 3.904, p >0.690) shows no significant association between the variables.

Table 4.7

Race and Diagnosis - new categories

Frequencies

	Diagnosis	1	2	3	4	Total
***Race:*1(B)**		4	16	9	1	**30**
2(C)		5	35	20	6	**66**
3(W)		2	14	6		**22**
	Total	**11**	**65**	**35**	**7**	**118**

Chi Square = 3,904 df = 6 p= 0.69 not sigNificant

41,7% of cells expectedcell count <5.

4.3 TRAJECTORY

The trajectory of patients was coded under 11 categories, which described the transfers and movements from one ward to the next. Diagram 4.6 shows the frequencies and distribution of the transfers that happened between wards.

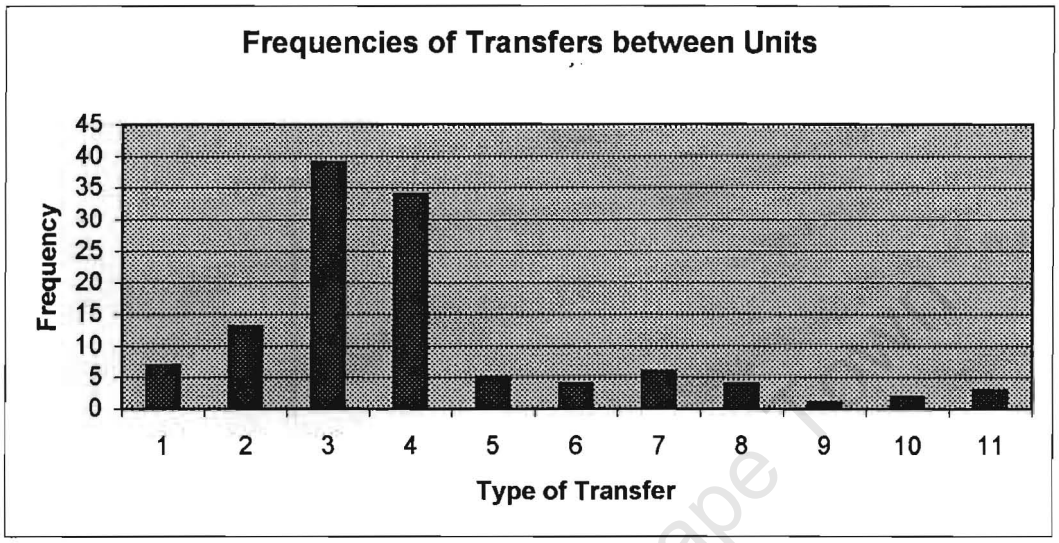


Diagram 4.6[13]

Table 4.8

Transfers	Frequency	Percentage
1	7	5.9
2	13	11
3	39	33.1
4	34	28.8
5	5	4.2
6	4	3.4
7	6	5.1
8	4	3.4
9	1	0.8
10	2	1.7
11	3	2.5

[13] 1= D/C same day, 2= 14 D/C, 3= 14-5 D/C 4= 14-5-3 D/C 5= 14-5-14 D/C & other, 6= 14-5-3-5 D/C & other, 7= 14-3 D/C & other, 8= 5-3 D/C, 9= 5D/C, 10= 3 D/C, 11= Abscond.

The transfers describe the movement patterns of the patients on the unit, between admission and discharge. Table 4.8 shows the frequencies and percentages of the transfers that happened in the unit. The results are that 5.9% of patients were discharged on the same day, 11% were admitted to ward 14 and then discharged from there. The most common pattern was for patients to be admitted to ward 14, transferred to ward 5 and discharged from there. This made up 33.1% of the patients. The pattern of transfer that mirrors the "ideal" patients' recovery, and preparation for discharge, was represented by the fourth category. These patients were admitted to ward 14, transferred to ward 5 and then to ward 3, and later discharged from there. This group made up 28.8% of the patients. The patients who went through this pattern of transfer but had to be transferred back from ward 3, made up 3.4% of the sample. Patients who were admitted to ward 14 and transferred to ward 5, only to be brought back to ward 14 made 4.2% of the patient sample. The least common admission pattern was patients admitted and discharged from ward 5, and they made up 0.8% of the patient sample, with those who absconded making up 2.5%. 1.7% of the patient sample who were admitted straight into ward 3 and discharged from there.

4.3.1 Trajectory and language

The association between transfers and the patients' language is illustrated in table 4.9. The table shows the different categories of trajectory, as well as the three languages represented in the patient sample. The chi-square test was carried out, the result ($X^2(20) = 21.332, p > 0.378$) of which shows that there is no significant association between the variables.

Table 4.9

Language and Traject

Frequencies

Traject:		1	2	3	4	5	6	7	8	9	10	11	Total
Lang:	1	2	5	6	9	1	2	3				2	30
	2	3	5	20	12	2		1	1			1	45
	3	2	3	13	13	2	2	2	3	1	2		43
	Total:	7	13	39	34	5	4	6	4	1	2	3	118

Chi Square = 21.332 df = 20 p = .378 not significant

81,8% of cells expected cell count <5.

Here 81.8% of the cells of the contingency tables had an expected cell count of less than 5, and this made it of interest to reduce the categories and repeat the chi-square test. The results of the repeated chi=square test, ($x^2(10) = 12.651, p > 0.244$), shown by table 4.10, indicate that there is no significant association between the variables. 50% of the cells had an expected cell count of less than 5.

Table 4.10

Language and Traject - new categories

Frequencies

	Traject	1	2	3	4	5	6	Total
Language	1	2	5	6	9	6	2	30
	2	3	5	20	12	4	1	45
	3	2	3	13	13	12		43
	Total:	7	13	39	34	22	3	118

Chi Square = 12.651 df = 10 p = .244 not significant

50% of cells expected cell count <5.

4.3.2 Trajectory and race

The association between transfers of patients and race, is shown in table 4.11. The categories for trajectories are grouped into 11 categories and race is represented as the three race groups in the patient sample. The chi-square test was done, to determine if there is an association between the transfer patterns in the unit and the race of the patients. The results ($X^2(20) = 22.372, p > 0.321$) indicate no significant association between the variables.

Table 4.11

Race and Traject

Frequencies

	Traject:	1	2	3	4	5	6	7	8	9	10	11	Total
Race:	1	2	5	6	9	1	2	3				2	30
	2	5	7	27	17	2	2	1	2	1	1	1	66
	3		1	6	8	2		2	2		1		22
	Total	7	13	39	34	5	4	6	4	1	2	3	118

Chi Square = 22.372 df = 20 P=0.321 not Signif -cant

The categories were reduced from 11 to 6, and the results ($x^2(10) = 12.819, p > 0.234$), shown in table 4.12, indicate that there is no significant association between the variables.

Table 4.12

Race and Traject - new categories

Frequencies

	Traject	1	2	3	4	5	6	Total
Race:	1	2	5	6	9	6	2	30
	2	5	7	27	17	9	1	66
	3		1	6	8	7		22
	Total	7	13	39	34	22	3	118

Chi Square = 12.819 df = 10 p = .234 not significant

50% of cells expected cell count <5.

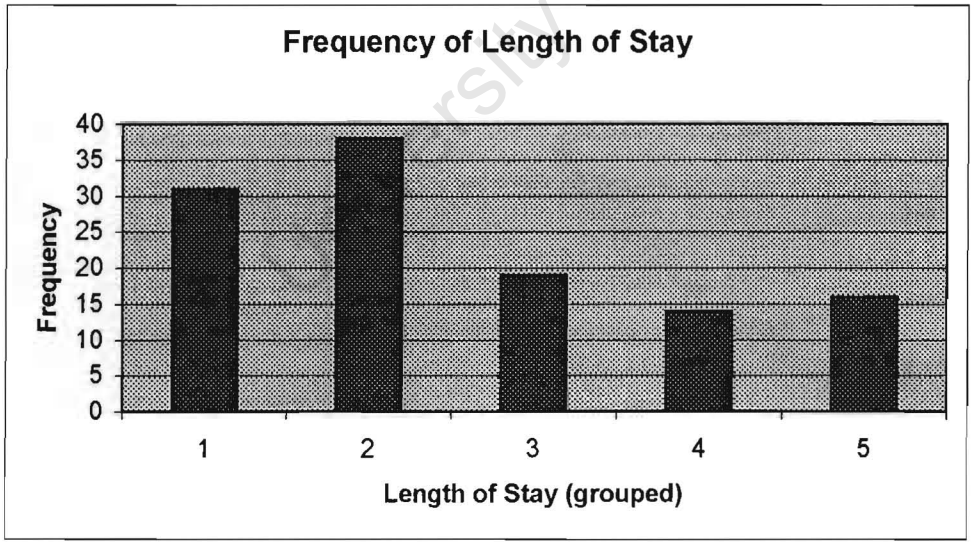
4.4 LENGTH OF STAY IN UNIT

The shortest length of stay in the unit is 0 days, the maximum is 152 days, and the mean length of stay is 23.10 days. Length of stay in the unit was grouped into 5 categories. Table 4.13 shows the frequency and percentages of the length of stay of each category. Patients who stayed less than 10 days in the unit, made up 26.2% of the sample, and those who stayed between 11 and 20 days made up 32.2% of the sample. The patients who stayed 20 to 30 days in the unit, made up 16.1% of the sample, and those who stayed between 31 and 40 days, made up 11.9%. The patients who stayed for more than 40 days, made up 13.6% of the patient sample. Diagram 4.7 shows the frequencies and distribution of length of stay.

Table 4.13

Length of Stay – grouped	Frequency	Percentage
1	31	26.2
2	38	32.2
3	19	16.1
4	14	11.9
5	16	13.6

Diagram 4.7[14]



[14] 1= -10, 2= 11-20, 3= 20-30, 4= 31-40, 5= +41.

Due to the length of stay in unit being a continuous variable, the difference between the different language and race groups in their lengths of stay in the unit, had to be measured using the ANOVA (3x3 designs). This allows the measuring of more than two variables, and the interacting effects of these (Howell, 1999). Table 4.14 shows that the main effect of race, on the dependent variable of length of stay, $F(1,113) = 0.035$, $p = 0.852$, was found to be not significant. The main effect of language, on the dependent variable of length of stay, $F(1,113) = 0.000$, $p=0.997$, was found to be not significant. This indicates that there was no significant difference in the length of stay in the unit depending on the patient's language and race.

Table 4.14

Dependent variable: length of stay in unit

Levene's test for homogeneity of variances:

	F(4,113) = 0,475	p = .754	not significant
	i.e. data suitable for ANOVA		
Main effect race:	F(1,113) = 0,035	p = .852	not significant
Main effect language:	F(1,113) = 0,000	p = .997	not significant
Interaction race/language	F(1,113) = 0,000	P = .996	not significant

The test to ascertain the interacting effects of the two variables, language and race on the length of stay in the unit, $F(1,113) = 0.000$, $p=0.996$, was found to be not significant. This indicates that there is no significant interaction of these variables on the length of stay.

4.5 LENGTH OF STAY IN WARD 14

In an attempt to make the distinction between the length of stay in the unit and time spent in ward 14, the length of stay in ward 14 was measured for each patient. Diagram 4.8 shows the frequency and distribution of the length of stay in ward 14 across the 4 categories. Table 4.15 shows the percentages in the length of stay in ward 14. There were patients who either did not stay in ward 14, or stayed for one day only, and these patients made up 25.4% of the sample. Most patients, 59.3% of them, stayed in ward 14 for between 2 and 10 days, 9.3% of patients stayed in ward 14 for between 11 and 20 days,

between 2 and 10 days, 9.3% of patients stayed in ward 14 for between 11 and 20 days, while 5.9% stayed for a period of longer than 21 days.

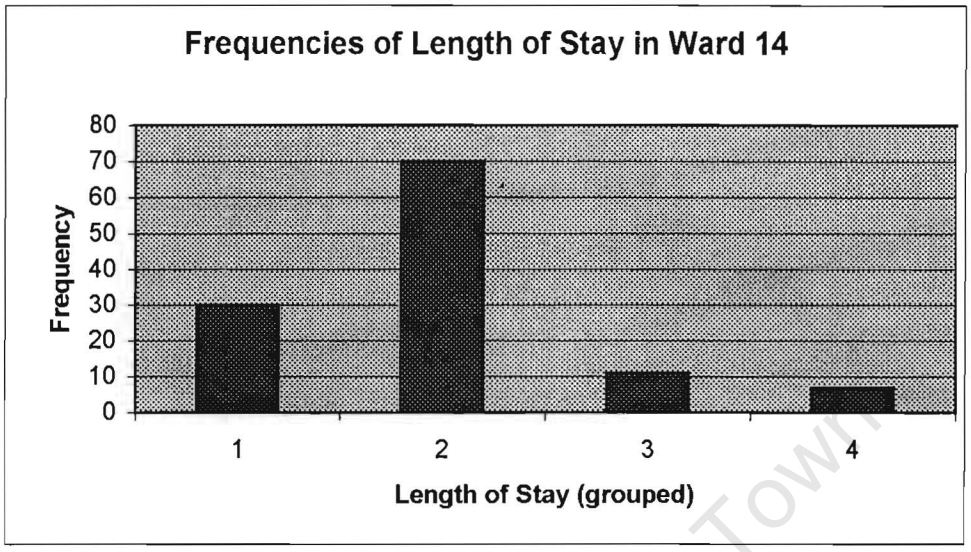


Diagram 4.8[15]

Table 4.15

Length of Stay in 14 – grouped	Frequency	Percentage
1	30	25.4
2	70	59.3
3	11	9.3
4	7	5.9

ANOVA (3x3 designs) was the test used to calculate the difference between the language and race groups in their lengths of stay in ward 14. Table 4.16 shows that the main effect of race, on the dependent variable of length of stay in ward 14, $F(1,113) = 2.379$, $p = 0.126$, was found not to be significant. The main effect of language, on the dependent variable of length of stay in ward 14, $F(1,113) = 0.367$, $p = 0.546$, was found not to be significant. This indicates that there was no significant difference in the length of stay in ward 14 depending on patient language and race. The effects of interaction between race and language on the dependent variable of length of stay in ward 14, $F(1,113) = 1.371$, p

[15] 1= -1, 2= 2-10, 3= 11-20, 4= +21.

= 0.244, was found to not be significant. The interaction of these variables, made no significant difference to the length of stay in ward 14.

Table 4.16

dependent variable: length of stay in 14

Levene's test for homogeneity of variances:

	F(4,113) = 0,264	p = .900	not significant
	i.e. data suitable for ANOVA		
Main effect race:	F(1,113) = 2,379	p = .126	not significant
Main effect language:	F(1,113) = 0,367	p = .546	not significant
Interaction race/language	F(1,113) = 1,371	p = .244	not significant

In summary, the statistical tests conducted to determine the association between the language and race of patients, and their diagnosis and trajectory, found no significant association between these variables. The statistical tests to determine the differences in length of stay in the unit and in ward 14, on the basis of the language and race of the patient, found that there were no significant differences.

4.6 THEMES FROM THE INTERVIEWS

The following themes emerged from the interviews that were conducted with nursing staff. They summarize the experiences of nurses in different wards, nurses' perceptions of the factors involved in transfers of patients, the problems that they encountered, and whether they perceived language and race to affect the transfers and decisions made about the management of patients. Recommendations concerning alleviation of any problems are also given.

4.7 FACTORS PERCEIVED TO INFLUENCE TRANSFERS

4.7.1 The behaviour of the patient

All the nurses in the sample felt that the behaviour of the patient contributed largely to the decision to transfer them from one ward to the next. The behaviour of a patient is watched for signs of aggressiveness, restlessness, and being generally considered "unmanageable". The nurse in ward 14 said transfer is appropriate, "When I see that a patient is calm at the table, in the bathroom, in the dormitories... So now I can see that this patient has been sleeping for some nights... and now she's sitting still."
The extent of the patient's psychotic state and the need to transfer them, only extends to their behaviour, as only their thought patterns are not sufficient to influence the decision to transfer. In ward 14, which is a closed ward, the nursing sister said, "Even if the patient is still disorganized with thought and is still delusional, if the patient is not disruptive in the ward, then we will transfer them." On the same topic another nurse in ward 14 said, "... because you can't transfer a patient who comes to you and speaks nonsense."

As the patient moves from ward 14 to ward 5, more is expected from the patient in terms of the signs that they display, to signal that they are ready for transfer. In ward 5, the nurse felt that communicating and socializing with other patients was a good sign for recommending that a patient be transferred. The nursing sister said, "If that patient is not psychotic, because that is why they are locked up in here, then I would say that this patient needs to be transferred." There was also the realization that if patients have social problems that have been misconstrued as psychosis, then these patients are transferred. This is particularly in closed wards, where such patients would be admitted under conditions that are designed for behaviourally disturbed patients. The nursing sister in ward 5 said, "Very often you get apsychotic patients being admitted for psychosocial problems, and that is what bugs me the most. Keeping them in a locked ward is unfair and is also very unethical to keep that person for so long."

4.7.2 Patient safety

There is the problem in the open ward, of the safety of the patient being jeopardized by the fact that there is no constraint to their movement. The nurse in ward 3 said, "When a patient is walking around the grounds... especially with the forensic men (patients), then we see that this patient cannot look after themselves, and so it's best for that person, for safety to be in a closed ward." In ward 3 part of the activities that prepare the patient for discharge are group therapy meetings. The attendance and participation at these groups seems to influence the discharge of the patient. The nurse said one of the reasons for transfer back to a closed ward is, " (if) they are more gone than here, because they are here to attend groups." In discharging, the nursing sister in ward 3, said, "We look at the overall condition, their social problems and then we decide that the patient is ready to go."

4.8 PROBLEMS EXPERIENCED WITH TRANSFERS

4.8.1 Pressure to transfer

All nursing staff found that the biggest problem with transfers is the lack of space and beds for patient transfer. In each ward there is pressure felt transfer the patients. In ward 14 it is the patients arriving for admission, and the need to transfer suitable patients to ward 5. Due to pressure placed on the wards to transfer patients, nurses find themselves having to make some adjustments that compromise the transferring process.

The nursing sister in ward 14 said that at times she has to decide which patient is to be transferred even though she may have been off duty for two days. She has to ask for the nurses' opinion, as she does not know the patient very well. She said, "Because sometimes the morning, the patient is quiet and behaving well and you decide that this patient has been quiet today, let me transfer her, then when the patient gets to ward 5 or ward 3, this is when their behaviour is disruptive." This leads to further complications of

having to return the patient to a ward that does not have bed space, and of trying to transfer another patient.

At times, the nurses find that there may not be any suitable patients to transfer, but the nurses have to transfer a patient that relative to other patients, seems to be more suitable to transfer. The nurse in ward 5 said, "When we don't have a suitable patient to take to ward 3, then we must look for a suitable patient to take to ward 3." This is not always a practical thing to do. In the case where there are no discharges, and the patient needs to go back to the closed wards from the open ward, the nurses will make a swap between the wards. The nurse in ward 3 said, "We try someone a little better just to come to us, especially over the weekend or when there is no place, then we make a swap if it's possible."

But at the same time, a nursing sister in ward 5 felt that the doctors did not really listen to what the nurses had to say regarding transfers , adding that they approach patients from different perspectives. She said, "They would think of book knowledge, whereas we seldom, although it is important, but we seldom use book knowledge. Because the book will get you one thing and your perception and contact will give you some other aspects."

4.8.2 Patients' family involvement

Pressures for making bed space, are also aggravated by families not fetching patients when they are discharged. When a patient is supposed to be fetched from ward 3, and the patient still occupies a bed that could otherwise be filled by another patient, this is a problem that is felt by all wards. The nurse in ward 14 said, "We normally have the bed ready for one patient, but the other patient is still waiting on the family. It does take a while." Nursing staff has at times had to take the matter of delivering patients home into their own hands, at their own cost. As the nurse in ward 3 said, "One Sunday morning, me and sister went with each other. I showed her the way, how to drive to Retreat and we took the patient home. Because the family says we are coming, (but) we don't have a car."

4.8.3 Shortage of staff

The lack of resources also extends to the wards being understaffed. Although there are emergency beds available the nursing sister in ward 3 said, "I prefer not to fill those beds due to shortage of staff. I told management and the doctors, I will only fill those three beds when they give me more staff." The transfer and discharge of patients has to be managed within the capacity of beds that are available, and sometimes improvisations have to be made.

4.9 EXPERIENCES OF THE EFFECTS OF LANGUAGE ON TRANSFERS

The effect of a patient's language on their management was described universally as one of the major problems. But not all nurses agreed that this had any effect on transfers in particular. The problems associated with patients' language being foreign to the clinical staff in general, are described by a nursing sister in ward 14; "If you understand the language of a patient its easier to really know what the patient is feeling and what the patient is going through." She finds that this will affect the transfer and decisions made on the management of the patient. Yet another nurse in ward 14 found that the process becomes hard if language is a problem, for the patient and nurses who have to be there for the patient. She said, "When a patient cannot express herself then it is difficult.... This is why we are here, it's to give a listening ear and to care."

4.9.1 Xhosa speaking patients

The general feeling was that English and Afrikaans speaking patients did not have a problem being understood, as most of the staff could speak one or both of these languages quite well. On the other hand, the Xhosa speaking patients were the ones who had problems, as there was no interpreter based in the unit, at the time of these interviews. The general approach to dealing with these patients was to find Xhosa speaking staff to help. As the nurse in ward 14 said, "I see that the patient wants to say something then I ask (someone) if it's a Xhosa speaking patient, to please come and listen." When there are group activities, like there are in ward 3, the same applies that

Xhosa speaking nurses or other staff are asked to translate. The Xhosa speaking nursing sister based in ward 14 explained that having to interpret for other members of staff is a problem because of the added workload. As she explains, "And sometimes you will be called while you are busy doing something else, and you are busy interpreting... in a rush to go back to what you were doing." She spoke of the difficulties that she perceived Xhosa speaking patients to have regarding expressing their feelings, saying "they are not used to verbalise their feelings, and not used to talking about their experiences and lives." She finds that this becomes a further problem in interpreting, if there is a third person speaking for the patient. "It is not the way it was from that person who was explaining."

4.9.2 What nurses have done to alleviate problems

In most cases, there is help available in the form of a staff member. However, sometimes there is no Xhosa speaking staff member in the ward. As the nurse in ward 3 explains, "There was one time that we didn't have anyone in the ward, then we phoned one of the nurses in ward 2 or whoever was available to come and help us." It is not always possible to get them to come when they are needed, as the sister in ward 3 explains, often "the Black sisters point blank refuse to interpret." This she feels is at the expense of the patient's mental health. When there is no one to interpret, the nursing staff spoke of having to improvise to accommodate the language barriers to the best of their ability. The nursing sister from ward 5, said "I try to listen because this (Chinese) lady does not speak English or Afrikaans, she uses body gestures and all that." She said that she tries to understand the gestures. The nurse in ward 3 spoke of an instance when she had to take a Xhosa speaking patient to Groote Schuur on her own. Her attitude was to make the most of the situation. She spoke English and the patient spoke Xhosa, "with signs and whatever we understood each other." In the ward she said she will "talk strange English" in an effort to bridge the communication gap.

The nursing sister from ward 5 had a different experience with language. She found that language was not a problem for her, as she said, "I normally try to work with people irrespective of what their language is." Although she said she did not experience any

problems, it was unclear how she coped with Xhosa speaking patients, as she does not speak the language herself.

Nursing staff all agree that an interpreter is needed in the unit. Not all nursing staff were based in the unit when there was an interpreter employed there. The Xhosa nursing sister who was in the ward when there was an interpreter said, "It was much better then, that lady was very good with interpreting." And in the same vein the nurse in ward 14 said that it was not only with Xhosa speaking patients that an interpreter is needed. Although she is Afrikaans speaking, she finds documentation that comes with patients from places such as Stikland hospital written in Afrikaans, difficult for the doctors to read. She said, "Then there is a doctor who does not understand, even myself I don't understand because I am used to writing in English." The nursing sister in ward 3 recommended "that management should also send us for Xhosa lessons to enable us to communicate better with the patients."

4.10 EFFECTS OF RACE ON TRANSFERS

All but one nurse said they did not think that the race of a patient made a difference to the management and transfer of patients. The nursing sister in ward 5 finds that the race of the patient makes a difference in the treatment of the patient. In her opinion, " A white lady coming from G22... will go to ward 14 just for admission, and they will come straight from there, irrespective of what their condition maybe." She said that many times they would have a problem with the patients' behaviour and "then you have to say look this patient needs to be there 24 hours just to be observed." She found that most of the time, the doctors do not listen to the nurses. She finds "our doctors to be very racist" and when they attempt to discuss this issue with them, then "it's that we are racist." She considered herself to be an old nurse, and that this meant that she did not see patients' colour. In her opinion if she treated any patient differently on the basis of race, she will "set a precedent to other problems." She feels that the solution to all this is to make it compulsory that all patients spent 24 hours in ward 14, purely for observation.

In summary, the nursing staff experiences were that language does contribute to the management of patient, but not all agree that this affects the transfers of patients from ward to ward. Depending on the nature of the ward, the behaviour, safety and mental health of the patient will influence the decision to transfer patients. The nursing staff perceived numerous pressures that affect the transfer of patients, lack of resources as well as external factors. The nurses tried to find ways of coping with these problems, and most expressed the need for an interpreter to be re-employed in the unit. Race was largely not perceived to be of any influence in the management and transfers of patients. The next section will be the discussion of these results and recommendations for possible future research.

CHAPTER FIVE: DISCUSSION AND RECOMMENDATIONS

The desegregation process of health services began in the late 1980's with the realisation by clinicians that language issues had been neglected during the apartheid era. The move towards the integration of mental health services in general, saw the heightened need for clinicians to understand more languages, or alternatively to increase employment of interpreters. In psychiatric assessment, language and increased cultural awareness were beginning to be of utmost importance in a changing mental health service (Swartz, 1989). But later in the 1990's the language issue was still not being given priority, a situation that is true internationally and locally, and has a lot to do with the history of language in this country (Swartz et. al., 1997). Many reasons for the complex nature of language in psychiatry have been put forward, not least being the issue of under-resourced institutions.

This study was essentially conducted to explore the issue of language and race and the effect that these have on the management process of patients in a mental health hospital. The study aimed to approach the issue with an open mind and establish if there are any connections that can be drawn regarding race and language.

The study had to be conducted on archival material that was complete, and this implied the need to examine folders of patients that were out of the system already. This meant that although the archival study was done on a period of three months in 2001, the second part of the study had to be carried out with nursing staff currently based in the unit. A fundamental difference between the two periods in which the quantitative and qualitative parts of the study were conducted, is that there was a part-time interpreter in the unit, based at ward 14 during the January to March 2001. Although none of the admission policies have changed between these two periods of time, it is still possible that the results were influenced by the presence or absence of an interpreter.

The clinical implications of the results in this study seem to point to the fact that as far as the management of patients is concerned, language and race do not seem to make much of a difference. The data essentially looked at the numerical values of the different decisions that were made, on the basis of patients' race and language. There seems to be no significant difference in the trajectory of the patients from admission, their movement between wards, until their discharge. There seems to be no significant difference in the diagnosis of the patients on the basis of their race and language. There is no significant difference in the length of stay in the unit between the different language and race groups, and lastly, there seems to be no difference in the length of stay in ward 14, on the basis of patients' race and language.

The interviews with the nursing staff pointed to difficulties experienced in the management of patients in the unit, and their perceptions of the role of language and race in these matters. From these interviews, the perception is that language contributes largely to the management of patients. Not all agree that it affects the transfers of patients. Race was largely perceived not to influence the management of patients. This raises many questions, because nurses agree that there were difficulties arising from language difference in particular.

The role of nurses in psychiatric wards is important because of their hour by hour experience of patients. Therefore their input to this study was essential, as it was the nursing staff that initially brought the issue of language and race to the foreground in the unit. Their close contact with the patients as well as their position in the hierarchy, as regards the decisions made about the management of the patients made their perceptions valuable on this matter.

5.1 Decision making

A theme that emerged in the nurses' experiences was the pressure placed on the wards to admit, transfer and discharge. In particular the nursing staff experience the pressure of having to "choose" suitable patients to transfer, even when this is impossible due to a

lack of "suitable" patients at the time. They are forced to nominate for transfer patients who may be psychotic. At the same time there is a feeling that doctors do not listen to the opinions of nursing staff regarding the management of patients. The nature of the nursing staff's role is that although they are part of, and contribute to the decisions of a multi-disciplinary team, the final decisions rest with those higher up the hierarchy. In a sense although the nursing staff have direct contact and knowledge of their patients, the decisions happen to them rather than because of them. Is it the dilemma of this position that can account for the perception that doctors do not listen to nursing staff? As Johnson (1996) wrote, people's conceptual framework matters in the subsequent perceptions and experiences they have, as these are informed by their assumptions and beliefs.

5.2 Language effects

The effect that language has on the management of patients was reported to be of great influence. In particular Xhosa was seen as the language that presented the staff with problems around understanding patients and the need for interpretation. It is interesting to note that the nursing staff mostly did not find that the language affected transfers. Only Nurse 2 who is Xhosa speaking felt that it did. She spoke about her experiences of Xhosa speaking patients finding it difficult to speak about their feelings, and not being accustomed to verbalizing their feelings. As a result she finds that this inhibits understanding the patients' state of mind and their emotions, and can influence one's decisions regarding patients' suitability for transfer. But the statistical data suggests otherwise. This raises the possibility that one's racial identity influences the perception one has of the role of language in the management of patients. It is inherently easier for a Xhosa nurse to have additional insight into Xhosa patients' reality and this points to the need for greater cultural sensitivity essential for other nursing staff.

Nurses reported the need to 'make do' with the situation of not having an interpreter, and the result has been the need to improvise and find ways to cope. This has some effect on the quality of management that the nursing staff, and the rest of the clinical team can impart to their patients. The results of this study suggests that work relationships are

bound to be strained, as black nurses are feeling over-worked by the additional task of interpreting for the ward, as well as for other wards. As Swartz (1989, 1991a) has noted there are immense emotional implications that language issues have on staff and patients alike. The need to appoint an interpreter is clearly important on multiple levels, not only for the improvement of patient-doctor communication, and quality of patient care but to always avoid tension between different staff members.

5.3 Race effects

The lack of resources and the fact that language issues are the main cause for inequality in accessing mental health services (Drennan, 1996, 1999), are of grave concern as essentially these seem to affect Xhosa speaking patients more than any other group. One cannot speak of bias in patient care on the basis of language without further adding, that this is a racial bias because only one racial group is affected. It is interesting that in 2001, there was a perception amongst nursing staff that the race of patients affected their management, and this was discussed in many ward rounds as a contentious issue that needed resolving. Yet a year later in 2002, the perception of most of the nurses in the sample was that race does not affect the management of patients. Moreover, without an interpreter, their situation is arguably worse than it was in 2001. This raises questions such as what has changed in the experiences of nursing staff? As there is a great turn-over in the staff members, registrars, intern clinical psychologists as well as nursing staff, is this a reflection of a new team that has different experiences? Is this 'silence' a result of raising a sensitive subject, and the need people have to portray particular impressions to the interviewer? Discussing race has been found to make people uncomfortable, as is the fear of being labeled racist (Swartz & Drennan, 2000). One hypothesis is that this issue has been met with resistance and anxiety from when the nurses raised it with the multi-disciplinary team, and that this has resulted in the topic being too sensitive for open discussion.

In the same way it is of interest that an older nurse perceived race to be influential in the management of patients. Does the length of time a nurse has worked in the ward

influence her perception of the pertinent issues surrounding management, as she has been in service since before the integration process? When differences in opinion concerning the best decision for patient management arise, are issues of race reverted to as an explanatory model?

Having established that there is the element of nursing staff feeling like they are "not heard", is the fundamental issue that of feeling "invisible" within the system? The issue of the way in which decisions are made is something that nursing staff seem to feel like they cannot debate and challenge due to their position in the hierarchy. It is possible that the feeling of being "invisible" in this system brings out remnants of sensitivities from the old regime, in that in both there is the same effect of not acknowledging the contribution of part of the population.

In summary, it seems that the management of patients is fair according to the archival material. This is good news as it indicates that some progress has been made in the integration of services. But it also seems that there are issues that affect a subtle level of management. These may have been due to managerial problems within the wards, which have lead to some tensions between doctors and nurses. There is also the lack of resources and adequate facilities. It can be assumed that the lack of communication between clinicians and patients may mean that some crude decisions are made regarding management. But it is also true that the research did not find that in 2001 race and language affected the trajectory of patients. In 2002 nursing staff say that the race and language of patients does not affect trajectory, a situation that may reflect the reality of the racialization of the old regime giving way to other concerns.

5.4 LIMITATIONS OF THE STUDY

This study used a small sample to ascertain the perceptions of nursing staff, and they may not be representative of the full range of experiences and perceptions of the nursing staff based in the female admissions unit in Valkenberg hospital. However this sample

suggests that further interviews of nursing staff in the unit would help provide some further insight into their experiences.

The archival study did not yield sufficient information about the reasons for patients' transfers from ward to ward, as not all staff notes were available and accessible. This part of the study raises questions for future research, which may look at the actual reasons for transfers, and the race and language of patients. This would compare and contrast the nursing notes in movement charts, with the case manager's notes from consultations and ward round decisions.

5.5 RECOMMENDATIONS

5.5.1 Interpreters

One of the salient themes to emerge from this study has been the need expressed by all nurses for the appointment of interpreters. Although the presence or absence of interpreters cannot be clearly linked to the differences in the transfers of patients in this study, the role of interpreters and their invaluable contribution to the multi-disciplinary team in South African psychiatry has long been established (Swartz, 1989, 1991b, 1998; Crawford, 1994; Swartz, et. al., 1997; Drennan, 1996a, 1996b, 1999; Muller, 1994). The language issue in mental health has been addressed repeatedly through the 1990's, and issues surrounding the history of language politics in South Africa, policy issues, staff shortages and the emotional dimension of language have been explored (Swartz, et. al., 1997; Swartz & Drennan, 2000). However, considering all the literature produced, and the common sense need for the presence of an interpreter in serving a multilingual patient population, there are still problems in acquiring and retaining interpreters. The need for market related, remuneration packages for interpreters (Drennan, 1996) has to be emphasized again, to attract candidates to these positions. The value that the system places on the work that interpreters do needs to be reflected in their salaries.

5.5.2 Interventions

The need for some basic language skills for the staff in general is needed. There needs to be some recognition that the experience of nursing staff is that the management of patients is being conducted in a haphazard manner due to the lack of formal interpreting facilities. At the same time, cultural sensitivity to the types of behaviours and expressions of feeling that patients are used to could serve to enhance patient care. This is clearly ambitious in a setting where shortage of staff and resources is a fundamental issue. However there needs to be some understanding of a patient's cultural background.

During my internship placement at the unit there was a staff group that was attended by the whole unit, albeit sporadically. The group was facilitated by a social worker and it was held fortnightly after ward round. The group was not as consistent as it could have been ideally, and the attendance of nursing staff was sporadic due to understaffed wards. The need for staff support groups and workshops is essential in the provision of much-needed support, and a platform to address issues affecting the nurses. Although these have not always been successful in the past, further effort to support people working in stressful environments needs to be made, for the benefit of both staff and patients.

5.5.3 Further research

Research into the management of patients, and the effect that race and language has on this, can be expanded to examine whether gender affects the results gathered. Additionally, as mentioned elsewhere, the issue of class is important, as the educational backgrounds of patients make a difference to the elimination of language as a barrier for adequate treatment.

Further research needs to be carried out using a bigger sample of nursing staff in order to get a wider view of the perceptions and experiences of nursing staff. The rest of the multi-disciplinary team, given their individual roles in the management of patients, is an important source of information as regards the language and race issue. Indeed the

comparison of attitudes and experiences across professions would give insight into the nature and origin of these perceptions.

The policy of keeping all patients at ward 14 for twenty-four hours for observation, which was proposed by nursing staff in the past, is controversial because of the fear of doing more harm to the patients than good. However if it were possible, a comparative study would essentially be a way of putting the issue to rest. If all patients were kept in ward 14 for twenty-four hours, would the perception that there is bias in management of patients disappear in nursing staff?

As mentioned before, lack of adequate communication between patients and caregivers has led to some decisions in management and treatment being compromised. Communication is an essential part of psychiatric treatment and further research needs to carry out an ethnographic study that monitors the finer details of the management of patients. In this way the interaction of nursing staff and patients can be observed to ascertain which patients they interact and communicate with. In group therapy, the process can be monitored to establish which patients talk, and with whom the facilitators interact. In addition, ward rounds can be observed to figure out which patients get discussed and which ones get called in to meet the team. This type of study could monitor language, race and possibly add other variables, such as class and educational status of patients.

5.6 CONCLUSION

This was a study that set out to explore the factors that are involved in the trajectory of patients admitted to the women's admissions unit, at Valkenberg Hospital. This study began as a result of observations made by nursing staff of bias in the admission process of patients, towards those who were English speaking. This they felt resulted in patients having to be re-assessed as a result of having by-passed the closed wards, for the more open wards.

The study was conducted using archival material as well as interviews with nursing staff members. Of the 149 folders retrieved 118 of these met the criteria set out. Six nursing staff members taken from the unit, representing all three wards, were interviewed. The quantitative results of the study suggest that no significant differences can be found to exist in the management of patients, in so far as the trajectory, the diagnosis and the length of stay of patients is related to their race and language. The experiences of nursing staff were that many factors are involved in the decision making of the psychiatric team. However the nursing staff experiences and perceptions regarding the issue, were that language contributed largely to the management of patients in so far as it made it difficult to give proper care. Not all agreed that language problems affected transfers of patients from ward to ward. The nurses were working under difficult conditions, having to find ways to cope with the problems. From the interviews it is not clear whether all the difficulties experienced by the nurses could be attributed to the presence or absence of an interpreter, but all felt that an interpreter would be of value in their work. The race of the patients was largely perceived not to influence the management of the patients, although Xhosa speaking patients, who also belong to one race, were the ones who presented with the problem of not being understood. Recommendations regarding the appointment of interpreters in facilities which serve multi-lingual communities, and reassessing the remuneration of interpreters as a matter of urgent concern were made. Language policies, which would systematically make it easier for staff to a have a basic understanding of the languages in provinces they work in are needed. Intervention for staff in the form of support groups, workshops and even basic empowering language skills, would develop cultural sensitivity and insight, and prevent the deterioration in quality of the treatment of patients as a result of language and race barriers.

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Dr. Van Heerden
Administrative Block
Valkenburg Hospital
Cape Town.

P.O. Box 34671
Groote Schuur
7937
27-04-2002

Dear Dr. Van Heerden,

Re: Permission to access data for research purposes.

I would like to write a Masters in Clinical Psychology thesis on the following topic: The trajectory of patients in the female admission ward at Valkenberg hospital. (Research proposal enclosed)
Dr. Anna Gevers has given me her written support regarding the proposed research. (Letter enclosed). I hereby ask for permission to access patients' files for the purpose of this research.

Yours sincerely,

Kehiloe Beukes (Ntsekhe).

Supervisor: Sally Swatrz

ENQUIRIES
NAVRAE
TELEPHONE
TELEFOON
Dr S Kaliski
4403195

REFERENCE
VERWYSING

PROVINCIAL ADMINISTRATION: WESTERN CAPE
Hospital and Health Services Branch
PROVINSIALE ADMINISTRASIE : WES-KAAP
Tak Hospitaal - en Gesondheidsdienste
ULAWULO LWEPHONDO : INTSHONA KOLONI
Isebe LezeMbilo neeNkonzo zeNtlalo

DATE
DATUM
12 August 2002

Ms K Ntsekhe
PO Box 34671
Groote Schuur
7937

RE: **The trajectory of patients in the female admission ward at Valkenberg Hospital**

1. Thank you for applying to do research in this hospital.
2. After due consideration of your protocol permission has been granted for you to use the hospital facilities for your project.
3. Please remember that you will need official acceptance from the Ethics Research Committee at UCT before commencing with your study.
4. It may be helpful to forward a copy of this approval to the hospital.

Good luck with your studies,
Yours sincerely,

Signature removed

DR. SEAN KALISKI
For: Senior Medical Superintendent

VALKENBERG HOSPITAL
PRIVATE BAG X1
OBSERVATORY
7935
FAX: (021) 440 3199

VALKENBERG HOSPITAAL
PRIVAATSAK X1
OBSERVATORY
7935
FAKS (021) 440 3199

No.	Age	Age1	Race	Lang	Admis	Diag	Trajector	L.ofstay1
1	35	3	2	2	1	2	4	5
2	51	5	2	2	1	3	7	2
3	36	3	2	2	1	2	3	4
4	48	4	3	3	1	3	3	2
5	52	5	2	2	1	6	1	1
6	19	1	2	3	1	4	3	3
7	44	4	1	1	2	3	11	1
8	51	5	2	2	1	1	2	1
9	52	5	1	1	1	4	7	5
10	41	4	1	1	1	4	1	1
11	36	3	2	2	1	3	1	1
12	33	3	2	2	1	5	1	1
13	46	4	3	3	2	3	8	2
14	47	4	3	3	1	3	4	4
15	35	3	1	1	1	4	1	1
16	50	4	3	3	1	1	8	11
17	40	3	2	3	1	3	3	2
18	26	2	2	3	1	4	6	4
19	22	2	2	3	2	6	4	3
20	20	1	1	1	1	5	3	3
21	47	4	1	1	1	4	4	3
22	47	4	2	2	1	1	4	3
23	53	5	2	2	1	3	3	2
24	31	3	1	1	1	2	3	2
25	57	5	2	2	3	4	3	2
26	29	2	2	2	2	3	3	2
27	49	4	2	3	1	5	3	5
28	37	3	1	1	1	3	4	2
29	34	3	2	2	1	3	3	2
30	52	5	2	2	1	2	3	3
31	19	1	2	2	1	2	5	5
32	26	2	2	3	1	3	2	1
33	28	2	1	1	1	3	4	3
34	50	4	2	3	1	3	1	1
35	36	3	2	2	1	4	3	2
36	39	3	3	3	1	1	3	1
37	48	4	1	1	3	4	4	4
38	53	5	3	3	3	3	2	1
39	35	3	2	3	1	4	10	3
40	21	2	1	1	1	2	7	2
41	51	5	2	2	1	2	8	1
42	35	3	1	1	3	5	6	5
43	43	4	3	3	3	3	4	2

44	33	3	1	1	3	3	11	2
45	19	1	1	1	1	6	2	2
46	51	5	1	1	1	4	3	4
47	47	4	2	2	3	4	4	3
48	21	2	1	1	1	5	4	4
49	28	2	2	3	1	4	3	5
50	49	4	3	3	1	3	4	5
51	60	5	1	1	3	3	3	2
52	47	4	2	2	1	4	3	2
53	49	4	3	3	2	3	4	3
54	29	2	2	2	1	2	3	1
55	57	5	3	3	3	4	3	1
56	56	5	1	1	3	4	4	2
57	20	1	2	2	1	5	3	2
58	39	3	2	2	1	3	4	4
59	28	2	2	2	2	5	3	1
60	49	4	2	3	1	2	3	2
61	39	3	3	3	2	3	7	3
62	27	2	2	3	1	5	4	4
63	37	3	1	1	1	3	3	2
64	50	4	2	2	1	4	4	5
65	25	2	2	2	3	5	2	1
66	47	4	2	2	1	5	3	2
67	64	6	3	3	3	3	4	5
68	38	3	2	3	1	4	4	2
69	20	1	2	3	3	2	8	3
70	50	4	3	3	1	2	10	2
71	30	2	2	2	1	2	3	4
72	23	2	2	2	1	1	2	1
73	23	2	1	1	1	5	2	1
74	56	5	2	2	1	4	3	1
75	28	2	2	2	2	3	4	4
76	37	3	1	1	1	3	5	5
77	36	3	2	2	1	5	11	2
78	52	2	2	2	1	6	3	3
79	48	4	2	3	3	4	6	3
80	40	3	3	3	1	2	5	1
81	33	3	2	2	1	5	3	2
82	37	3	3	3	1	3	4	2
83	27	2	3	3	1	4	3	2
84	18	1	2	3	1	2	9	2
85	21	2	3	3	1	5	3	5
86	58	5	2	2	1	6	2	1
87	46	4	3	2	1	4	4	3

88	60	5	2	2	1	4	4	4
89	45	4	2	3	3	2	4	4
90	27	2	2	2	1	6	3	3
91	27	2	1	1	1	1	7	1
92	30	2	1	1	2	3	4	3
93	26	3	1	1	3	1	6	5
94	31	3	2	2	1	3	2	1
95	36	3	2	2	1	5	4	5
96	37	3	2	2	3	4	5	4
97	31	3	1	1	1	1	4	2
98	61	6	1	1	1	4	3	2
99	39	2	2	3	1	4	4	5
100	48	4	2	2	1	2	4	2
101	64	6	2	3	2	4	2	1
102	45	4	2	3	1	4	1	1
103	45	4	2	2	2	3	4	5
104	29	2	2	3	2	1	4	2
105	30	2	3	3	3	4	3	1
106	46	4	2	2	2	4	3	5
107	36	3	1	1	3	4	4	2
108	30	2	2	2	1	4	4	2
109	53	5	3	3	3	4	7	3
110	41	2	1	1	1	3	2	1
111	28	2	1	1	1	3	2	2
112	43	4	3	3	3	3	4	3
113	38	3	3	3	1	4	5	1
114	19	1	2	3	1	1	3	2
115	48	4	1	1	1	1	2	1
116	40	3	2	2	1	4	3	2
117	23	2	2	3	3	3	3	4
118	44	4	2	2	1	6	3	1

APPENDIX 4: INTERVIEW SCHEDULE

1 What are the patient factors that influence the patients' transfer process?

2 What are the problems that you experience regarding transfers?

3 What is your experience of how race and language affect patients' transfers?

4 What is your experience of the difference between having an interpreter in the ward and not having one?

5 What would you recommend to alleviate problems regarding transferring and management of patients?

APPENDIX 5: CODING SHEET
Coding sheet

Variables:

Age:

1. <20
2. 21-30
3. 31-40
4. 41-50
5. 51-60
6. >61

Race:

1. Black
2. Coloured
3. White

Language:

1. Xhosa
2. Afrikaans
3. English

Previous Admissions:

1. 0-4
2. 5-9
3. >10

Transfers:

1. d/c same day.
2. 14 d/c
3. 14-5 d/c
4. 14-5-3 d/c
5. 14-5-14 d/c & any other
6. 14-5-3-5 d/c & any other
7. 14-3 d/c & any other
8. 5-3 d/c
9. 5 d/c
10. 3 d/c
11. Abscond

Length of stay in unit:

1. >10
2. 11-20
3. 20-30
4. 31-40
5. 41>

Length of stay in 14:

1. <1
2. 2-10
3. 11-20
4. >21

Diagnosis:

1. MDE – suicidal ideation
2. MDE/BPAD- psychotic
3. BPAD – manic episode
4. Schizophrenia (incl. relapse)
5. Psychotic episode – drug/ alcohol induced or due to GMC or p/partum
6. Other

Transfers 1 (new):

1. 14 d/c
2. 14 d/c
3. 14-5 d/c
4. 14-5-3 d/c
5. 5,6,7,8,9,10/
6. Abscond

Diagnosis 1 (new):

1. MDE/BPAD – suicidal
2. 2,3,5.
3. Schizophrenia (incl. relapse)
4. Other