RESEARCH

THE SOCIAL SUPPORT NETWORK FOR BLACK PSYCHIATRIC INPATIENTS

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ABSTRACT

A survey was carried out of almost 50% of Black inpatients in a state psychiatric hospital to evaluate the level of accessibility of the family network of the patients. Staff were interviewed on the problems they have with contacting families. The survey shows the extent of inadequate access and identifies reasons for the problem.

OPSOMMING

'n Opname is gedoen van 50% van die Swart binnepasiënte in 'n staatspsigiatriese hospitaal om die vlak van toeganklikheid van die familie-netwerk van hierdie pasiënte te evalueer. Onderhoude is ook met personeel gevoer in verband met die probleme wat hulle ondervind om families te kontak. Die opname toon die omvang van onvoldoende (berukbaarheid) en identifiseer redes vir die probleem.

INTRODUCTION

Social support networks are an important aspect in the care, treatment and rehabilitation of psychiatric inpatients (Liberman, 1988). The overriding goal of practice is to keep the client in the community and in contact with his or her existing network as much as possible because of the eroding effects of frequent separations.

If and when hospitalisation is necessary, the client and network members should be encouraged to keep in contact with one another. The psychiatric nurse should be there to ensure that the client's progress is enhanced by improving network building skills, and improving connections between the client's personal and professional network* by involving the family during treatment (Ellison, 1983).

* In this study, a social network refers to all the people known by a person with whom interaction occurs. Social support network refers to all these people in the network who offer psychological support and tangible assistance.

PROBLEM STATEMENT

In Natal, making contact with the family of a black hospitalized psychiatric patient is difficult in many ways for the following reasons:-

1. From admission the patient may have no traceable family. Patients found wandering the streets, or those presenting themselves to the hospital or brought by escorts or police are sometimes not able to give important personal information due to the degree of mental illness.

2. Patients do not receive regular visits from their next of kin and sometimes may be discharged without the staff ever meeting their next of kin. Homes are sometimes far and the difficulties of getting to hospital many.

3. Contacting the family by correspondence can be complex as there is often no proper address. Patients from the rural areas do not use a street name or house number when giving their addresses. The addresses given by patients are not always helpful, since they use property-owner's names, the local shop or local school's address. On one property people with the same name and surname may be found. If no member of the family attends the school or goes to the local shop, correspondence will never reach home. Even if people do go to the local shop, checking on post is not a priority. Also the school and shop may have been closed, rendering this exercise futile.

4. Residential addresses often change because of arbitrary removal of homes and uprooting of communities, particularly among politically unstable communities such as in Natal at the time of doing this research. The desertion of homes and destruction by fire may also be mentioned in this regard. So the last address known by the patient may be outdated.

5. The use of a telephone would make communication easier but most patients do not have a telephone. Where the next of kin works in the urban area a work telephone number could be of use but patients very seldom know this number.

The result of this lack of contact with the social support network is firstly, that treatment is more difficult and less effective. Secondly, some patients end up in a care and rehabilitation centre since their families cannot be traced and they cannot be discharged on their own responsibility.

The next of kin similarly would experience the difficulties of failing to trace the person who wandered away from home. They may think the person died because of the escalation in the number of deaths, others may hope the person returns one day.

If contact with the family is so minimal, the team cannot answer questions about the background, premorbid personality or cause of illness.

SIGNIFICANCE OF SOCIAL SUPPORT

A reasonable amount of tested evidence points to the positive relationship between social support and mental health (Mullis and Beyers, 1987). This relationship is explained by three schools of thought.

The first school explains support as having a direct effect on mental health. Well-being is seen to be the result of strong social support influencing and enhancing growth and development and reducing social isolation (Litwin and Auslander, 1990). The strength of this view is in the preventative aspect. Stress has been found to have a harmful effect on people and social support networks seem to protect them, improve on well-being and their level of adjustment to stressful situations such as illness (Primomo, 1990).

This takes us to the second view which suggests that social support acts as a buffering agent by mediating and moderating stress. Due to the moderating effect of social support on life stresses, it has been found to reduce the need for rehospitalisation (Sokolove and Trimble, 1986).

Another group views support as meeting certain needs. It is in the presence of social support that requirements are met when certain tasks are performed. Support is thus given and gained in the process of carrying out tasks (Mullis and Byers, 1987). The same sources of support can affect people with different needs in a varied way.

Table 1 Patient Sample According to Age and Gender						
Age in Years	Male	%	Female	%	Total	%
16 - 24	44	34.3	4	7	48	26
25 - 34	49	38.3	23	40.3	72	39
35 - 44	25	19.5	8	14.3	33	17.8
45 - 54	7	5.5	14	24.6	21	11.3
55 - 60	3	2.3	3	5.3	6	3.2
60 & ABOVE	-	-	5	8.8	5	2.7
TOTAL	128	100	57	30,8	185	100
MEAN	33	69.2	39			

The weakness of the whole argument is that it ignores the negative by-products of support networks. Wortman (in Malone, 1988) observed that well intentioned efforts to provide support may be seen as unhelpful by the recipient, causing negative outcomes.

RESEARCH QUESTIONS

1. How many inpatients have a home address reachable by either post or transport?
2. In how many cases can the next of kin be contacted by telephone either at work or at home?
3. How many patients have visits from their next of kin whilst hospitalised?
4. How is access to the family influenced by variables such as age, sex, marital status, and type of admission?
5. What are the main factors and problems encountered by the health professionals in accessing families?

STUDY DESIGN

A survey was done in a psychiatric hospital situated in an urban area in the Natal Midlands. The study was carried out by the researcher alone over 5 days in September 1991.

SAMPLING

Patients

The research sample was drawn from the total hospital population of 381 patients cared for in 13 wards. Of this population 48,5% were stratified according to gender and then randomly selected and thus the sample consisted of 128 males and 57 females. In one ward where the numbers were very low, all patients were included despite the gender ratio not being correct.

STAFF

All the psychiatric professional nurses in charge of the thirteen wards, the psychiatric community professional nurses and the three hospital social workers were included in the survey.

DATA COLLECTION

Patients

A study of hospital records was used to collect data on age, sex, marital status, next of kin, address, telephone number and any 'leave of absence' record. Patient interviews were held to obtain information not available in the records. This included information on any visits received from family or significant others but such information depended on the patients' mental state.

Staff

Semi-structured interviews were carried out with staff members. These were used to obtain information on any difficulties they experienced in contacting the support network and whether attempts have been made to overcome these difficulties.

PATIENT SAMPLE DESCRIPTION

Table 1 reflects the age and gender of the 185 patients surveyed. Most patients were male and under the age of 34 years; the age range for both sexes was 16-66 years with a median of 29 years.

Single/unmarried patients constituted 81.1% of the total population. Married females made up 26.3% of women whereas only 11.7% of males were married in this population. There were more widows (5.3%) than widowers (0.8%). This population had no divorced males and only one woman was divorced.

Certified patients made up 64.9% (70 men and 50 women) of the sample. Only 5 (2.7%) patients were admitted by consent. Two men but no women were admitted voluntarily. It was interesting that 41.4% of the male patients were in forensic units and of this total 33.6% were state patients and 7.8% admitted for observation. Of the female population 25.4% were state patients with no patients for observation at the time of study.

ACCFSSIBILITY

Table 2 shows that for 6% of the patients no address was available, while only 32.4% had clear individual addresses. All the others used depository addresses (61,6%).

Table 2: Addresses used by Patients (n=185)

Gender	Reachable Home Address	%	% Property Owner	%	% School Shop	%	% Farm	%	Unknown	%	Total
Male	42	33.0	51	40.0	27	21.1	3	2.3	5	4.0	128
Female	18	31.6	22	38.6	11	19.3	-	-	6	10.5	57
TOTAL	60	32.3	73	39.5	38	20.5	3	1.6	11	6.0	185

Table 3: Factors Comprising Network Access according to Gender (n=185)

	YES						NO						DON'T KNOW	
	M	%	F	%	T	%	M	%	F	%	T	%	T	%
Transport*	75	40.5	34	18.4	109	58.9	44	23.8	18	9.7	62	33.5	14	7.5
Telephone**	30	16.2	15	8.1	45	24.3	98	53.0	42	22.7	140	75.7		
Visitors***	47	25.4	27	14.6	74	40,0	81	43,8	30	16.2	111	60.0		
Leave of Absence**** (State Patients=41)	11	26.8	3	7.3	14	34.1	26	65.9						

* Accessibility of patients' homes by transport. ** Accessibility of telephone for contacting patients' families.
*** Visitors received by patients since hospital admission. **** Applies only to state patients.

Table 3 summarises the accessability of the social network in terms of four different contact avenues. A home address reachable by transport seems to be the avenue available to most patients (58,9%), while a telephone is the least available avenue (24,3%). All avenues (except an address reachable by transport) are available to less than 50% of the sample.

FACTORS INFLUENCING FAMILY ACCESS

Accessibility of the family was rated according to a score of 0-3. The patient received one mark for each of the following:-

- reachable home address
- telephone number
- visitors from home

Where none of the above factors were present the score was 0. This accessibility score was then correlated with different demographic factors to establish their influence on accessibility.

The influence of **gender** on accessibility of the family is summarised in Table 4, showing that for 45.6% women of opposed to 36,7% men, there were no obvious ways of communicating with patients' families. On the other hand, more women than men had the maximum score of 3. On testing, it was found that access is significantly different for men than women (t value 7,36; significant at 5% level).

A t-test of 9.53 showed a significant relationship between **marital status** and accessibility of the family (on a 5% level). The number of divorced and widowed people is so small that it might not be an important finding. The difference between single and married is mainly on levels 2 and 3 (Table 5).

The influence of the type of admission is summarised in Table 6 A t score of 4.46 showed that there is a significant relationship between type of admission and accessability of the family (on the 5% level). The certified and state patients have a very poor level of access.

STAFF INTERVIEW RESULTS

The following factors were seen by nursing and social work staff as influencing accessibility of the family.

ENVIRONMENTAL FACTORS:

- The patients' homes were inaccessible because of poor infrastructure, no proper roads or addresses. No house number, especially in the rural and informal settlement areas, was mentioned by 63% of staff interviewed.
- In underdeveloped areas, shops and schools are far from homes. If shops and schools are used as residential addresses, post may be checked very seldom.
- Few houses had telephones
- Community staff are afraid of leaving government vehicles alone and walking too far, for fear of the vehicle being stolen
- The psychiatric institution itself is far from patients' homes

ADMISSION PROCEDURE

- Patients are at times picked up in the streets and certified by police with no information about the families available.
- The people escorting patients to the psychiatric hospital are not necessarily the relatives. They may be hired by the local magistrate in the relevant residential area.

PERSONAL FACTORS

- The degree of mental illness of the patient is such that he cannot give a clear history of his illness.
- Illiteracy is still a problem with patients not able to describe clearly a place of employment or give telephone numbers of relatives.
- Social workers have found that patients withhold addresses because the hospital seems better than home. Some patients admitted for observation do not want their families to know where they are.

SOCIAL FACTORS

- The family reacts negatively to patients because of the stigma of mental illness.

Table 4. Gender & Accessibility (n=185)

	MALE		FEMALE		TOTAL	
ACCESS	f	%	f	%	f	%
0	47	36.7	26	45.6	73	39.5
1	40	31.3	14	24.6	54	29.2
2	25	19.5	6	10.5	31	16.8
3	16	12.5	11	19.3	27	14.6
Total	128	69.2	57	30.8	185	100.0

Table 5. Access and Marital Status (n=185)

ACCESS	M	%	S	%	W	%	D	%	TOTAL	%
0	12	40.9	60	40.0	1	25.0	0	0.0	73	39.5
1	9	30.0	43	28.7	1	25.0	1	0.5	54	29.2
2	3	10.0	28	18.7	0	0.0	0	0.0	31	16.8
3	6	20.0	19	12.7	2	50.0	0	0.0	27	14.6
Total	30	16.2	150	81.1	4	2.2	1	0.5	185	100.0

M Married S = Single W = Widowed D = Divorced

Table 6: Type of Admission and Access

ACCESS	CERT	%	SP	%	CONSENT	%	OBS	%	VB	%
0	48	39.7	17	36.2	1	20.0	7	70.0	0	0.0
1	33	27.3	19	40.4	0	0.0	2	20.0	0	0.0
2	24	19.8	5	10.6	1	20.0	1	10.0	0	0.0
3	16	13.2	6	12.8	3	60.0	0	0.0	2	100.0
Total	121	65.4	47	25.4	5	2.7	10	5.4	2	1.1

CERT = certified patient SP = state patient
OBS = observation VB = voluntary patient

- The family gets relief when the patient is removed from home.
- Family members may not be at home or away working when the home is visited.

OTHER FACTORS

- Community services are centered in urban areas with few facilities available in rural areas.
- There are few mental health societies. This was specifically mentioned by the social workers.
- Hospital social workers depend on field social workers who usually have their own case loads which take precedence.
- Social workers fall under different administrative authorities such as the province and the various homelands so liaising and coordination is difficult.

CONCLUSION AND RECOMMENDATIONS

Poor access to patients' homes was evident with only 32.4% of patients having a reachable home address, only 59% of homes being reachable by transport and only 24.3% having telephones.

Variables such as age, sex, marital status and type of admission play a role in network accessibility. A higher percentage of females than males had no access, but on the other hand more females scored high for accessibility than males.

More support was given to ages below 18 and above 66 years. For ages between 25 and 39 years the mean score was 0. On the whole these adults formed a neglected group.

Single people had less support and on level 3 there were more married than single patients. Certified and state patients had poor support and there was a lack of decentralised psychiatric services. This means that patients from rural areas have to travel to urban areas for treatment.

If there is no clinic near the patients' homes, psychiatric illness may not be detected early and unnecessary hospitalisation may result.

The other finding was the fragmentation of services whereby it is difficult for social workers to refer cases to other social workers in the rural areas. Likewise, liaison between the Department of Justice, correctional services and health services should be improved so that patients know where and when to go.

Admission procedures could be bettered so that the family accompanies the patient to hospital or gives full particulars to whoever brings the patient to hospital.

Psychiatric care should be available at various health care levels with extension to the rural communities. Less hospitalization can be envisaged because both the patient and family have accessible health care facilities. Health education on mental health/illness should be aimed at families, so that they are able to understand and accept their mentally ill member. Health education is essential in forensic psychiatry so that patients and their families know their rights or what to do.

Community psychiatric nurses and primary health care workers should be involved with community development. The introduction of available resources such as postal systems and clinics to the rural areas and even some urban areas will augment the delivery of appropriate services.

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