The analysis of child cases referred for psychological services in private practice within the Northern KwaZulu-Natal region

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Declaration

I, Sithembiso Mnguni, hereby declare that the thesis entitled: **The analysis of child cases referred for psychological services in private practice within the Northern KwaZulu-Natal region**, is my own work and has not been previously submitted. All the sources used have been indicated and acknowledged by means of complete referencing.

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Abstract

Psychological services are considered to be central to health promotion for young children as they promote psychological well-being through awareness programmes, skills development and therapeutic services. This study aimed at investigating child cases that were referred for psychological services in private practice within the Northern KwaZulu-Natal region. The study examined the barriers to accessing psychological services and the Ecological theory, which supported the study, was also discussed.

This study adopted a quantitative approach, using a survey questionnaire. Thirty-one records of both males and females were analysed, all of whom were of school-going age between the ages of six and 18 years. The quantitative data were captured and analysed using the Statistical Package for Social Sciences (SPSS) and presented in contingency and frequency tables.

The key findings and literature indicate that teachers made the most referrals, while mothers were found to make the least. The study revealed that the most common reasons for referral were academic and concentration difficulties and that the majority of the referrals were made in 2008. It was found that there were differences in boys' and girls' presenting problems with boys presenting with psychological/emotional difficulties and girls presenting with cognitive difficulties. Lastly, the study found that there was a lack of information regarding mental health service providers which speaks to an inadequate number of mental health providers in South Africa, especially in rural areas.

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Abbreviations

ADHD	Attention deficit hyperactivity disorder
CAMH	Child and adolescent mental health
CFC	Child and Family Centre
DBE	Department of Basic Education
DBST	District-based support team
DoE	Department of Education
DoH	Department of Health
GP	General practitioner
HPCSA	Health Professions Council of South Africa
KZN	KwaZulu-Natal
LMIC	Low and middle-income countries
LSA	Learner support agent
SBST	School-based support team
SES	Socioeconomic status
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization

Chapter One: Introduction

1.1 Background of the study

Psychological services are central to health promotion for young children. The focus of psychological services is on promoting psychological well-being and improving daily functioning through awareness programmes, skills development and therapeutic services (Nkwanyana, 2013; Naidoo & Jeena, 2014). Moreover, the aim of psychological services is to enhance and promote children's psychological well-being, as much as they intend to reduce psychological distress (Nkwanyana, 2013).

Children and young adolescents are considered to be the most vulnerable to mental health problems (Rickwood, Mazzer & Telford, 2015). Martadza, Saedon, Darus, Badli, Ghazalan and Yunus (2019) stated that a large number of children are currently facing mental health challenges. Mental health problems are seen as the main source of the burden of disease in children and adolescents, this is because they affect between 10% and 20% of children and adolescents worldwide (Harnois & Gabriel, 2000; Wilger, 2015; Mokitimi, Jonas, Schneider & de Vries, 2019). Moreover, the mental health of children aged between 10 and 19 years has a huge influence on their future health, educational, social and economic circumstances as adults, particularly in contexts of poverty and vulnerability (Docrat, Lund & Chisholm, 2019). The statement above not only highlights the importance of early interventions, but it also shows a great need for methods to help prevent further comorbidity and chronicity in adulthood (Martadza et al., 2019). According to Rickwood et al. (2015), there is a significant gap when it comes to children and adolescents seeking help, both boys and girls are most likely to seek help for their mental health problems from their parents. However, Docrat et al. (2019) argued that there is a discrepancy between individuals who are in need of mental health services and the available services for children and adolescents in South Africa.

According to Weisz, Weiss, Walter, Suwanlert, Chaiyasit, and Anderson (1988), children do not often think of themselves as troubled and rarely refer themselves for treatment. Parents, teachers, and psychologists are the caretakers of the child's mental health (Weisz et al., 1988). Therefore, it is understandable that many children access healthcare services through parents or caregivers (Raviv, Raviv, Propper & Fink, 2003; Coomer, 2011). Children and adolescents go through many developmental changes with issues of identity, relationships, physical

changes, and transitions to schools and colleges, making it difficult to identify mental health difficulties (Reinke, Stormont, Herman, Puri & Goel, 2011). However, children's problems that adults do not consider to be serious scarcely receive attention even if they may be of concern to the child (Weisz et al., 1988).

The number of children and adolescents needing psychological help is higher than those receiving such support (Ruane, 2010). As Zuma (2017) pointed out, while the number of children who require psychological services has increased considerably, studies have shown a discrepancy between the number of children who need psychological services and the number of children who use these services.

The concepts addressed in this study included the following: the role of psychological services in the public and private sector, barriers to accessing psychological services, the role of mental health service providers in managing child cases, referrals, and problems that may be experienced.

To understand how children are identified and referred to mental health services, the researcher used Bronfenbrenner's Ecosystems theory. Recent studies (Wilger, 2015; Watson-Singleton, Okunoren, LoParo & Hunter, 2017; McLachlana, Catherine & Galec, 2018; Alcalá & Balkrishnan, 2019; Mokitimi et al., 2019) have shown the diverse impact of psychological services, the risk factors associated with the development of psychological difficulties, as well as the barriers to accessing psychological services.

1.2 Statement of the problem

There are different views on psychological services (including access to these services) in South Africa, specifically in the KwaZulu-Natal (KZN) province. It was, therefore, considered particularly important to analyse child cases referred for psychological services. The reason for selecting children of school-going age was that "a lot of improvement is needed in psychological services as well as mental health support systems for children" (Tolan, 2005, p. 1).

It has been estimated that 20% of children and adolescents have experienced mental health issues in the form of social, emotional, and behavioural difficulties (Mfidi, 2017). KZN is said to have numerous environmental risk factors for mental disorders (Burns, 2010). It is thus

important to consider the state of psychiatric and mental health services to deal with mental disease burden (Burns, 2010). Due to their common occurrence, psychological problems are a huge concern in society (Mckenzie, Pinger, & Kotecki, 2012). Notably, in a global context, psychological difficulties in childhood continue to be a challenge in healthcare systems (Scott, Mihalopoulos, Erskine, Roberts & Rahman, 2015). The study by Docrat et al. (2019) estimated that 38% of the population consists of children and adolescents, and the majority of mental health disorders have their onset before the age of 18 years. According to Tolan (2005), children's mental health has been neglected despite it being vital in children's development. "This then spreads beyond the children, it also affects the well-being of the adults caring for the children and in some cases, it extends to teachers as well as those who employ these parents and caregivers" (Tolan, 2005). Moreover, it is essential to consider that a large number of adult mental disorders develop during childhood or adolescence, stages when they could potentially be prevented or identified and treated (Mokitimi, Schneiders & de Vries, 2018).

1.3 Purpose of the study

The purpose of this study was to gain an understanding of the various child cases referred for psychological services. To achieve the purpose, each of the cases was examined to get a comprehensive understanding of the referrals' source and the problems, characteristics, and common trends associated with the referrals. In addition, the study sought to examine the role of mental health practitioners in managing the cases referred for psychological services.

1.4 Objectives of the study

1) To identify the reasons for referral and referral sources for psychological services in private psychological practice in the Northern KZN region.
2) To explore the characteristics of child cases reported in private psychological practice in the Northern KZN region to profile such cases.
3) To describe the presenting problems in children referred for psychological services in the Northern KZN region.
4) To examine mental health service providers' role in managing child cases referred for psychological intervention in the Northern KZN region.

1.5 Research questions

1) What are the reasons for referral and sources of referral in a private psychologist's practice in the Northern KZN region?

2) What are the characteristics of child cases reported in a private psychologist's practice in the Northern KZN region?
3) What are the presenting problems in children referred for psychological services in the Northern KZN region?
4) What is the role of mental health service providers in managing child cases referred for psychological intervention in the Northern KZN region?

1.6 Significance of the study

Mokitimi et al. (2019) argued that mental health problems can negatively affect young individuals. Children and adolescents with mental health difficulties need a strong support system, which entails the involvement of family members and educational systems; if left untreated, the difficulties can persist into adulthood (Scott et al., 2015). Scott et al. (2015) further stated that children and adolescents with mental health difficulties are at risk of developing mental and physical health problems in adulthood. In addition, children with untreated mental health problems are at risk of having difficulties with academic achievement (failure and difficulty with learning at school) and social adjustment (problems maintaining relationships and transitioning to adult life), which affects their potential to live fulfilling and productive lives (Wilger, 2015; Mokitimi et al., 2019).

Currently, there is limited research on the consequences of child and adolescent mental health disorders in African countries but more in low and middle-income countries (LMICs) (Mokitimi et al., 2018). This means that little research has been conducted with regard to children who are referred to psychological services within South Africa, specifically in the Northern KZN region. A reason for this is that mental health has often been overlooked due to many developing countries being deemed low-income countries (Bakare & Munir, 2011).

This study was considered significant because its purpose was to give a better understanding of the child cases referred for psychological intervention.

1.7 Scope and delimitations of the study

The study was carried out in one psychologist's private practice in Northern KZN. Therefore, findings may be limited and cannot be utilised to give a generalised view of children in other areas of South Africa.

1.8 Operational definition of terms

Child

An individual who is under the age of 18 years (Government Gazette, 2006).

Psychological services

Services rendered by a psychologist, including psychotherapy, crisis interventions, and assessments (Sommer-Flanagan & Heck, 2013).

Mental health

The capacity of the individual or group and the environment to interact with one another in ways to help improve psychological, social, and emotional well-being. It governs how individuals think, relates to others, make choices, and contribute to the community (WHO, 2001).

Mental health problems

Conditions that affect the way in which individuals think, feel and behave, to the extent where they have a negative impact on their (individuals) daily functioning (Law, Faulconbridge & Laffan, 2015).

Mental health service provider

A mental healthcare provider, as defined by this study, is an individual who is experienced in addressing multiple emotional, behavioural and educational difficulties and plays a primary role in the identification, referral process, and service provision for young people (Sansanwal, Derevensky & Gavriel-Fried, 2016).

1.9 Summary and overview of the study

Chapter one provided an introduction to the study. It also provided a brief background to the study, the study's rationale, the study's objectives, and the key research questions to be answered.

Chapter two presents the review of related literature. This chapter introduces the most relevant research findings and the theoretical framework that supported the study.

Chapter three describes the methodology used in the study. This includes an outline of the research design, the sampling procedure, data collection, and analysis. It also briefly discusses the ethical considerations of the study.

Chapter four presents the results of the study based on the analysis of the data that was collected.

Chapter five provides a detailed discussion of the findings, with links to previous literature and the theoretical framework of the study.

Chapter six provides a summary of the study. It also presents limitations and recommendations for future research as well as a brief conclusion to the study.

Chapter Two: Literature Review

2.1 Introduction

This chapter reviews the literature on referral problems, sources of referral, the characteristics of child cases referred for psychological services, and the role of mental health practitioners in managing child cases. It provides a definition and an overview of psychological services, including the historical background of both international and national studies relating to psychological services. The chapter also examines some of the barriers to accessing psychological services. Finally, the chapter ends with a discussion of the theoretical framework that supports the study.

2.2 Definition of Psychological Services

Psychological services are defined as the various services rendered by psychologists or mental health professionals (Matabane, 2015). According to Sommers-Flanagan and Heck (2013), psychological services include counselling, therapy, research, psychoeducation, crisis interventions, and assessments. Sommers-Flanagan and Heck (2013) added that psychological services consist of establishing rapport (building a therapeutic relationship), collecting assessment data, developing a case formulation, and introducing psychotherapy. The regulations implementing the Individuals with Disabilities Education Act (IDEA) amendments of 1997 defined psychological services as "administering psychological and educational tests, and other assessment procedures, interpreting assessment results, obtaining, integrating and interpreting information about child behavior and conditions related to learning; consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interview, and behavior evaluations; planning and managing a program of psychological services, including psychological counselling for children and parents, and assisting in the development of positive behavioral intervention strategies" (Florida State Department of Education (FDoE), 2000, pp. 4-5). The definition provided above means that psychological services play an important role in providing a support structure for children and adolescents. Although psychological services appear to come in different forms, they appear to be similar across various contexts.

Based on the definitions stated above, it can be said that the major services that make up the provision of psychological services are counselling, assessment, referral, intervention programmes, consultation, and collaboration.

2.3 Historical Background of Psychological Services: Global and South African Perspectives

2.3.1 *Global context of psychological services*

When discussing the history of psychological services, it is important to note that their emergence and development differs from country to country, as do events surrounding their development. Globally, mental health care continues to receive a small portion of the total health budget. Psychological and psychiatric services receive the least funding, infrastructure development, staff, and the provision of appropriate medical supplies and treatments (Burns, 2010). With that being said, it is not surprising that children and adolescents' mental health needs are not being addressed adequately in policy, practice, and research (Williams, Horvath, Wei, Van Dorn, & Jonson-Reid, 2007).

In the United States of America (USA), children and adolescent mental health services began in the 1890s and continued throughout the 1930s (Flaherty & Osher, 2003). Although the development of mental health services for children and adolescents has been slow, there is an ongoing movement constituting a precise proliferation of school-based mental health services that are being planned and implemented (Flaherty, Weist & Warner, 1996). The USA has increasingly incorporated mental health services in schools to address the difficulties associated with the limited access to children and adolescent mental health services (Flaherty et al., 1996; Weist, 1997). However, the USA continues to have a gap between children and adolescents' mental health needs and accessible services to address those needs (Weist, 1997).

In England, before establishing the National Health Service, psychological services were ruled by the 1890 Lunacy Act and the 1930 Mental Treatment Act (Turner, Hayward, Angel, Fulford, Hall, Millard & Thomson, 2015). Throughout the development period, public spending on mental health was extremely low compared with physical health, particularly concerning services for children, adolescents, and the elderly (Turner et al., 2015). Despite the passing of the new Mental Health Act in 2007 and the announcement of mental health being one of three

clinical priorities together with cancer and heart disease in the 2000 NHS Plan, spending on mental health has not increased as expected (Turner et al., 2015).

Several countries in Asia have recently started developing child and adolescent psychological services (Hong, Yamazaki, Banaag & Yasong, 2004). However, this does not mean that children's mental health services were not provided in these countries before western medicine was introduced. Mental health service providers have always been able to assist children and adolescents with emotional, behavioural, and academic difficulties. According to Hong et al. (2004), the development of psychological services in China began in the 1920s following the development of the child protection movement. China currently offers psychological services for children and adolescents as part of mental health education. These services aim to assist children with learning, emotional or behavioural difficulties in the mainstream school system (Van Schalkwyk & D'Amato, 2013). “Granting that development made in the USA surpass those in Asian countries, Singapore is said to have a more developed system for providing psychological services to children and adolescents” (Van Schalkwyk & D'Amato, 2013, p. 126). In Malaysia, psychological services for children and adolescents were established around 1963 (Kok, Low, Lee & Cheah, 2012). Presently, therapeutic services are not well received by the Malaysian population. Van Schalkwyk and D'Amato (2013) argued that there are insufficient psychological services for children and adolescents in that country. On the contrary, some studies (Kok et al., 2012; Martadza et al., 2019) argued that psychologists in Malaysia have recently made a huge contribution beyond psychological assessments and interventions. They continue to have a positive influence in areas such as health promotion programmes, behavioural medicine, neuropsychological assessments, and professional management issues (Martadza et al., 2019).

Published information regarding mental health resources for children and adolescents is not available in many African countries. Mental health services on the African continent were largely influenced by political and medical factors (Modie-Moroka, 2016). Due to there being little written on the provision of mental health services on the continent, it has been difficult to trace such services' history (Modie-Moroka, 2016). Modie-Moroka (2016) mentioned that in 2003, the Draft National Policy on Mental Health was presented to the Botswana Parliament. Its goal was to provide access to mental health services that would aid the development of individuals. Despite the policy's introduction, Botswana continues to have an inadequate number of skilled and qualified mental health service providers, which is seen as a barrier to

accessing mental health care (Modie-Moroka, 2016). Like other countries, Namibia's mental health service provision is lower than the government estimates (Coomer, 2011). According to Coomer (2011), Namibia did not provide data for the WHO's Child and Adolescent Mental Health Resources assessment. Nor did it provide information on the number of mental healthcare professionals working with children as recorded by the Health Professions Council. Similar to other African countries, Namibia is also experiencing difficulties addressing the needs of children with mental health difficulties and disorders (WHO, 2005).

The majority of countries continue to have a huge discrepancy between the need for mental health services and the financial resources, staff, and infrastructure to meet these services' needs (Rathod, Irfan, Gorczynski, Rathod, Gega & Naeem, 2017).

2.3.2 *South African context during the apartheid era*

Before the democratic change in 1994, South Africa faced inequalities in the mental health services available to different racial groups. Mental health provision in South Africa was characterised by the racially divided and heterogeneous allocation of mental health services and resources. These were applied predominately to individualised remedial, therapeutic, hospital-based, tertiary modes of intervention that served the needs of the minority white population primarily (Van Wyk & Naidoo, 2006).

South Africa does not have a long history of involving "non-white" people in policy-making, planning, and implementation of mental health services, and this has delayed the development of relevant psychological services delivery systems (Di Lupuwana, Simbayi & Elkonin, 1999). During the apartheid era, most black people had difficulties accessing psychological services because a majority of them lived in rural areas (Deumert, 2010). Similarly, Lund and Fisher (2006) stated that mental health services were segregated by race and ethnic group, and they were centralised – the best-resourced facilities were located in urban areas while the rural areas were under-resourced.

According to Di Lupuwana et al. (1999), the white population group has always had access to psychological services. Moreover, only the needs of a small privileged sector of the South African society has received attention. This may largely be attributed to cost and the shortage of psychologists outside the white community. Psychologists are largely inaccessible because most clinicians are white and tend to practice in urban areas among clients who can afford their

services. Hence, the level of psychological services in black communities is extremely low because there is a shortage of psychologists in these communities (Di Lupuwana et al., 1999). In the South African context, mental health services' availability continues to be highly dependent on where one is geographically located; this makes it extremely difficult for people living in rural areas to access psychological services (Zuma, 2017).

The study conducted by Smalley, Yancey, Warren, Naufel, Ryan, and Pugh (2010) found that more than 85% of mental health professional shortages are in rural areas, and a large number of areas in the USA do not have a psychologist, psychiatrist or social worker. In the South African context, Pillay and Lockhart (1997) suggested that it is important to keep in mind that there is a lack of educational psychological services in the more rural and peri-urban areas than urban contexts.

Mental health services for children are non-existent in rural areas (Pillay & Lockhart, 1997). Tolan and Dodge (2005) found a huge gap between the mental health needs of children and the support and services available to meet those needs. Despite knowing the importance of mental health in children's development, children's mental health remains neglected worldwide. Meaning that children in rural areas do not have access to satisfactory mental health services.

2.3.3 *Psychological services in South Africa post-apartheid*

The World Bank considers South Africa as a middle-income country (Mokitimi et al., 2019). According to Mokitimi et al. (2019), this suggests that South Africa is a country with a high-income inequality and, therefore, it has some of the greatest health disparities in the world.

The post-apartheid South African government introduced systems to help overcome inequalities in the healthcare sectors. During this time, psychological services were extended through community mental health centres serving geographical areas and high-risk groups, indigenous lay-healers enabled and utilised, and communities mobilised to resist and better cope with the psychological consequences of apartheid (Gibson, 2004; Seedat, Mackenzie & Stevens, 2004). Meaning that the majority of mental health services are still found in urban areas, and access to mental health services remains a huge concern.

With regard to funding, infrastructure development, and staffing in KZN, psychiatric, and mental health services were historically disadvantaged and presently still are (Burns, 2010).

This is evident in the study by Docrat et al. (2019). It was argued that public sector psychologists and psychiatrists are largely located within the urban areas of provinces, which is consistent with existing evidence. Furthermore, Ahmed and Pillay (2004) stated that mental healthcare resources' distribution is largely skewed in favour of an urban white middle-class English and Afrikaans speaking minority. Suggesting that South Africa continues to have factors contributing to the inadequate provision of mental health services, including the lack of financial resources and limited information and knowledge to comprehend the impact of mental disorders (Docrat et al., 2019).

In the South African context, access to mental health services is highly reliant on where one resides. Thus, it has become a major problem for individuals living in rural areas to access psychological services (Zuma, 2017). Wilger (2015) argued that the limited number of mental healthcare workers in rural areas is linked to the lower utilisation of mental health services. Ahmed and Pillay (2004, p. 630) further stated that "As a consequence of apartheid, the large majority of 'blacks' are poor, live in apartheid-designated townships, and have limited access to mental healthcare resources, primarily government mental health facilities which are usually under resources and overcrowded." By comparison, the minority of people who do have ready access to mental health facilities are more likely to be white, financially better off, and live in the major metropolitan areas or have easy access to the mainly white private psychologists (Pillay, 2004). This indicates that apartheid's effects apartheid continues to negatively impact South African communities in that healthcare services remain unequal. This, in turn, negatively impacts the distribution of psychological services across the country (Gibson, 2004; Zurakat, 2015). In a similar vein, Burns (2013) stated that the provision and promotion of mental health in South Africa remains inadequate, inaccessible, and inappropriate.

According to Campbell, Kearns, and Patchin (2006), the National Department of Health (DoH) implemented compulsory services to train South African psychologists to facilitate geographic redistribution. This initiative aimed to improve mental care and promote equality of access to all South African citizens, especially those in previously disadvantaged areas (Swarts, 2013).

According to Docrat et al. (2019), limited access to mental health services of good quality has led to accessing mental health services at an inappropriate level of care. Which has contributed mainly to individuals in need of mental health services only consider these services when experiencing severe symptoms, leaving many mental illnesses untreated (Docrat et al., 2019).

The South African government provides the main source of funding through tax-based health budgets; however, South Africa continues to have inadequate data available for mental health financing (Docrat et al., 2019). Regarding provincial and national budgets, South Africa's public mental health expenditure in the 2016 and 2017 financial year was USD615. 3 million. Unfortunately, the country currently does not have a specific budget for mental health (Docrat et al., 2019). According to Docrat et al. (2019), each province is allocated a set amount of funds from national revenue, and this amount is spent according to the province's priorities.

Child and adolescent mental health (CAMH) services in the school environment play a significant role in bridging the gap between needing and accessing services by reaching children who would not normally have access to these services (Scott et al., 2015). Furthermore, Scott et al. (2015) stated that the school environment could provide affordable and culturally appropriate programmes that would benefit children's mental health. However, mental health services are not a priority in South Africa as there are outdated psychiatric hospitals and an insufficient number of mental health professionals available to deliver these services (Docrat et al., 2019). As a consequence, South Africa does not have a well-developed child and adolescent mental health strategy. This acts as a barrier to achieving a functional child and mental health collaborative system at a district level (Babatunde, Van Rensburg, Bhana & Petersen et al., 2020).

2.3.4 *Psychological services in KwaZulu-Natal (KZN)*

In South Africa, particularly in the KZN province, mental health services are historically and currently disadvantaged in terms of funding, infrastructure development, and staffing (Burns, 2010). In the KZN province, there is a population of over eight million people. The majority of the province's mental health services are only available to those living in Durban and Pietermaritzburg (Pillay & Lockhart, 1997). Moreover, mental health care available in urban areas allows for an increase in private practice, whereas, as noted above, there is a lack of mental health services in rural areas.

Over the years, several authorities have been responsible for providing mental health services in KZN. However, there has not been much change as the services remain inequitable – there are well-developed community mental health services in the urban areas. In contrast, rural areas' services remain poor (Mkhize, Green-Thompson, Ramdass, Mhlaluka, Dlamini & Walker, 2004). Despite KZN being the home of 20% of the South African population, it only

has 7.4% of public sector psychiatrists and 16.4% of public sector psychiatric nurses (Petersen & Bhagwanjee, 2000). With respect to mental health specialists, KZN is considered under-resourced when compared to other provinces like Gauteng and the Western Cape (Petersen & Bhagwanjee, 2000). Previously, attempts to rationalise mental health services and align them more with the new policies have led to the development of new health policies (Mkhize et al., 2004).

A study conducted in Northern KZN by Petersen, Bhana, Campbell-Hall, Mjadu, Lund, Kleintjies, Hosegood, and Flisher (2009), revealed that most people living in that area believed that one of the reasons for the lack of attention paid to common mental health problems in children was the shortage of mental health specialists for referrals. The study also found that children and adolescents with mental health difficulties had no specialist services (Petersen et al., 2009). Contributing to most children and adolescents not receiving the help they need.

Burns (2010) argued that people living in the KZN province are known to have a higher risk for mental health problems than people living in other provinces. This may largely be due to the many risk factors of mental illness, including a significant number of people living beneath the poverty line, the level of income inequality, the unemployment rate, and the high prevalence of HIV/AIDS (Burns, 2010). In agreement, Mokitimi et al. (2018) stated that the little evidence available has revealed that poverty and unemployment play a role in developing child and adolescent mental health disorders.

Child and adolescent mental health services play a significant role in the prevention and promotion of young individuals' mental health and well-being. They also reduce the mental illness risk factors and provide remedial services using evidence-based strategies for those who need treatment (Mokitimi et al., 2018). The Department of Health considers mental health services for children and adolescents as part of general mental health services (Petersen et al., 2009). According to Babatunde et al. (2020), mental health services in the public sector that are provided by psychologists are primarily concentrated and based at the regional district hospital.

In the study conducted by Petersen et al. (2009), teachers stated that the Department of Education (DoE) in KZN had restricted interventions as it uses existing referral opportunities to manage problems identified within the school setting. Furthermore, it was expressed that

"this has led to the Department of Social Development managing child and adolescent referrals, mainly from the Child Protection Unit of the SAPS, Childline, a crisis telephone service, and from teachers, school nurses and the clinics as outpatients" (Petersen et al., p. 147). Suggesting that there is an inadequate number of social workers. As it stands, there has been an insufficient number of changes made, and inequality of services continues to be a problem. There are well-developed community mental health services in urban areas and poor services in rural areas (Mkhize et al., 2004). To prevent mental illness and create mental and psychological well-being in each successive generation, there should be a focus on programmes that promote and help prevent mental health problems (Mkhize et al., 2004).

The study by Babatunde et al. (2020) visited schools in the Amajuba district of Northern KZN and found no qualified staff members (psychologists or social workers) or resources to administer and provide the necessary assessments and interventions. There was also a lack of information regarding the referral pathways. The situation has led to the delay in, and often the lack of, access to mental health services and the development of required interventions to help children affected. Furthermore, there were many challenges in the early identification of children and adolescents in need of mental health services. Most conditions were said to have progressed, and these could have been identified in their early stages, especially because they affect the child's academic performance and functioning. Fortunately, there were a few cases where caregivers took the children to the hospital (for other health concerns), which led to the children being identified as having mental health issues (Babatunde et al., 2020).

Similar to most studies, the study conducted by Babatunde et al. (2020) found that the school system makes most referrals and that most difficulties are identified by the child's educator. Following the identification, child assessments are administered, and interventions are made before referring the child for further care.

2.4 Barriers to Accessing Psychological Services

Most communities in South Africa use public hospitals or primary healthcare clinics, which may contain several barriers when accessing mental health services. Studies recognise that many individuals with mental health disorders experience social difficulties such as stigma, the lack of support, and financial barriers which arise from and include low economic status, unemployment, illiteracy, and poverty (WHO, 2001; WHO, 2009; Kakuma, Kleintjes, Lund, Drew, Green, Flisher, 2010; Law et al., 2015).

Owens, Hoagwood, Horwitz, Leaf, Poduska, Kellam, and Ialongo (2002) argued that there are three types of barriers to accessing psychological services for children. Firstly, are structural barriers, which comprise inadequate mental health service providers, long waiting lists, and a lack of or insufficient health insurance, a lack of financial resources, and transportation problems. Secondly are the barriers related to individuals' attitudes and perceptions about mental health difficulties. These include the failure of primary caregivers, educators, and healthcare providers to identify the child or adolescent's need for mental health services, denial of the severity of a mental health problem, and not believing in seeking treatment. Third, are the barriers associated with the way individuals perceive mental health services and service providers. This includes the difficulty of trusting mental health providers, the lack of desire on the part of children to receive help, and the stigma related to receiving help. According to the study by Watson-Singleton et al. (2017), several factors may act as barriers to accessing psychological services. These include stigmatisation, socioeconomic status, minority status, culture, and the severity of the child's symptoms, age, and parental stress. These may have a negative impact on how psychological services are perceived.

Further factors that may also be contributing to barriers in accessing psychological services include the following: the shortage of services in rural areas, lack of information or knowledge concerning psychological services, not having medical insurance, social norms, discrimination, inappropriate mental health policies, and centralised mental healthcare services (Melville, Cooper, Morrison, Finlayson, Allan, Robinson & Martin, 2006; Coomer, 2011; Schierenbeck, Johansson, Andersson & Van Rooyen, 2013). In addition, Barry and Jenkins (2007) stated that children and adolescents might be affected indirectly by influences from the larger society that impact their family's financial, emotional, and physical health status. Schierenbeck et al. (2013) mentioned that young children and adolescents with mental disabilities are regularly marginalised and face discrimination.

2.4.1 *Segregation and geographical inequalities*

Historical factors have had an impact on the provision of public sector mental health services. Sukeri, Betancourt, and Emsley (2014) stated that the apartheid government ensured the segregation of mental health services, resulting in the maldistribution of health workers and inequality between the different racial groups in terms of accessing health care. As a result, great disparities continue to exist between urban and rural areas.

According to Nicolson (2009), there is a lack of psychological services for children, especially in areas where the majority of people are black. Most mental health professionals' practice in urban areas and university towns (Roberts & Steele, 2005; Kurtin, Barton, Winefeld & Edwards, 2009; Rasesemola, Maatshoge & Ramukumba, 2019). Rathod et al. (2017) argued that the geographic spread of mental health services has a huge impact on access and outcomes in mental health.

Individuals living in rural areas often have difficulty accessing psychological services because they are largely concentrated in urban areas (Rathod et al., 2017). Furthermore, the lack of transportation has been identified as a barrier to accessing health care in general (Aisbett, Boyd, Francis, Newnham & Newnham, 2007; Schierenbeck et al., 2013; Rathod et al., 2017). This suggests that people living in rural areas have limited access to psychological services and do not receive the treatment they need.

2.4.2 *Lack of financial resources*

According to Uba (1992), unemployment and the lack of health insurance make mental health care inaccessible. Individuals who are unemployed or have low-level jobs often do not have health insurance benefits, while others are not aware of the existence of health insurance. Furthermore, the lack of financial resources and health insurance makes it difficult to afford the consultation fee and decreases the chances of the child making any follow-up appointments that are needed (Coomer, 2013). Similarly, Pope and Arthur (2009) and Murphey et al. (2013) argued that individuals and families with a low income normally do not have private insurance and that this means that they are unable to access psychological services. According to Rowan, McAlpine, and Blewett (2013), there has been an increase in the number of people who decline mental health care because of its cost. Moreover, Murphey et al. (2013) found that children and adolescents who do not have access to health insurance are unlikely to use psychological services than those who do have insurance.

Currently, access to health insurance is strongly influenced by income. According to Coomer (2011), physical illnesses often take precedence over mental health conditions for medical aid schemes. South African data suggest that medical aid schemes discriminate between physical and psychological illness (Coomer, 2011). In addition, this is seen as a huge problem as it affects service provision. Medical aid schemes' reluctance to provide equal financial support

for mental health conditions compared to physical conditions is seen as discriminating and perpetuating a stigma (Coomer, 2013). According to Soderlund and Hansl (2000), South Africa has a history of over 100 years of private health insurance arrangements, with little public provision of insurance. The medical aid debate can be considered as a barrier to accessing psychological services in South Africa. According to a newspaper report entitled "Educational psychologists' not being paid" (The Witness, 2017), seven public and private medical aid schemes were, since April 2016, refusing to pay for services provided by educational psychologists. "As a result of medical aid schemes refusal to pay nonclinical psychologists to counsel people with depression and mental illness, people do not receive the help they need" (Child, 2016). This has left educational, counselling, and industrial psychologists feeling like their practices are at risk because of the regulations that restrict their treatment of patients. The Health Professions Council of South Africa (HPCSA) mentioned to News24 that it was aware of the difficulties, but the scope's alteration was driven by insufficient regulations (News24, 2017). In contrast, Kahn (2017) argued that the regulations were intended to define non-clinical psychologists' scope of practice better. "The aim was to protect patients by making sure that psychologists did not offer services they were not skilled to offer and also to increase their scope of practice in certain areas" (Kahn, 2017). However, few studies have been done to help better understand the consequences of the medical aid debate.

2.4.3 *Lack of knowledge and information*

The lack of knowledge about resources has been identified as a barrier to accessing psychological services. Babatunde et al. (2020) argued that a shortage of resources often leads to a lack of mental health awareness, which leads to inadequate mental health literacy. Meaning that there is limited knowledge in the KZN communities, which acts as a barrier to identifying mental health symptoms early (Babatunde et al., 2020).

Despite parents' ability to identify symptoms and abnormalities at an early stage, their lack of knowledge and inability to determine the nature of the child's condition often leads them to only seek mental health care for the child when he or she is identified and referred from the school (Babatunde et al., 2020). A study conducted by Schierenbeck et al. (2013) found that most communities in the Eastern Cape province do not have adequate information and knowledge regarding mental health disorders. Thus, caregivers do not access mental health services because they do not have adequate information on where and how to go about seeking care (Babatunde et al., 2020).

In some cases, individuals in society are not aware of the mental health disorders that receive the least attention and, therefore, do not seek mental healthcare services. This is because policymakers and government officials neglect to focus on other mental health-related difficulties (Schierenbeck et al., 2013). It is also noted that inadequate information regarding drug prescription and medical treatment often results in patients being reluctant to take medication and, in some cases, patients not believing that the medication will actually help (Schierenbeck et al., 2013). Highlighting the importance of psychoeducation on mental health difficulties and the available treatments (Schierenbeck et al., 2013).

2.4.4 *Stigma*

Stigma is known as the fear of being viewed negatively by others if one seeks help for a problem (Deane & Chamberlain, 1994). According to Crisp, Gelder, Rix, Meltzer, and Rowlands (2000), stigma often results from society's tendency to prescribe negative labels to individuals who seek psychological services.

The stigmatisation of people with mental disabilities by their families, friends, and society is seen as another barrier to accessing psychological services. This may be largely affected by individual background factors, which include social, economic, and educational status (Takeuchi & Sakagami, 2018). People are often discouraged from seeking care for mental health-related problems due to stigma (Schierenbeck et al., 2013; Wilger, 2015). In the study by Coomer (2011), it was argued that stigma is often viewed as a barrier to accessing mental health services because people do not want to acknowledge that they or their loved ones have a mental health disorder, or they fear a negative reception from service providers and the community if they ask for help. According to Wilger (2015), individuals in rural areas are more inclined to view help-seeking for mental health care more negatively than do individuals living in urban areas. In most cases, individuals living in rural areas are more comfortable and, therefore, more inclined to seek help from agents that normalise their experiences, such as community leaders (Rathod et al., 2017).

According to Takeuchi and Sakagami (2018), previous research proposed that the stigma is often linked with individual traits; in most instances, males are stigmatised more severely than females, and younger people more so than older people. In addition, individuals who possess behavioural difficulties are often stigmatised, and children and adolescents with mental health

problems are perceived and labelled as “crazy” or “weak” (Wilger, 2015). Stigma affects the willingness of family members to intervene or take their children to mental health practitioners. Furthermore, Matabane (2015) mentioned that stigma associated with seeking psychological services is related to the view that seeking psychological services makes individuals less socially acceptable.

2.4.5 *Cultural beliefs*

In some communities, the use of psychological services may be viewed as inconsistent with certain cultural values (Diala, Muntaner, Warath, Nickerson, Veist & Leaf, 2000). Traditional cultural beliefs of the community are identified as another barrier (Schierenbeck et al., 2013). For instance, some cultural perceptions and understanding of mental health make people more inclined to seek traditional healers' help (Schierenbeck et al., 2013). This may be largely because there are more traditional practitioners than Western-trained mental health practitioners, particularly in the rural areas of South Africa.

Traditional healers are part of the African culture and play a huge role in the health and well-being of a significant part of the black population (Meissner, 2004). They are seen as providing culturally appropriate care linked to indigenous explanatory models of illness held by many South Africans (Petersen, 2004). Crawford and Lipsedge (2004, cited in Zuma, 2017) mentioned that most people from KZN found Western medicine useful for treating physical illness but not mental illness because, from a cultural point of view, mental health difficulties are seen as better understood by traditional healers. Moreover, Petersen (2004) mentioned that the traditional practitioner's role is to provide psychosocial support and highlight areas of conflict in a person’s life that need to be addressed. Another reason why individuals may be more likely to seek the help of traditional healers is that traditional healers are said to be more geographically and culturally accessible to many individuals, especially those living in the rural areas of KZN (Burns, 2011). In addition, the likelihood of seeking a traditional or spiritual healer may be influenced by the lack of trust in Western interventions. In some cases, this leads to individuals using both traditional and Western healers (Rathod et al., 2017).

Having traditional healers in Africa provides an alternative option for health care. However, some individuals who experience mental health difficulties choose to access this form of mental health service. In contrast, others are forced to seek help from traditional healers because of barriers experienced elsewhere (Coomer, 2011).

2.4.6 *Language*

A lack of proficiency in English contributes to the difficulty in communicating effectively, thus creating difficulty in meeting the needs of many individuals. According to Guo (2012), in most cases, language difference causes a breakdown in communication. Most service providers in South Africa are English, Afrikaans speakers, and language may influence service delivery effectiveness in public sectors (Deumert, 2010). Healthcare providers who cannot speak the client's language are said to create a communication barrier, which impacts access to services (Ross & Deverell, 2010).

Based on what has been stated above, it is evident that many families with children, even those with a large number of financial resources, find it difficult to access appropriate and effective services. The mental healthcare systems discriminate against people whose first language is not English or Afrikaans. According to Ahmed and Pillay (2004), psychologists offer their services in their preferred language, rather than that of their clients. Ahmed and Pillay (2004) further stated that psychologists refuse to work with clients who have a first language other than English or Afrikaans. Furthermore, in a study conducted by Coomer (2013) on the experiences of parents of children in search of mental health care, it was found that there were language barriers between mental health service providers and those seeking services. Mental health service providers were said to be reluctant to speak the client's indigenous language despite being conversant in it.

Barriers to accessing mental health services, whether externally driven (structural) or internally driven (perceptions), need to be viewed in the broader context of the social and health environment (Owens et al., 2002).

2.5 Referral Problems and Sources of Referrals

Roberts and Steele (2005) stated that early care and learning settings provide a second primary referral for further assessment and intervention. The referral process often begins with school teachers in early care (Green, Clopton & Pope, 2014; Crosier, 2018). Guidance teachers and psychologists at schools are known to make a massive contribution in making referrals and marketing psychological services by educating parents about them (Di Lupuwana et al., 1999). Although parents generally refer their children for professional help, schools are known as the first contact for mental health problems that present within the school environment and teachers

are increasingly recognised as common sources of referral for psychological services (Loades & Mastroyannopoulou, 2010).

Zurakat (2015) argued that school counsellors often refer children that need psychological services that are beyond their scope of practice to appropriate qualified professionals. Yet general practitioners (GPs) are less likely to refer children for psychological services, and the reasons that determine referral by GPs are not well understood (Kramer & Garralda, 2000). Kramer and Garralda (2000) further stated that referrals made by GPs to psychological services are linked with more severe forms of mental disturbance. In a study conducted by Nicolson (2009), it was found that most referrals were from several different sources including medical practitioners, social workers, school psychological services, and a paediatric department. Although there are several referral sources, it is evident that most referrals are made in the school setting.

The most common referral problems noted by Loades and Mastroyannopoulou (2010) are emotional disorders in girls and behavioural disorders in boys. According to Seedat, Kruger, and Bode (2003), learning difficulties are the most important reason children and young people (mainly from age six to 18 years) are referred to as psychological services. Seedat et al. (2003) found that the most common referral problems were violent victimisation and sexual abuse.

Babatunde et al. (2020) argued that there are major challenges in the early identification of children and adolescents in need of mental health services. Most referrals are said to have progressed and could have been identified in the early stages, especially because they affect the child's academic performance. The study conducted by Babatunde et al. (2020) found that most referrals are made by the school system, where the child's educator identifies most difficulties. There is very limited information and understanding of the referral process in the school environment. Therefore, it is unclear what contributes to the identification and referral process being effective or ineffective (Van Dorn & Jonson-Reid, 2007). The lack of information and understanding of the referral process often leads to children not receiving the necessary support from schools.

2.6 Risk Factors associated with the Development of Psychological Difficulties

Various factors may lead to the development of mental health problems in children and adolescents. Understanding the potential causes of psychological problems is crucial for

developing effective intervention (Law et al., 2015). According to Law et al. (2015), an awareness and understanding of the risk factors can lead to the development of preventative strategies such as building protective structures in social care and reducing bullying in the school environment.

The World Health Organization (WHO) (2012) suggested that individual factors such as physical illness, and cognitive and emotional immaturity can be considered as potential risks for developing mental health difficulties. Nolen-Hoeksema (2014) stated four major trans-diagnostic risk factors for mental health problems suggested by the sociocultural approach. First, a socioeconomic disadvantage is a trans-diagnostic risk factor for many economic factors. "People who live in poverty-stricken neighbourhoods are more exposed to substance abuse, juvenile delinquency, inadequate school, depression and anxiety" (Nolen-Hoeksema, 2014). McLachlana et al. (2018) argued that the effects of psychological distress on mortality were higher in people with a disadvantaged socioeconomic background. In agreement, Alcalá and Balkrishnan (2019) added that individuals who go through hardships are more likely to develop mental health difficulties, which include depression, anxiety, and suicide attempts. Despite some studies finding that low-income households and low parental education are strong predictors of mental health problems among children (Reiss, 2013), more recent studies (Scott et al., 2015; McLachlana et al., 2018) argued that it remains unclear why individuals with psychological distress have a greater risk for health issues. Moreover, Alcalá and Balkrishnan (2019) stated that there are many reasons why childhood adversity puts individuals at risk for mental illness. These include changes in brain chemistry and function, social and cognitive impairments, and engaging in unhealthy behaviours such as substance abuse to cope with trauma and stress. Owens et al. (2002) found that factors such as the unemployment of caregivers and divorce were associated with the development of mental health problems. In support of this, Babatunde et al. (2020) found that absent parents and dysfunctional family systems place children and adolescents at an increased risk for mental health problems. In addition, children from socioeconomically disadvantaged families are three times more likely to have mental health problems than their peers who are not from a disadvantaged background (Reiss, 2013). This was also noted by Rathod et al. (2017), who stated that individuals with lower socioeconomic status (SES) are at eight times greater risk of developing schizophrenia than those of the highest SES.

Second, exposure to traumatic events due to war, famine, and natural disasters may be seen as a risk factor for mental health problems in individuals (WHO, 2012; Nolen-Hoeksema, 2014). In addition, social factors such as urbanisation, internal migration, and lifestyle changes contribute to the high burden of psychological problems. All individuals in society have the potential to be affected by psychological difficulties. However, some groups are known to be more at risk than others (Law et al., 2015). This leads to the third trans-diagnostic risk factor stipulated by Nolen-Hoeksema (2014), namely, the norms and policies placed in a society that stigmatise and marginalise certain groups put children (and others) in these groups at increased risk for mental health problems (Nolen-Hoeksema, 2014). Moreover, environmental circumstances such as the stigmatisation and neglect of children can contribute to loneliness and feelings of neglect (WHO, 2012).

The fourth (and final) factor is that some types of psychopathology are influenced by society through explicit and implicit rules about the kinds of atypical behaviour deemed suitable, and some disorders appear to be specific to certain cultures (Nolen-Hoeksema, 2014). For example, anorexia nervosa appears to be different in Asian cultures compared to American or African cultures. Furthermore, many Asian cultures, such as Chinese, Japanese, and Malayan tend to somatise psychological and emotional distress symptoms to different body parts (Rathod et al., 2017). This is mainly because somatic symptoms are usually understood through a perceived imbalance in body functions and not stigmatised as much as psychological problems.

2.7 Common Presenting Problems in Children and Adolescents

In a study based at the Riley Child Guidance Clinic, children that are referred typically display emotional, behavioural, learning, or developmental problems (La Clave & Campbell, 1986). According to the study by La Clave and Campbell (1986) in the years 1973 and 1983, there were more boys than girls with psychological difficulties. However, while it is not known whether girls and boys differ in their presenting problems, boys were noted to be referred for acting out and disruptive behaviour, whereas girls were referred for underachievement and anxiety-related difficulties (La Clave & Campbell, 1986). According to La Clave and Campbell (1986), the Riley Child and Guidance Clinic acquired referrals according to the following: one-third from physicians, one-third from schools, and one-third were self-referred.

Pillay and Lockhart (1997) found that the highest number of children referred for psychological services in rural/peri-urban areas in KZN was for cognitive difficulties. Physical and sexual

abuse also constituted a large number of presenting problems among clients aged 18 years and younger. In addition, the majority (70.9%) of physical and sexual abuse presenting problems were found in girls. Similarly, Petersen (2004) conducted a study that revealed that the most common presenting problems of clients under 18 years were cognitive difficulties, learning difficulties, physical/sexual abuse, depression/anxiety, and somatic complaints.

A study by Hong et al. (2004) on the development of the child and adolescent mental health in Shanghai found that the most common problem children and adolescents had was cognitive difficulties. This was followed by ADHD, learning difficulties, emotional disorders, behavioural disorders, tic disorders, psychosis, autism, and multiple diagnoses (Hong et al., 2004).

The study by Mokitimi et al. (2019) provided an estimation of disorders that are more likely to affect children and adolescents' mental health. Reviewing international studies, the authors revealed that 17% of children have a high chance of being diagnosed with a CAMH disorder. Generalised anxiety disorder (GAD) had the highest frequency (11%), followed by post-traumatic stress disorder (PTSD) and major depressive disorder/dysthymia (both 8%), oppositional defiant disorder (ODD) (6%) and ADHD (5%) (Mokitimi et al., 2019).

A study by Nicolson (2009) analysed a range of psychological cases that were referred to the Child and Family Centre (CFC) at the University of Kwa-Zulu-Natal, Pietermaritzburg. According to Nicolson (2009), in 1982, there were 151 cases presented at the CFC. Of these 151 cases, 88% were white, 3% were black, and 9% were from other racial groups. Ages ranged from three to 17 years. In the year 2009, the most common presenting problems were problematic behaviour, which included stealing and running away, and learning and emotional difficulties (Nicolson, 2009). Similarly, a study conducted on learners' mental health problems in boarding high schools revealed that learners were more likely to have behavioural and emotional problems and learning difficulties (Hong et al., 2004).

A survey designed to assess roles, types of referrals, consultation practices, and crisis team management was completed by school psychologists who were members of the National Association of School Psychologists (Bramlet, Murphy, Johnson & Wallingsford, 2002). In terms of the results of the survey, reading problems were the most common referrals in schools. Other problems included defiance, cognitive difficulties, and peer relations. Internalising

problems were the least common referrals. These difficulties included depression, anxiety, withdrawal, and suicidal thoughts (Bramlet et al., 2002). According to Bramlet et al. (2002), the ratio of practitioners to students was increasingly improving. Literature shows that most children and adolescents referred for psychological services present with cognitive, learning, behavioural, and emotional difficulties.

2.8 The Role of Mental Health Service Providers in Managing Child Cases

Mental health service providers are individuals who play a major role in identifying and referring to children and adolescents (Sansanwal et al., 2016). Sansanwal et al. (2016) stated that mental health service providers are skilled in addressing various emotional, behavioural, and academic difficulties. According to Moolla (2011), the mental health practitioner evaluates the individual's environment, focusing on the relationship between the individual and the larger social context. Mental health service providers involved in managing and referring children and adolescents for mental health services are located at different levels of the community, health, and education systems. They included “nurses in clinics, social workers in the communities, educators, learner support agents, and school health nurses in schools” (Babatunde et al., 2020). Moreover, mental health service providers may include primary care professionals, emergency responders, and school staff members (teachers, school counsellors, school psychologists, school social workers, school nurses, and other school staff) (Moolla, 2011).

Mental health service providers need to work in a system to effectively identify and correctly refer children in need of psychological services. Roles played by individuals working in a system are central to the overall functioning of the system (Moola, 2011). Therefore, it is important to have clearly defined roles when working in a system. The role of mental health service providers is to help support and participate in the delivery of a range of mental health promotion and prevention programmes (Barry & Jenkins, 2007). Moreover, mental health service providers are expected to manage child cases in schools and act in affirmative and skilful ways to respond to a student body that represents significant demographic changes (Rogers, Ingraham, Bursztyn, Cajigas-Segredo, Esquivel, Hess, Nahari & Lopez, 1999). This may also include the role of identifying potential mental health problems and helping community members access services (Barry & Jenkins, 2007). Below is a breakdown of the types of mental health service providers and their role in managing child cases.

2.8.1 *School counsellor*

A school counsellor is described by the HPCSA (2005) as an individual who provides psychological screening, basic assessment, and intervention. According to Zukarat (2015), school counsellors are individuals who are employed within the school environment to support learners social, vocational, and academic needs, to develop their success and adjustment. Pillay (2011) stated that school counsellors are responsible for providing therapy and developing career programmes for learners.

Over the years, the school counsellor's role has been redefined and expanded. According to Daniels (2013), the school counsellor's main responsibilities have been divided into three sections: counseling, consultation, and coordination. Daniels (2013) mentioned that school counsellors engage in preventative work and have always played an important role in guiding and supporting learning outcomes for all students and improving the achievement of learners. Taking into consideration that school counsellors deal with various societal issues that affect learners, it can be said that they assist learners in coping with any challenges that impact their psychological, emotional, and behavioural development. They respond to the educational needs of learners and facilitate the learning process (Daniels, 2013). It is thus evident that school counsellors in South Africa play a wide-ranging role. When dealing with learners in need of psychological services beyond their scope of practice, school counsellors are encouraged to refer such cases to appropriate qualified professionals (Zurakat, 2015).

2.8.2 *Learner support agent*

The DoE employs learner support agents (LSAs) as part of the poverty alleviation programme to support learners (Department of Education, 2014). Due to limited financial resources, most schools in South Africa cannot afford to employ psychologists or school counselors. In response, some schools have employed LSAs to support learners. LSAs have been employed to run on-site peer education programmes and provide support to all learners. They are responsible for linking learners who have psychological difficulties with local supporting structures and providing ongoing support. LSAs play the role of identifying learners with psycho-social, behavioural, and academic difficulties. Furthermore, they are responsible for referring learners to appropriate support.

2.8.3 *School social worker*

A school social worker is an individual who is employed within the school environment to deal with the emotional, social, academic, and behavioural difficulties of learners (Van Sittert & Wilson, 2018). The South African government recognised the need to employ school social workers in the education system in 1973. However, the South African Council for Social Service Professions only acknowledged it as an area of specialisation in 2009 (Van Sittert & Wilson, 2018). Van Sittert and Wilson (2018) state that in the year 1983, KZN became the first province to appoint a school social worker.

School social workers play an important role in supporting learners. They render services within schools that include crisis intervention, case management and counselling, grief support, violence prevention, and establishing a supportive environment in schools (Van Sittert & Wilson, 2018). Similarly, Weber (2018) stated that school social workers are responsible for identifying various factors influencing learners' academic performance. School social workers' role and responsibility are to find advanced and creative ways to promote and increase parents' involvement (Weist, 1997). Previous studies (Williams et al., 2007; Van Sittert & Wilson, 2018) stated that school social workers are also responsible for providing individual and family counselling, conducting support groups, child and adolescent school attendance, clothing needs, and special education.

Concerning managing child cases, school social workers play the role of collaborating with teachers, supporting and assisting them in dealing with learners experiencing difficulties (Van Sittert & Wilson (2018). In addition, school social workers are known as the starting point in assessing children with difficulties at school as they are usually the first person to whom the child is referred.

2.8.4 *Educators*

Educators play a vital role in identifying and seeking help for children and adolescents with mental health difficulties (behavioural, emotional, social, and developmental) (Babatunde et al., 2020). According to the DoE (2014), to fulfil their duty to teach and facilitate the learning process, teachers are responsible for planning interventions and providing support daily for all learners. Due to educators being considered as gatekeepers to CAMH care, their involvement is crucial to achieving effective CAMH service delivery (Babatunde et al., 2020). With regard

to learners who have been referred to psychological services, teachers are expected to take on the role of a case manager to facilitate support (DoE, 2014).

The role of teachers is to ensure safety and to identify children who may need services for mental health, learning, or behavioural difficulties (Weist, 1997). Similarly, the DoE (2014) stated that teachers are responsible for gathering information and detecting learners who need psychological services, as well as providing interventions to address and support the needs of learners referred for psychological services.

2.8.5 *School psychologist*

When it comes to managing child cases referred for psychological intervention, the role of psychologists is largely focused on the learners (Moolla, 2011). Psychologists can intervene at an individual and group level, either directly or indirectly, in a curative or preventative manner (Moolla, 2011). Not only is it important for psychologists to understand how schools affect learners, but it is equally important for them to understand how learners affect schools. Psychologists also need to understand how the school as a system influences teachers and learners (Moolla, 2011). Additionally, the role of psychologists has been to support children and families with problems and diagnose disorders. Psychologists have been vocal advocates of the need to develop new models of intervention that can increase the reach of services and implement programmes to reduce risk factors and promote protective factors to prevent mental disorders in children (Hunsley et al., 2014; Crosier, 2018).

Moolla (2011) stated that psychologists are responsible for administering various assessments and interventions which target emotional, behavioural, and learning difficulties experienced by children and adolescents. Similarly, other studies have stated that the psychologist's role in managing cases is to evaluate cases using standardised psychological tools and provide psychological interventions; and diagnose, assess and treat psychological problems that affect children's overall functioning (Wahass, 2005; Van Schalkwyk & D'Amato, 2013; Martadza et al. 2019). Moreover, the psychologist's role is to help provide effective services to support children and youth to succeed academically, socially, behaviourally, and emotionally (Castello, Arroyo-Plaza, Tan, Sabnis & Mattison, 2017). Psychologists provide direct educational and mental health services for children and youth and work with parents, educators, and professionals to create supportive learning and social environments for all children (Castello et

al., 2017). Therefore, it can be concluded that the psychologist's role in managing child cases is to diagnose and manage those cases to improve the child's functioning.

2.8.6 *Healthcare practitioner*

Healthcare practitioners range from a healthcare worker employed by the government to private medical or paramedical practitioners. They play an important role in managing child cases and in conducting more formal assessments (DoE, 2014),

A general practitioner (GP) role in detecting and managing cases has increasingly come into focus. The GP's role involves a relationship with the whole family, and the GP may know events leading to a family crisis (Kramer & Garralda, 2000). A holistic approach in primary care is significant when managing children who have been identified as having psychological difficulties. This is because the primary care team treats psychosomatic problems and pays attention to the physical and emotional aspects as appropriate. The primary care team (which includes nurses, social workers, psychologists, counsellors, etc.) in preventing and treating mental health problems in children may be broader and more intensive than the GPs and includes interventions with children and mothers (Kramer & Garralda, 2000).

While mental health service providers' roles and responsibilities are crucial in managing child cases, the literature suggests that these roles often overlap. Moreover, it is essential to note that some South African schools are uninformed about other referral pathways and do not have any qualified staff to provide CAMH assessment, counselling, and intervention (Babatunde et al., 2020). This is a strong indicator that the Integrated School Health Programme (ISHP) teams have not integrated mental health care into their programmes (Babatunde et al., 2020). This suggests that many children and adolescents with psychological difficulties do not receive assistance or necessary placement.

2.9 Policy Guidelines Relating to the Provision of Mental Health Services of Children and Adolescents in South Africa

Policies are important to guide the development of systems of care, training programmes for practitioners, and research endeavours (Shatkin, Balloge & Belfer, 2008). Some countries have successfully developed national policies and plan to address mental and developmental disorders in children and adolescents (Scott et al., 2015). In South Africa, mental health practitioners and school teachers have to adhere to guiding policies devised by the health and

education sector (Mfidi,2017). According to Mokitimi et al. (2018), various circumstantial factors play a role in determining policy development and implementation. Mental disorders carry significant weight when it comes to disease in children and adolescents worldwide, 10 to 20% of them being affected.

Post-apartheid, the South African government has taken significant steps to create a policy framework to provide comprehensive and community-based services for children, adolescents, and adults (Dawes, Lund, Sorsdahl & Myers, 2012). However, only a few countries uphold policies designed to address the mental health needs of children and adolescents (Shatkin et al., 2008). The creation of government policies addressing child and adolescent mental illness is important in helping countries to recognise the importance of children's mental health (Shatkin et al., 2008). There have been various policy guidelines for children and adolescent mental health in South Africa. These were developed to provide adequate psychological services. Some of these policies are briefly discussed below.

2.9.1 *The National Health Policy Guidelines for Improved Mental Health in South Africa (1997)*

The main objective of the National Health Policy Guidelines was to prioritise services for children (Lund & Fisher, 2006). It is mentioned that the priority for mental health services for children should be prevention and that the services need to be integrated into general primary health care.

2.9.2 *The White Paper for Transformation of the Health System in South Africa (1997)*

The "White Paper for the Transformation of the Health System in South Africa" has a chapter that addresses mental health (Department of Health, 2009). It proposed a comprehensive, community-based mental health service at the national, provincial, district, and community levels, which is integrated with other services. The White Paper has had a huge impact on the South African education system, particularly regarding the provision of psychological services (Muribwathoho, 2015).

According to the DoE (1995b), the government is responsible for providing counselling in education services by all possible means and providing the necessary support and educational services for parents and children within the community. In the same year, the DoE released a set of policy guidelines for improved mental health care. These guidelines were consistent with

and informed by the Education White Paper (see below) and identified services for children and adolescents as one of the most significant areas for intervention (Dawes et al., 2012).

2.9.3 *Education White Paper 6*

The DoE developed a framework policy document called White Paper 6 on "Special Needs Education: Building an Inclusive Education and Training System" (2001). Its purpose is to enable a consistent screening, identification, assessment, and support for all learners.

White Paper 6 aims to have an inclusive education and training system to address learning development barriers in South Africa (Department of Education, 2001). More specifically, all factors which prevented learners from accessing educational services are viewed as barriers to learning development (DoE, 2003). In addition, White Paper 6 views education support as support for every learner; this means that all learners receive an equal opportunity for effective learning, and services to learners experiencing barriers to learning are provided.

The White Paper 6 is intended to help schools become inclusive and supportive and designed to help schools accommodate learners with diverse learning needs, including physical, emotional, social, or psychological learning needs (Johnson & Lazarus, 2003). According to August (2018), in assisting and accommodating learners with psychological difficulties, alternative methods have been made to assess learners. Therefore, children and adolescents who are not coping in the school environment due to academic, emotional, or physical difficulties can be granted concessions to achieve maximum results and function in society. Examples of alternative methods include being given extra time during examinations and having scribes or amanuenses (readers and writers) (August, 2018). For learners to be granted concessions, schools need to apply through the District Examination Concessions Committee concessions. For several reasons, which include long waiting lists and having to follow-up, parents prefer their children to be assessed by an educational psychologist in private practice (August, 2018).

2.9.4 *Policy on Screening, Identification, Assessment, and Support (SIAS)*

The SIAS policy aims to provide a framework for identifying, assessing, and providing programmes for children and adolescents in need of support. Its purpose is to improve the learning process by supporting learners with difficulties (Department of Basic Education, 2014). This policy includes forms to be used by teachers, school-based support teams (SBSTs),

and district-based support teams (DBSTs) to screen, identify and assess learners to make the necessary referrals (Department of Basic Education, 2014).

The SBSTs were established to address learning barriers and identify learners that are "at-risk." The goal of the SBST is to provide support for teachers and caregivers. Schools that do not have an SBST should involve the DBST to assist in setting one up. The DBST and other government departments are responsible for providing support to the SBST (Department of Basic Education, 2014).

The policies mentioned above reveal what is currently available in terms of provision of psychological services in South Africa, as well as the transformations that have since taken place. Due to the majority of children being diagnosed when they reach school going age, it may be suggested that these policies may assist in children being diagnosed quicker once they have entered the education system. These policies impact on the provision of psychological services by aiming to ensure that they are well catered for in the school setting.

2.10 Conceptual Framework

The Ecological models of human development (Bronfenbrenner, 1979) highlight how children are influenced by multiple interacting systems, including the social context in which they live, such as neighbours, the physical environment, culture, and society (Barry & Jenkins, 2007). The Ecological models provide a holistic understanding of the individual experiencing difficulties impacting learner development (Daniels, 2013). The Ecosystems theory guided this study as it sheds light on how children's access to psychological services is directly and indirectly affected by the various interrelating systems.

2.10.1 *Bronfenbrenner's Ecosystems theory*

Bronfenbrenner's Ecosystems theory is a striking one for our work on the individual because it is extensive yet focused; it allows for focus on community relationships and individual learner development. According to Burns (2016), Bronfenbrenner's Ecosystems theory is defined as the study of multiple interconnected environmental systems that influence individual development. Psychological services resulting from the ecological perspective aim to understand individuals concerning their social contexts, including the home environment, family, school, and the wider community, and how these contexts influence their worldview.

Moreover, Bronfenbrenner's theory enables us to acknowledge and understand children's developmental contexts as important influences in the formation of their psychological capacities. Discussed below are the system levels that the individual relates to, and these comprise the microsystem, mesosystem, exosystem, and macrosystem. The levels are depicted in Figure 2.1 below.

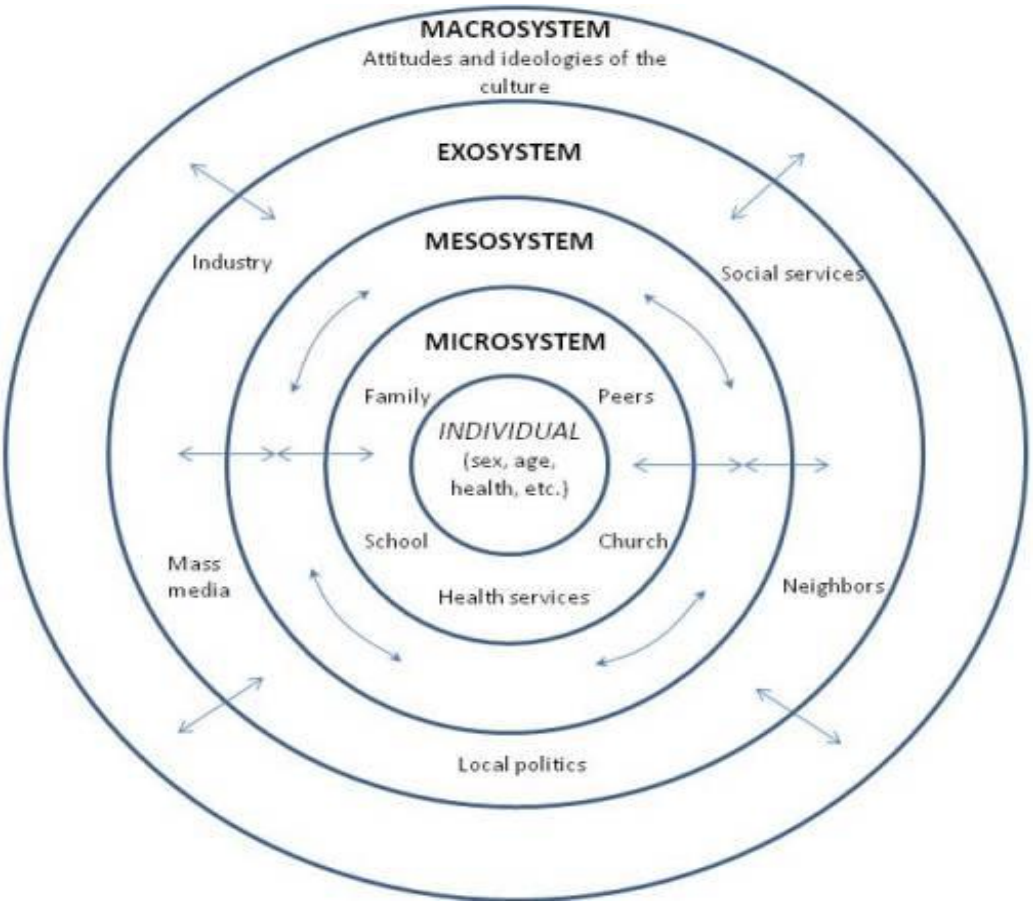

Figure 1: Bronfenbrenner's Ecological model

Source: Bronfenbrenner (1979).

2.10.2 *The microsystem level*

The microsystem encompasses the relationships the individual has with his or her immediate surroundings. These surroundings include the school and the home environment, with the actors being the teachers, parents, and peers (Paquette & Ryan, 2001; Zurakat, 2015). Relating this to the present study, the teacher and mental health service providers (school counsellor, psychologist, and social worker) function within the school system and other actors to impact

the child's development. This means that teachers and mental health service providers play an important role in identifying and making the necessary referrals to a more qualified mental health professional (private psychologist) for further intervention.

Bronfenbrenner (1992) viewed "the instability and unpredictability of family life as the most destructive force in a child's development. This deprives children of the constant mutual interaction with important adults that is necessary for development." This means that if the relationships in the immediate micro-system break down, the child will not have the tools to explore other parts of the environment.

2.10.3 *The mesosystem level*

The mesosystem "comprises the linkages and processes taking place between two or more settings containing the developing person" (Bronfenbrenner, 1992, p. 227). The child's development should thus improve if the roles, activities and relationships in which he or she engages are consistent in both settings (school and home environment). For example, if there is a strain in the relationship between the school (teacher) and parents or primary caregivers of the child, it could have a negative impact on the child's development and ability to develop and reach his/her full potential.

According to Muribwathoho (2015), actions taken in the school setting can influence action in the home environment. Furthermore, this highlights the important role parental involvement plays when it comes to psychological services. They are seen as partners working with school counsellors and psychologists for the child or adolescent's benefit (Muribwathoho, 2015). This suggests that if a child has been identified by a teacher or counsellor as needing further psychological intervention, the school will then involve the parents, the family values, cultural beliefs, and financial status (context) of the family, which all play a role in determining whether the child will seek professional psychological services (Zuma, 2017).

2.10.4 *The exosystem level*

The exosystem refers to the interactions between different systems where the child is not an active member, but which influences his or her life. Furthermore, it looks at how external factors that the individual does not have control over, such as the social, financial, and political, work together to influence their behaviour (Zuma, 2017). It consists of

neighbours/neighbourhood area, extended family members, and social agencies, contributing to the child developing mental health problems.

An environment with a high level of poverty, substance abuse, and juvenile delinquency is a risk factor for children developing mental health difficulties such as anxiety and depression (Nolen-Hoeksema, 2014). Some customs and cultural practices in communities also put the child at risk of developing mental health problems (Nolen-Hoeksema, 2014). The exosystem further explains that the context from which an individual comes influences their ability to access psychological services. Limited access to mental health services to provide the necessary support may influence children's ability to seek mental health services. The exosystem underscores the critical role of mediating structures such as schools, workplaces, and communities in providing key contexts for social interventions operating from the micro to the macro levels (Barry & Jenkins, 2007).

2.10.5 *The macrosystem level*

The macrosystem comprises the larger societal factors that affect the child's life. The macrosystem is said to be formed by cultural values, beliefs, and customs of the larger society where the child lives, including the policies that impact him or her. Cultural ideas and policies that stigmatise or marginalise certain groups in communities influence how mental health problems are perceived and put children at increased risk for mental health problems (Nolen-Hoeksema, 2014; Zuma, 2017). Furthermore, cultural norms and values can affect how parents respond to society's views of mental health services.

2.11 Summary

To gain a better understanding of psychological services in South Africa, this literature review chapter began with a definition of psychological services and a brief historical background of these services. The chapter has focused on the many factors that play a role when referring children to psychological services. Findings from various studies were reviewed. Based on the literature reviewed, there has not been enough research done in South Africa that focuses on children's referral to psychological services. There appears to be a common theme, in many countries, of insufficient resources and service providers to address the needs of children and adolescents with mental problems. The literature indicates that there may be inadequate mental health providers in South Africa, especially in rural areas. The chapter has highlighted stigma, segregation, a lack of knowledge and information, financial resources, cultural beliefs, and

language to be of significance when it comes to barriers to accessing psychological services. The chapter concluded with a discussion of Bronfenbrenner's Ecosystems theory, showing how the systems comprising the theory affect children with mental health problems.

Chapter Three: Methodology

3.1 Introduction

This chapter presents an outline of how data were obtained, the design of the study, and the method of analysis of the child cases referred for psychological services. The study's location and descriptive data relating to demographic information will be presented. This chapter will also describe the sample size and the sampling method as well as the procedures used in the study. It covers issues of reliability and validity and ends with the ethical considerations pertaining to the study.

3.2 Location of the Study

Northern KZN comprises towns such as Newcastle, Emadlangeni, and Dannhauser. The population of the area is estimated to be 531 327 people who are accommodated in 110 963 households (Annexure A, 2019). Newcastle has the highest population which is estimated at 389 117 people (84 272 households) (Annexure A, 2019). According to UNICEF's 2012 annual report for South Africa, 21.9% of the child population resides in the KZN province (UNICEF South Africa, 2013). Due to its accessibility to the researcher, the study was conducted in a psychologist's private practice called Ithubalethi Health and Wellness Centre in Newcastle.

3.3 Paradigm and Research Design

This study was informed by a positivist paradigm, making use of quantitative research methodologies of data collection, sampling, and data analysis. The positivist paradigm acknowledges that one reality exists, and real events can be observed and explained for the benefit of others (Kaboub, 2008; Martinell, 2018). Making use of this paradigm has helped the researcher remain independent of the outcomes of the study. All information in the study was based on factual findings from clients' files, which made the positivist paradigm the appropriate one for the study.

The study was conducted as a quantitative one to analyse child cases referred for psychological services in private practice within the Northern KZN region. Christensen, Johnson, and Turner (2015) stated that a quantitative research study collects different types of numerical data to answer a given research question. In terms of the present study, the collected data covered demographics, presenting problems, and referral sources.

3.3.1 *Quantitative research*

Quantitative research served to give a clear overview of the child cases referred for psychological services, as it uses a rigorous and controlled design to examine phenomena using precise measurement (Rutberg & Bouikidis, 2018). The quantitative approach was considered appropriate for this study as it explores a lot of the unanswered research questions and makes a meaningful impact (Polit & Beck, 2012).

3.4 Research Population

Data was collected from a psychologist's private practice database to understand the referral agents, the reasons for referral, the nature of the clients' characteristics, and the interventions rendered to meet the clients' needs. The client base for the practice comes from both the rural and urban areas of the Northern KZN region. There are different views on psychological services (including access to these services) among the population. Some people prefer to go to traditional healers while others, as in this study, consult psychologists. Therefore, it was considered important to analyse the child cases referred for psychological services in private practice within the Northern KZN region. The researcher profiled and presented information from clients (both male and female) of all races, between six and 18 years old, who were school-going age learners. The child had to have been referred to the private practice between 2009 and 2018. The files were selected regardless of the religion and socioeconomic status of the clients. The researcher selected school-going age learners because psychological services and mental health support systems, in terms of learners, need much improvement (Tolan, 2005).

The records of learners who do not fall under the General Education and Training phase (GET), Intermediate phase, and Further Education and Training phase (FET), were not accessed because it was assumed that they are not equally equipped with the necessary skills and knowledge. A total of 68 case files were identified as possibly relevant as they concerned children with learning barriers. However, after further perusal, it was found that only 31 of these cases concerned children from the Northern KZN region, and it was these 31 cases that were used for the study.

3.5 Sampling

As outlined above, a sample of 31 cases was drawn from a psychologist's private practice, and these cases formed the basis for the study. Non-probability sampling (more specifically, purposive sampling) was used in identifying the cases. It was chosen due to its practical considerations with regard to cost and time. According to Christensen et al. (2015, p. 171), "when using purposive sampling, the researcher specifies the characteristics of the population of interest and then locates individuals who match the needed characteristics." This study focused on child cases with learning barriers at a psychologist's private practice. Owing to the method of sampling and the focus on one psychology practice, the study's findings cannot be generalised to all children and adolescents referred to psychological services in KZN. Although the researcher attempted to make the sample as representative as possible, caution should be taken in generalising within and beyond the population involved in the present study.

3.6 Demographic information

Before starting the research, the researcher hoped to access a minimum of 30 records; however, the researcher ended up accessing 31 records (17 male and 14 female). The majority of the referred male clients made up 54.8% of the total sample, while 45.2% were female. Of the 31 cases, 64.5% were African, 25.8% were white, 9.7% were coloured, and 3.2% were Indian.

Table 1 below provides a summary of the clients' demographic information.

Table 1

Clients' Demographic Information

Biographical information	Race	Frequency (count)	Percentage (%)
Race	African	20	64.5
	White	7	22.6
	Coloured	3	9.7
	Indian	1	3.2
Age group	6- 9	10	32.3
	10- 13	7	22.6
	14- 18	14	45.2

3.7 Research Instrument and Data Collection

When collecting data, it is important to gain entry and establish rapport (Padgett, 1998). In this regard, the researcher sent an email to the Ithubalethu Health and Wellness Centre Director explaining the research's purpose and asking for permission to conduct the study. Permission was granted, and a consent form attesting to this was signed and provided. With the research supervisor's assistance, a survey questionnaire was developed by the researcher to investigate the key questions of interest to the study. Its development was guided by the objectives of the research and the reviewed literature. Due to the small sample, the researcher did not conduct a pilot study. In order to enhance reliability and validity of the research instrument, the researcher recorded data from case files herself and was the sole recorder. In order to increase validity of the research instrument, the researcher developed an in-depth questionnaire (asking specific questions) to assist with data collection and completing data collection. Furthermore, all recordings were checked for consistency with the use of client case files and then coded and checked against a template to ensure that categories of responses fell into consistent groups. The research supervisor provided feedback on the items' appropriateness on the survey questionnaire, its readability, the clarity of its contents, and the relevance of its items. This review helped ensure that the research instrument was appropriate for the study. The survey questionnaire is attached as Appendix A.

The survey questionnaire was divided into six sections: Section A recorded the demographic information regarding the client. Section B concerned the referral source and Section C recorded information regarding the presenting problems. Section D concerned the status/outcome of the case, and Section E recorded the diagnosis profile. In terms of the profile, the researcher had to indicate the primary learning disorder that the child was diagnosed with. The sixth and final section, Section F, was created for any additional information.

3.8 Procedure

The purpose and nature of the study were first explained to the psychologist, ensuring that she was aware that all the clients' data would be treated confidentially and coded to ensure their anonymity. She was also informed that as a participant who had given consent to the researcher to access clients' records in her private practice, she was allowed to refuse to participate or cease participation at any time during the research. This is elaborated on under "Ethical considerations" below. The completion of each questionnaire took the researcher

approximately 30 to 45 minutes and was completed in a private space at the Ithubalethu Health and Wellness Centre.

Once the data collection was complete, each set of questionnaires was given a letter (the letter "Y" if the client was a male or "X" if the client was a female) and a number to ensure the anonymity of the participants. Each questionnaire was coded and then captured. The captured data were then analysed using SPSS. The statistical analyses that were performed included frequency analyses as well as descriptive statistical analyses to create descriptive statistics in the form of contingency tables. Data analysis is discussed in more detail at 3.10 below.

3.9 Reliability and Validity

Reliability refers to the consistency or stability whereby occurrences are assigned to the same category by different observers or by the same observer on different occasions (Hammersley, 1992; Christensen et al., 2015). Reliability suggests that recurring and stable outcomes will be the same under identical or similar conditions. In this study, reliability was achieved through the standardisation of the instruments (how they were administered). Validity is the truthfulness of inferences made from a study; it is also the extent to which a variable measure what it is supposed to measure (Christensen et al., 2015). According to Christensen et al. (2015), a valid study requires reliability; however, reliability is not enough to ensure validity.

This study required the researcher to write items (such as age, gender, etc.) and construct questions that have psychometric properties to provide reliable and valid data. The researcher used the data obtained from the clients' records to construct a detailed table of the overall demographic information relating to the sample, including gender and age.

There was limited and missing information in some of the clients' files, and hence the researcher could not complete all the items in the survey questionnaire for all the cases. This may compromise the reliability of the study. Given that some of the cases had missing information, and the questionnaire was not piloted, the study's findings' reliability and validity are limited.

The referral of clients to the private practice and considering that the psychologist at Ithubalethu Health and Wellness Centre is an educational psychologist could have created the potential for sample bias. For example, schools and parents may be more likely to refer to

children with similar difficulties. Moreover, the sample was biased as it largely consisted of individuals who had medical aid or who could afford psychological services in the private sector.

3.10 Data Analysis

The researcher manually recorded all data onto the data collection instruments. The recorded data was then transferred for descriptive statistical analysis into the SPSS. Subsequent to this the analysed data was transferred to MS Excel and MS Word for final reporting. The researcher made use of the data obtained to create frequency and contingency tables. The main purpose of a contingency and frequency table is to organise and give a summary of the values and relationships that exist between categorical variables (Christensen et al., 2015). Due to the small sample size, Fisher's exact tests were used, and a p-value of less than 0.05 means that the null hypothesis (also known as H0) is rejected; when the p-value is greater than or equal to 0.05, the H0 is accepted. Descriptive statistics were used to analyse clients' demographics as well as the types of presenting problems. Descriptive statistical analyses, including the calculation of frequency distributions, were used to determine whether there were any inconsistencies or missing information. According to Terre Blanche, Durrheim, and Painter (2006), frequency tables are used to display the distribution of the variables under consideration effectively. Furthermore, the data were analysed, and the results were presented according to the research questions guiding the study. According to Christensen et al. (2015), data can be used as a basis for inferences about the phenomenon under investigation or as a basis for decisions; they must be summarised, and the relevant information must be extracted.

3.11 Ethical Considerations

Ethical principles are important in guiding research and addressing ethical issues raised while the research is being conducted (Gibson & Brown, 2009). Reliable research not only depends on selecting an appropriate instrument and/or research method but also requires adhering to research ethics (Zurakat, 2015). The University of KwaZulu-Natal has a Research Ethics Committee aiming to ensure that ethical requirements are complied with when research is conducted.

Once ethical clearance was obtained from the University of KwaZulu-Natal's Research Ethics Committee (Appendix D) the researcher began to analyse and code the clients' records. Permission to use a questionnaire that facilitated the recording of the details of child cases

reported to the educational psychologist in private practice was requested. This was done in the form of a letter that clearly stated the study's reasons and that clients' identities would remain protected (Appendix B). The questionnaires used to obtain the data are being kept in a locked and secure cupboard for five years; thereafter, they will be shredded. For this study, the following ethical practices were taken into consideration:

3.11.1 *Informed consent*

Informed consent refers to informing the research participants about the nature of the study. This includes anything from the purpose and procedures to any potential risks and benefits (Christensen et al., 2015). To get informed consent, the researcher contacted the Ithubalethu Health and Wellness Centre Director before data collection to establish a collaborative partnership through trust and to gain approval for how the clients' records would be accessed and used. This can be seen in the information sheet (Appendix B) that explained the purpose of the research and the consent form (Appendix C) that stated that participation in the study was voluntary and that withdrawing participation was allowed at any time.

3.11.2 *Confidentiality*

An important ethical aspect is the issue of confidentiality of the findings of the study as well as safeguarding participants' identities (Maree, 2014). To ensure confidentiality and the protection of the clients' identities, the researcher, after collecting the data, removed all information that could have been linked to the clients' identities. As noted above, the survey questionnaires are being safely kept under lock and key, and this will be the case for five years, after which they will be destroyed.

3.11.3 *Social value*

Social value is attained when the topic being studied leads to a better understanding of the issues involved and to interventions that will be of value to the participants and community (Wassenaar & Mamotte, 2012). The researcher hoped that the study would help in gaining a better understanding of psychological services and the characteristics of, as well as the trends in child cases referred to psychological services. To ensure social value, the researcher took responsibility for addressing issues in the Northern KZN region by including the findings and recommendations for future studies. It is hoped that the study will provide insight into the referral system and an understanding of the roles played by stakeholders in managing child cases that have been referred for psychological services.

3.11.4 *Approval to conduct the study*

The researcher submitted the proposal for the study to the University of KwaZulu-Natal Humanities and Social Sciences Research Ethics Committee (HSSREC) for ethical approval. (Appendix D). Ethical approval was granted (reference number HSS/0890/018M), and data collection commenced soon thereafter.

3.12 Summary

This chapter provided details of the methodology and design of the study. The chapter also discussed the sampling technique adopted and the procedures for the collection and analysis of data. Lastly, the ethical issues involved in the study were addressed.

Chapter Four: Results of the Study

4.1 Introduction

This chapter presents the findings of the study. The findings are presented in relation to each of the research questions formulated at the start of the research and outlined in Chapter one. Cross-tabulations and Fisher's exact tests were used to determine the relationships between variables and gain a better understanding of the child cases referred for psychological services. Moreover, a 5% level of significance was used. H0 is rejected when the p-value is less than 0.05, which says there is a relationship between the variables. If the p-value is greater than or equal to 0.05, H0 is accepted and there is no relationship between the variables. Trends, referral, and presenting problems, and other outcomes were identified. The tables below consist of abbreviations derived from the survey questionnaire (Appendix A).

4.2 Presentation of results by the Research Questions

4.2.1 What are the reasons for referral and sources of referral in a private psychologist's practice in the Northern KZN region?

Table 2

Reasons for Referral

Reason for referral	Frequency (count)	Percentage (%)
Academic difficulties	16	51.6
Academic and behavioural difficulties	1	3.2
Emotional difficulties	1	3.2
Educational assessment	4	12.9
Educational assessment & anxiety	1	3.2
Concentration difficulties	5	16.1
Behaviour & concentration difficulties	2	6.4

Therapy	1	3.2
Total	**31**	**100.0**

Table 2 above shows that academic difficulties were the most mentioned reason for referral mentioned by 51.6% of the sample. Only one (3.2%) case was referred for academic and behavioural difficulties, one for emotional problems, one for an educational assessment and anxiety, and one for therapy. No referrals for behavioural difficulties only were made. The second-highest number of referrals, five (16.1%), were made for concentration difficulties.

Table 3

Client's Source of Referral

Source of referral	Frequency (count)	Percentage (%)
Biological mother and/ or father	9	29.3
Teacher	18	58.0
Teacher & caregiver (s)	2	6.5
Medical doctor	1	3.2
Clinical psychologist	1	3.2
Total	**31**	**100.0**

Table 3 shows that teachers made the most referrals (58%), followed by the biological mother and/or father. The least number of referrals (one) came from a medical doctor (3.2%) and clinical psychologist (3.2%).

Table 4

Gender of the Source of Referral

Gender of referral source	Frequency (count)	Percentage (%)
Male	2	6.5
Female	21	67.7
Unknown	8	25.8
Total	**31**	**100.0**

Table 4 shows that the highest number of referrals were made by females (67.7%). The least number of referrals, two (6.5%) were made by males. The table also shows that the gender of 25.8% of individuals who referred children to private practice is unknown. This suggests that insufficient attention was paid to recording the gender of the referrers.

Table 5

Frequency of Client Referrals Per Year

Year client was assessed	Frequency (count)	Percentage (%)
2009	1	3.2
2010	1	3.2
2011	2	6.5
2012	0	0.0
2013	5	16.1
2014	4	12.9
2015	4	12.9
2016	1	3.2
2017	4	12.9
2018	9	29.0

Table 5 shows that the highest number of cases in the sample were referred in 2018, that is nine (29.0%). The least number of cases were referred in 2009 (one), 2010 (one), 2011 (two) and 2016 (one). In terms of the sample, there were no child cases referred in 2012.

4.2.2 What are the characteristics of child cases reported in a private psychologist's practice in the Northern KZN region?

Table 6

Cross-tabulation between Clients' Age and Referral Reason

		Reason for referral								
Age		**Academic**	**Academic & behaviour**	**Emotional**	**Educational assessment**	**Educational assessment & anxiety**	**Concentr-ation**	**Behaviour & concentration**	**Therapy**	**Total cases**
6-9 years	Count	3	0	0	0	0	5	2	0	10
	% within age	30.0%	0.0%	0.0%	0.0%	0.0%	50.0%	20.0%	0.0%	32.3%
10- 13 years	Count	6	1	0	0	0	0	0	0	7
	% within age	85.7%	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	22.6%
14- 18 years	Count	7	0	1	4	1	0	0	1	14
	% within age	50.0%	0.0%	7.1%	28.6%	7.1%	0.0%	0.0%	7.1%	45.2%
Total	**Count**	**16**	**1**	**1**	**4**	**1**	**5**	**2**	**1**	**31**
	% within age	**51.6%**	**3.2%**	**3.2%**	**12.9%**	**3.2%**	**13.1%**	**6.5%**	**3.2%**	**100.0%**

Table 6 above shows that children and adolescents were mostly referred for academic difficulties (51.6%). Children and adolescents between the ages of 14 and 18 years had the highest number of referrals (45.2%), followed by those between six and nine years of age. H0 is accepted (p-value of 0.333 which is greater than 0.05), and the reason for referral is independent of age group. Children of any age can be referred for any psychological difficulties.

Table 7

Cross-tabulation between Clients' Gender and Referral Reason

Gender		Reason for referral								
		Academic	**Academic & behaviour**	**Emotional**	**Educational assessment**	**Educatio-nal assessm-ent & anxiety**	**Concentr-ation**	**Behaviour & concentrat ion**	**Therapy**	**Total cases**
Male	Count	8	0	0	2	0	4	2	1	17
	% within gender	47.1%	0.0%	0.0%	11.8%	0.0%	23.5%	11.8%	5.9%	54.8%
Female	Count	8	1	1	2	1	1	0	0	14
	% within gender	57.1%	7.1%	7.1%	14.2%	7.1%	7.1%	0.0%	0.0%	45.2%
Total	**Count**	**16**	**1**	**1**	**4**	**1**	**5**	**2**	**1**	**31**
	% within gender	**51.6%**	**3.2%**	**3.2%**	**12.9%**	**3.2%**	**16.1%**	**6.5%**	**3.2%**	**100.0%**

Table 7 above shows that more males than females were referred to the private practice. Males (8) and females (8) were equally referred for academic difficulties. This means that more than half of the sample was referred for academic difficulties (51.6%). The table also shows that more males were referred for concentration difficulties (23.5% compared to 7.1% of females). H0 is accepted (p-value of 0.500, which is greater than 0.05). This means that the reason for referral is independent of gender.

Table 8

Cross-tabulation between Race and Referral Reason

Race		Reason for referral								
		Academic	**Academic & behaviour**	**Emotional**	**Educational assessment**	**Educational assessment & anxiety**	**Concentr-ation**	**Behaviour & concentration**	**Therapy**	**Total cases**
African	Count	12	1	0	1	0	4	2	0	20
	% within race	60.0%	5.0%	0.0%	5.0%	0.0%	20.0%	10.0%	0.0%	64.5%
White	Count	2	0	1	2	1	1	0	0	7
	% within race	25.0%	100.0%	12.5%	25.0%	12.5%	12.5%	0.0%	0.0%	22.6%
Coloured	Count	2	0	0	1	0	0	0	0	3
	% within race	66.7%	0.0%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%	9.7%
Indian	Count	0	0	0	0	0	0	0	1	1
	% within race	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	3.2%
Asian	Count	0	0	0	0	0	0	0	0	0
	% within race	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**Count**	**16**	**1**	**1**	**4**	**1**	**5**	**2**	**1**	**31**
	% within race	**51.6%**	**3.2%**	**3.2%**	**12.9%**	**3.2%**	**16.1%**	**6.5%**	**3.2%**	**100.0%**

Table 8 above reveals that African children had the highest number of referrals, particularly those with academic difficulties, followed by white children. More African children were referred for academic and concentration difficulties in comparison to white children. Coloured and Indian children had the least number of referrals. H0 is accepted (p-value of 0.400, which is greater than 0.05); this means that there is no dependency between the reason for referral and race.

Table 9

Previous Intervention Provided for the Client

Previous intervention	Frequency (count)	Percentage (%)
Psychological counselling	1	3.2
Psychiatric evaluation	1	3.2
Occupational therapy	1	3.2
Speech therapy	2	6.4
Remedial classes	1	3.2
None	25	80.6
Total	**31**	**100.0**

As reflected in Table 9 above, the study found that most children (80.6%) did not have any previous interventions. One male and one female, constituting 6.4% of the sample, had previously been to a speech therapist.

Table 10

Known Conditions

Known conditions	Frequency (count)	Percentage (%)
Medical	1	3.2
Physical	3	9.7
Psychological	1	3.2
Total	**5**	**16.1**

Table 10 above shows that 9.7% of children were known to have physical conditions. These included a cleft lip, a cleft palate, a club foot, and motor and physical difficulties. The majority of the children referred did not have any known conditions or illnesses.

Table 11

Cross-tabulation between Client's Grade and Referral Reason

Grade		Reason for referral								
		Academic	**Academic & behaviour**	**Emotional**	**Educational assessment**	**Educational assessment & anxiety**	**Concentr-ation**	**Behaviour & concentration**	**Therapy**	**Total cases**
R- 3	Count	2	0	0	0	0	5	2	0	9
	% within Levsch	22.2%	100.0%	100.0%	100.0%	100.0%	55.6%	22.2%	0.0%	29.3%
4- 6	Count	6	0	0	0	0	0	0	0	6
	% within Levsch	100.0%	100.0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	19.6%
7- 9	Count	6	1	0	2	1	0	0	0	10
	% within Levsch	60.0%	10.0%	0.0%	20.0%	10.0%	0.0%	0.0%	0.0%	32.3%
10- 12	Count	2	0	1	2	0	0	0	1	6
	% within Levsch	33.3%	0.0%	16.7%	33.3%	0.0%	0.0%	0.0%	16.7%	19.4%
Total	**Count**	**16**	**1**	**1**	**4**	**1**	**5**	**2**	**1**	**31**
	% within Levsch	**51.6%%**	**3.2%**	**3.2%**	**12.9%**	**3.2%**	**16.1%**	**6.5%**	**3.2%**	**100.0%**

Table 11 above shows that children from grade R to grade 3 were mostly referred for concentration difficulties. The results also show that children from grade four to grade six were only referred for academic difficulties (19.6%). Children and adolescents from grade seven to grade nine were also mainly referred for academic difficulties. This indicates that a majority of children in the sample were referred for academic difficulties. Results for adolescents from grade 10 to grade 12 were the most varied: academic difficulties (33.3%), emotional problems (16.7%), educational assessment (33.3%), and therapy (16.7%). H0 is accepted (p-value of 0.167, which is greater than 0.05); this means that there is no dependency between the reason for referral and grade.

Table 12

Type of School

Type of school	Frequency (count)	Percentage (%)
Private	5	16.1
Public	26	83.9
Total	**31**	**100.0**

Table 12 above shows that more than half of the children referred to the private practice go to public schools (83.9%), and only a few attend private schools (16.1%). Interestingly, the children who go to private schools are all male. A total of seven clients (3 males and 4 females) were reported to have previously repeated a grade.

Table 13

Cross-tabulation between School Quintile and Referral Reason

School Quintiles		Reason for referral								
		Academic	Academic & behaviour	Emotional	Educational assessment	Educational assessment & anxiety	Concentr-ation	Behaviour & concentration	Therapy	Total cases /17
Quintile 1	Count	0	0	0	0	0	0	0	0	0
	% within types	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Quintile 2	Count	1	0	0	0	0	0	0	0	1
	% within types	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.2%
Quintile 3	Count	0	0	0	0	0	0	0	0	0
	% within types	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Quintile 4	Count	9	1	0	0	0	0	0	0	10
	% within types	90.0%	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	41.9%
Quintile 5	Count	6	0	1	3	1	1	2	1	15
	% within types	40.0%	0.0%	6.7%	20%	6.7%	6.7%	13.3%	6.7%	48.4%
Total	**Count**	**7**	**1**	**1**	**3**	**1**	**1**	**2**	**1**	**17**

% within types	22.6%	3.2%	3.2%	9.7%	3.2%	3.2%	6.5%	3.2%	54.8%

Table 13 above shows that quintile 4 had the highest number of children referred for academic difficulties – four boys and six girls. Only one child (male) in quintile 2 was referred for academic difficulties, and this was the only reason for referral in this quintile. The majority of the children referred to the private practice attended schools grouped in the 5th quintile. H0 is accepted (p-value of 0.343, which is greater than 0.05); this means that there is no dependency between referral and school quintiles.

Table 14

Primary Caregiver of the Client

Primary caregiver	Frequency (count)	Percentage (%)
Biological mother and/or father	25	80.6
Grandparents	3	9.7
Aunt	3	9.7
Total	**31**	**100.0**

Table 14 above reveals that 80.6% of the children had a biological parent as a primary caregiver. However, only 32.3% of the children had parents (biological mother and father) as their primary caregiver. Three children had grandparents as their primary caregivers, and three had an aunt as the primary caregiver.

Table 15

Primary Caregiver's Highest Level of Education

Highest level of education	Frequency (count)	Percentage (%)
Attended high school but did not finish	3	9.7
High school diploma	1	3.2
Attended college but did not finish	2	6.5
Bachelor's degree	5	16.1
Unknown	20	64.5
Total	**31**	**100.0**

Table 15 above shows that five children's primary caregiver had a bachelor's degree, three attended high school but did not complete it due to unknown reasons. Two of the children's caregivers attended college but did not complete it, and one child's primary caregiver had a high school diploma. Most cases had an unknown status due to this category of information, for the most part, not being recorded. This made it impossible to conduct a cross-tabulation to test for dependence.

Table 16

Cross-tabulation between Employment Status and Presenting Problem

Caregiver's employment status		Presenting problem(s)							
		Physical	Medical	Emotional	Psychological	Trauma	Academic	Emotional & psychological	Total cases
Employed	Count	0	0	1	11	1	10	1	24
	% within currstat	0.0%	0.0%	4.2.%	45.8%	4.2%	41.7%	4.2%	77.4%
Unemployed	Count	0	0	4	0	0	0	0	4
	% within currstat	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	12.9%
Unknown	Count	0	0	0	0	0	3	0	3
	% within currstat	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	9.6%

Table 16 above reveals that of the 24 children whose caregivers were employed, 11 (45.8%) presented with psychological difficulties, closely followed by 10 (41.7%) who presented with academic difficulties. H0 is accepted (p-value of 0.146, which is greater than 0.05); this means that there is no dependency between the reason for referral and caregiver's employment status.

Table 17

Number of Children in Clients' Family

Number of children in family	Frequency (count)	Percentage (%)
1	8	25.8
2	10	32.3
3	5	16.1
4	2	6.5
7	1	3.2
Unknown	5	16.1
Total	**31**	**100.0**

Table 17 above shows that 10 (32.3%) of the children had one sibling, making them one of two children in the family. Eight (25.8%) children were only child and five (16.1%) children had two siblings, making the client one of three children in the family. They were followed by two (6.5%) children who had three siblings, making the client one of four children in the family. Only one (3.2%) child had six siblings, making him or her one of seven children in the family.

Table 18

Cross-tabulation Between the Area of Residence and Presenting Problem

		Presenting problem(s)							
Area of residence		**Physical**	**Medical**	**Emotional**	**Psychological**	**Trauma**	**Academic**	**Emotional & psychological**	**Total cases**
Rural	**Count**	0	0	0	0	0	3	1	**4**
	% within location	0.0%	0.0%	0.0.%	0.0%	0.0%	75.0%	25.0%	**12.9%**
Semi-rural	**Count**	0	0	4	3	0	4	0	**11**
	% within location	0.0%	0.0%	36.4%	27.3%	0.0%	36.4%	0.0%	**35.5%**
Urban	**Count**	0	0	1	8	1	6	0	**16**
	% within location	0.0%	0.0%	6.3%	50.0%	6.3%	37.5%	0.0%	**51.6%**
Total	**Count**	**0**	**0**	**5**	**11**	**1**	**13**	**1**	**31**
	% within location	**0.0%**	**0.0%**	**16.1%**	**35.5%**	**3.2%**	**41.9%**	**3.2%**	**100.0 %**

As reflected in Table 18 above, the highest number of children (51.6%) lived in an urban area. The second-highest number of children (35.5%) lived in a semi-rural area. The least number of children lived in an area that is considered rural (12.9%). The residential area appears to impact the number of children who were able to go to the psychologist. H0 is rejected (p-value of 0.013, which is less than 0.05). This means that there is a dependency between the reason for referral and the area of residence. Therefore, presenting problems are related to the area of residence.

Table 19

Clients' Method of Payment

Payment method	Frequency (count)	Percentage (%)
Medical aid payment	19	61.3
Cash payment	12	38.7
Total	**31**	**100.0**

Concerning the method of payment and as evident in Table 19 above, a majority of the clients (61.3%) were covered by a medical aid scheme, namely, Bonitas (3), Discovery (2), GEMS (9), MENSHIELD (1), Polmed (1), REMEDI (2) and Witbank Coalfields (1). Due to the cases being from private practice, the total number of clients who belong to a medical aid scheme is expected to be high.

4.2.3 What are the presenting problems in children referred for psychological services in the Northern KZN region?

Table 20

Cross-tabulation Between Referral Reason and Presenting Problem

Presenting problem (s)		Reason for referral: Academic	Academic & behaviour	Emotional	Educational assessment	Educational assessment & anxiety	Concentr-ation	Behaviour & concentration	Therapy	Total cases
Physical	Count	0	0	0	0	0	0	0	0	0
	% within Cpp	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medical	Count	0	0	0	0	0	0	0	0	0
	% within Cpp	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Emotional	Count	4	0	0	0	0	0	0	1	5
	% within Cpp	80.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	16.1%
Psychologic-al	Count	0	0	1	1	1	5	2	1	11
	% within Cpp	0.0%	0.0%	9.1%	9.1%	9.1%	45.5%	18.2%	9.1%	35.5%
Trauma	Count	0	0	0	1	0	0	0	0	1
	% within Cpp	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	3.2%
Academic	Count	11	0	0	2	0	0	0	0	13
Total	% within Cpp	84.6%	0.0%	0.0%	15.4%	0.0%	0.0%	0.0%	0.0%	41.9%
Emotional & psychologic-al	Count	0	1	0	0	0	0	0	0	1
		0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.2%
Total	**Count**	**15**	**1**	**1**	**2**	**1**	**5**	**2**	**2**	**31**
	% within Cpp	**48.4%**	**3.2%**	**3.25%**	**6.4%**	**3.25%**	**16.1%**	**6.4%**	**6.4%**	**100.0%**

Table 20 above shows that 13 (41.9%) children presented with academic difficulties, and 11 (35.5%) children presented with psychological symptoms. The least number of children, one (3.2%) presented with emotional and psychological difficulties and trauma.

Table 21

Symptoms Appearing from Case Files

Symptom	Symptoms reported in child cases	Total cases	Percentage (%)
Psychological/emotional symptoms	Complicated grief, depressed mood, anger outbursts, anxious, feeling rejected, withdrawn, trauma	**18**	**58.1%**
Motivational symptoms	Does not finish tasks (class/homework), often lacks motivation even when prompted, irritable, low self-esteem	**5**	**16.1%**
Cognitive symptoms	Difficulty retaining and recalling information, symptoms of ADHD, concentration, delayed and difficulty with speech, developmental delays	**8**	**25.8%**

Table 21 above shows that the highest number of children, 18 (58.1%) presented with psychological and emotional traits/symptoms. With regards to gender, it was found that more boys (12) presented with psychological and emotional symptoms compared to girls (6).

Table 22

Diagnosis Profile

Primary diagnosis	Frequency (count)	Percentage (%)
Reading disorder	13	41.9
Mathematical disorder	11	35.5
Disorder of written expression	6	19.4
ADHD	5	16.1
Anxiety	2	6.5

Table 22 above shows that the number of children diagnosed with reading disorders is the highest (41.9%), followed by those with mathematical disorders (35.5%). The table also shows that the least number of children (6.5%) were diagnosed with anxiety disorders, both of whom were female.

Table 23

Cross-tabulation between Year and Clients' Presenting Problem

		Presenting problem(s)							
Year		**Physical**	**Medical**	**Emotional**	**Psychological**	**Trauma**	**Academic**	**Emotional & psychological**	**Total cases**
2009- 2011	**Count**	0	0	0	1	0	3	0	**4**
	% within Cpp	0.0%	0.0%	0.0.%	25.0%	0.0%	75.0%	0.0%	**12.9%**
2012- 2014	**Count**	0	0	2	0	0	2	0	**4**
	% within Cpp	0.0%	0.0%	50.0%	0.0%	0.0%	50.0%	0.0%	**12.9%**
2015- 2018	**Count**	0	0	3	5	0	8	1	**17**
	% within Cpp	0.0%	0.0%	9.6%	29.4%	0.0%	47.1%	5.9%	**54.8%**
Total	**Count**	**0**	**0**	**5**	**6**	**0**	**13**	**1**	**31**
	% within Cpp	**0.0%**	**0.0%**	**16.1%**	**19.4%**	**0.0%**	**41.9%**	**3.2%**	**100.0%**

Table 23 above reveals that the highest number of children who presented with academic difficulties visited the psychologist's private practice in 2015, 2016, 2017, and 2018. The highest number of children who presented with psychological difficulties were seen in 2015, 2016, 2017, and 2018. This means that more than half the sample (54.8%) falls between 2015 and 2018.

Table 24

Outcome of Cases

Recommendations	Frequency (count)	Percentage (%)
Referred to healthcare professional	4	12.9
Referred to remedial educator	5	16.1
Placement	11	35.5
Examination concession	6	19.4
Ongoing	3	9.7
None	2	6.5
Total	**31**	**100.0**

Table 24 above shows that the highest number of children (35.5% comprising six females and five males) were recommended for placement in a more specialised environment such as prevocational or special schools. The table also shows that 19.4% of children were referred for an examination concession; once again, the females (5) outnumbered males (1). The results show that 12.9% of children were referred to healthcare professionals such as a psychiatrist, dietician, occupational therapist, or counselling psychologist.

4.3 Risk and Protective Factors

Below are predisposing factors associated with the development of psychological difficulties in children and adolescents. These emerged from the information available in the case files.

Table 25

Risk Factors Found in Clients' Files

Home/Family environment-related	School environment-related	Child and adolescent related
Loss of parent, death	Bullying	Car accident
Parent divorce/separation	Large class size	Premature birth
Parent (mother) substance abuse during pregnancy		Delayed speech
Living apart from biological parents		Low motivation
Relocation		Relocating (resulting in changing schools)
Family history of learning/ psychological difficulties		

Cases that were referred for psychological services only had a few protective factors. The main protective factor was a supportive family and extended family (grandparents, aunts, and uncles). Having a supportive family acts as a protective factor for some children as they were identified in the home environment and accompanied by a family member for the psychological intervention. In addition, having supportive teachers and being in a supportive school environment helped identify children early.

4.4 Summary

This chapter presented the results of the study. The results showed that the clients' class teachers made most referrals and that children referred for academic difficulties were the most prevalent reason for referral. A statistically significant relationship was found to influence the type of presenting problem, namely, the child's area of residence. Lastly, the study also showed that for most cases, placement was recommended.

Chapter Five: Discussion

5.1 Introduction

This chapter discusses the research findings with reference to the literature reviewed. The discussion is organised according to the research questions investigated. The discussion will be followed by the theoretical analysis of the findings, a summary of the findings, recommendations for policy and practice, the limitations of the study, and recommendations for future research. The chapter (and study) ends with a conclusion.

5.2 Research Question 1:

What are the reasons for referral and sources of referral in a private psychologist's practice in the Northern KZN region?

5.2.1 *Reasons for referral*

The top two reasons for referral were academic difficulties (51.6%) and concentration difficulties (16.1%). The highest number of referrals were made in 2018. The study found that the number of cases referred for academic difficulties varied over time (in years), with the least number of referrals being made between 2009 and 2012 and the most being made in 2018.

The study found that African children had the highest number of referrals for academic difficulties. The highest numbers of children referred for academic difficulties were between the ages of 14 to 18 years; they were closely followed by children who were between 10 to 13 years. The study found that there was an equal number of male and female referrals for academic difficulties, and more than half of the sample was referred to for such difficulties (51.6%). These findings are in line with previous research by Kruger and Bode (2003). They reported that academic difficulties were the main reason children and adolescents (aged six to 18 years) are referred to psychological services.

Interestingly, the study found that children aged between six and nine years were the only ones referred for concentration difficulties. Furthermore, the findings show that it was only African boys who were referred for behaviour and concentration difficulties (also aged between six and nine years). This corresponds with previous studies (La Clave & Campbell, 1986; Petersen et

al., 2009), who found that boys were more likely to show externalising behavioural problems such as acting out and disruptive behaviour compared to girls.

5.2.2 *Referral sources*

The study found that teachers made the most referrals (58%). This suggests that most of the issues were identified by the children and adolescents' class teachers. This finding corresponds with the study by Babatunde et al. (2020), which found that educators play an important role in identifying and seeking help for children and adolescents with mental health difficulties. The study by Crosier (2018) also found that most referrals were initiated by teachers. Furthermore, previous studies (Loades & Mastroyannopoulou, 2010; Green et al., 2014; Babatunde et al., 2020) also found that teachers made the most referrals over the years. A large number of teacher referrals is indicative of the fact that schools are the main settings in which a large number of children and adolescents are found (Mfidi, 2017). Schools have become the main settings for identifying mental health disorders in children because families often rely on teachers to recognize, assess, manage, and treat such disorders experienced by their children (Wilger, 2015). This study's findings are not surprising considering that teacher's function within the child's immediate surroundings and also play a huge role in the child's development.

Findings of the study revealed that mothers were the second-highest source of referrals. This is in line with the notion held by Baker (2020) that mothers are more likely to be in contact with services that deal with mental health and learning difficulties compared to fathers. While figures in this study indicate that mothers are the second-highest source in referring children for psychological difficulties, their numbers are still low. This could be because most KZN children do not live with their mothers (Babatunde et al., 2020). However, mothers being the second-highest referrers is not surprising because they play a significant role in their children's lives, specifically in the home environment. Children tend to spend more time with their mothers. This is not in line with previous studies (O'Shea et al., 2016; Babatunde et al., 2020), which found that despite mothers spending a lot of time with their children in the home environment, they do not always recognise psychological difficulties in their children because of different cultural perceptions of distress.

The least number of referrals came from a medical doctor (3.2%) and clinical psychologist (3.2%). Furthermore, the study revealed that females made more referrals compared to males. It is important to note that the gender of some of the referral sources was unknown.

5.3 Research Question 2:

What are the characteristics of child cases reported in a private psychologist's practice in the Northern KZN region?

The study has shown that more males were referred to psychological services (54.8%) than females (45.2%). This is similar to previous research by La Clave and Campbell (1986), who argued that more boys are referred for psychological difficulties compared to girls. Previous studies (O'Shea et al., 2000; Green et al., 2014; Crosier, 2018; Martadza et al., 2019) also found that boys outnumbered girls concerning cases referred to psychological services.

Findings revealed that most referrals were made in the year 2018, with the 14 to 18-year age category having the most referrals (45.2%). Furthermore, the 14 to 18-year category consisted of an equal number of males and females. The six to nine-year age category had the second-highest number of children referred for psychological difficulties, and this category comprised more males than females. In addition, it was found that the highest number of referrals were of children aged eight years. These findings are supported by Bakare and Munir (2011), who found that the majority of children within the African context are usually referred to mental health services from the age of eight upwards after a child has started going to school. The 10 to 13-year age category had the least number of referrals, with the findings showing an equal number of males and females in this category. Children between grade R and grade nine appear to be more likely to require psychological intervention. This may be because children in these grades start taking on more responsibility (in the school and home environment) and experiencing more complex emotions. Furthermore, the study found that quintile 5 schools had the highest number of referrals. This may be because schools in quintile 5 are well-resourced and are financially stable compared to schools in lower quintiles. These results are similar to the findings by Rasesemola et al. (2019), who found that 86% of schools in the lower quintiles do not have adequate collaboration with or include mental health services.

Findings revealed that a majority (77.4%) of the primary caregivers were employed, and 12.9% were unemployed. The remaining data (9.6%) pertaining to the employment status of the child's primary caregiver was missing as no information was provided. The findings showed that there was a huge gap between the two methods of payment – more than half of the client payments were covered by medical aid, and the least number of clients paid in cash. These findings are not in line with the study by Rowan et al. (2013), who found that the individuals

or the caregivers of those with mental health difficulties were less likely to have medical aid compared to individuals without mental health problems. However, considering that the cases in this study were from private practice, the total number of clients who belong to a medical aid scheme is expected to be high.

Fisher's exact test for independence showed that presenting problems are influenced by the child's area of residence. This means where the child resides can influence the type of presenting problem. Children living in urban areas appear to be more at risk for psychological and academic difficulties. The results revealed that children living in semi-rural areas are more likely to experience emotional difficulties than those living in rural and urban areas. These findings are not in line with Rathod et al. (2017), who argued that most children in rural areas are more likely to battle academically compared to those living in urban areas.

5.4 Research Question 3:

What are the presenting problems in children referred for psychological services in the Northern KZN region?

The highest numbers of presenting problems were academic difficulties (41.9%) and psychological difficulties (35.5%). The highest number of children presenting with academic and psychological difficulties took place between 2015 and 2018. These findings are in line with previous studies (Hong et al., 2004; Nicolson, 2009), which found that children and adolescents were mainly presenting with psychological and academic difficulties.

5.4.1 *Common presenting problems*

The clients' symptoms were well documented in the case files. The study found that boys showed more psychological and emotional symptoms compared to girls. It was also found that more females had cognitive difficulties and symptoms compared to males. This is not in line with the study by Baker (2020), which found that cognitive challenges were more common among boys than girls.

This study's findings correspond with others (Pillay & Lockhart, 1997; Baker, 2020) in that the highest number of children referred for psychological services in KZN are for academic difficulties. Although not determined in this study, factors such as the large number of people living beneath the poverty line, the high level of income inequality, the high unemployment

rate, and the high prevalence of HIV/AIDS in the KZN province are said to predispose children to mental health problems (Burns, 2010).

The study found that the number of children diagnosed with reading disorders was the highest (41.9%). Only a few children were diagnosed with ADHD (16.1%), which is not in line with the study by Scott et al. (2015), who found that more than half of the clients referred were presenting with symptoms of ADHD. This study also shows that the least number of children were diagnosed with anxiety disorders (6.5%) both of which were female. This is in line with other researchers (Foster et al., 2005; Gupta et al., 2017) who argued that girls were more likely to have internalising difficulties (which include anxiety and adjustment issues) compared to boys. A study conducted by Baker (2020) also showed that girls were more likely to have emotional disorders, like anxiety and depression than boys.

5.4.2 *Outcome of the cases*

The outcome of the cases are reported cautiously owing to the small sample size used in the study. The study found a higher number of females recommended for placement at a prevocational or special school than boys. Children between grade four and grade 10 appear to be the only ones recommended for placement in a more specialised environment. Findings revealed that children who were recommended for examination concessions (19.4%) ranged between grade seven and grade 12. Interestingly, all these children were from urban schools grouped in the 5th quintile. According to August (2018), for learners to be granted examination concessions, schools need to apply through the District Examination Concessions Committee for concessions. The fact that this study only examined cases referred to a private practice suggests a possibility that most children and adolescents in the public sector are not accounted for in terms of concessions, as it is only the very few that can afford psychological assessments that are getting concessions. This could mean that disadvantaged individuals are likely to be on the waiting list of those who have applied for concessions. Upsettingly, this could also mean that children in need of concessions or support are not being identified in schools or the home environment. Similarly, Babatunde et al. (2020), who visited schools in the Amajuba district of Northern KZN, found that due to the inadequate number (or lack) of qualified staff, there was also insufficient information regarding the referral pathways.

5.5 Research Question 4:

What is the role of mental health services providers in managing child cases referred for psychological intervention in the Northern KZN region?

The study found that only two (6.4%) healthcare professionals made referrals. Although the reasons for this are unclear, this finding is in line with the study by Kramer and Garralda (2000), which found that GPs and healthcare practitioners were less likely to refer children to psychological services.

Due to the limited literature on the issue, mental health practitioners' role in managing child cases remains unclear. The lack of information suggests that mental health in South Africa has not received enough attention because of scarce population-based data (Coomer 2011). This highlights the need for mental health practitioners (specifically psychologists and guidance teachers) in the public sector (Martadza et al., 2019).

5.6 Risk and Protective Factors Emerging from Client Case Files

The risk and protective factors that emerged from the clients' case files are in line with the literature review findings. The results of this study and the reviewed literature suggest that there are various reasons why childhood adversity puts children and adolescents at risk for psychological difficulties. These include individual factors such as physical, cognitive, social, and emotional impairments (WHO, 2012; Alcala´ & Balkrishnan, 2019). Furthermore, the study found that parental divorce and change of residence (and a change of schools) are risk factors in developing mental health difficulties. On the same note, Owens et al. (2002) found that factors such as the unemployment of caregivers and divorce were strong predictors of mental health problems among children. Although there is limited information regarding protective factors, these appear to be children having a supportive environment at school and caregivers in the home environment.

5.7 Theoretical Analysis of Findings

This study shows how multiple interconnected environmental systems influence children (Burns, 2016). In terms of Bronfenbrenner's Ecosystems theory, a child's development largely depends on the environment in which they live. The interaction between the microsystem occurring in the home on the one hand, and the school environment on the other, plays a significant role in determining how early a child may be identified and referred to a psychologist for a formal assessment. The study found that most children who were referred

were eight years old. This strongly suggests that parents are solely dependent on teachers to make referrals, which is why some children are taken to a psychologist only after the teacher has requested that this be done. Failure of caregivers to work with the school contributes to the discrepancy between the number of children who need psychological services and the number of children who access these services. Moreover, considering the study's findings showing that teachers made most referrals, parents are not always informed or inclined to seek help for their child's condition. More parents, therefore, need to be aware, knowledgeable, and attentive when it comes to identifying difficulties in their children and knowing which referral pathways to seek.

In order to support the child, it is important to work on the roles, activities, and relationships in which the child engages in the home and school environment (Muribwathoho, 2015). This means that the family, school, community, and government need to work together for children to reach their potential. Although parents and children do not play an active role in developing policies and governance structures, decisions made in the larger South African context affect them. For example, mental health practitioners and teachers have to adhere to guiding policies devised by the health and education sector, which impacts how children are taught and supported in the school environment (Mfidi, 2017). The South African government created a policy framework for the provision of comprehensive and community-based services for children and adolescents (Dawes et al., 2012). The policies that apply to this study include the Education White Paper 6, which provides alternative methods, such as concessions, to support children who have difficulties in the school environment due to academic, emotional, or physical difficulties. However, applying for concessions often involves a lengthy process before children are granted concessions. Another huge concern is that many schools do not have counsellors to support learners with difficulties. The SIAS policy aims to provide a framework on how to identify, assess, and provide programmes for children and adolescents in need of support (DBE, 2014). However, it involves long waiting lists and follow-up sessions.

The community and broader population must be educated on mental illness. Individuals in the community must be informed about the appropriate referral systems. Changes in one of the systems have the potential to change other systems, which can have a positive influence on the child's development (Bronfenbrenner, 1979).

5.8 Summary

This chapter discussed the findings, by answering research questions guiding the study and discussed them in relation to previous studies in the literature and the theoretical framework underpinning the study. It was observed that the main difficulties faced by children and adolescents in the study are similar to those reported in the literature, although with some degrees of difference. Lastly, the study also found that most of the referrals were made by teachers.

Chapter Six: Conclusion

6.1 Summary of the Study

The focus of this study was to understand the referral agents, the reasons for referral, and the nature of the clients' characteristics, as well as the intervention rendered to meet the needs of the client in a psychologist's practice. The study also looked at the barriers that exist when accessing psychological services. The study began with a review of relevant literature. It also looked at Bronfenbrenner's Ecosystems theory, which formed the theoretical lens with which the study was viewed. The research questions investigated were: 1) What are the reasons for the referral and sources of referral in a private psychologist's practice in the Northern KZN region? 2) What are the characteristics of child cases reported in a private psychologist's practice in the Northern KZN region? 3) What are the presenting problems in children referred for psychological services in the Northern KZN region? 4) What is mental health service providers' role in managing child cases referred for psychological intervention in the Northern KZN region?

In a quantitative study, a sample of 31 (17 males and 14 females) of all races, between six and 18 years old, who were learners of school-going age was selected. A survey questionnaire, divided into six sections, was used to gather information about the clients. Data were analysed using the SPSS package, and cross-tabulations were used to determine the relationships between variables.

The results showed that most referrals and referral problems discussed in the study are, to an extent, similar to those described in the literature. Most children referred for psychological services were males. The main referral problems were academic, and concentration difficulties and a majority of the referrals were made in 2008. The study pointed out that the process of referring children and adolescents for psychological services works within a system. From an ecosystem perspective, the aim is to understand the child in relation to their social context, which in this case includes the home and school environment as well as the wider community. One can conclude that the interaction between home and school in the mesosystem plays a

significant role in the child being identified, assessed, and referred for further psychological intervention. Furthermore, the results showed that the teachers made the most referrals.

It was found that the highest number of referrals were of children aged eight years. Moreover, the study revealed that the child's residential area could influence the type of presenting problem, meaning that children living in urban areas appear to be more at risk for psychological and academic difficulties. The study found that there were differences between boys and girls presenting problems. Boys were found to have more psychological and emotional symptoms compared to girls. Whereas girls had cognitive difficulties. The study found that there was a lack of information regarding mental health service providers, and only two healthcare professionals (a GP and clinical psychologist) made referrals.

6.2 Recommendations for Policy and Practice

In order to support the child, it is essential to work on the roles, activities, and relationships in which the child engages in the home and school environment (Muribwathoho, 2015). This means that the family, school, community, and government need to work together for children to reach their potential. Although parents and children do not play an active role when it comes to developing policies and governance structures, decisions made in the larger South African context affects them. For example, mental health practitioners and teachers have to adhere to guiding policies devised by the health and education sector, which has an impact on how children are taught and supported in the school environment (Mfidi, 2017). The South African government created the policy framework for the provision of comprehensive and community-based services for children and adolescents (Dawes et al., 2012). The policies that apply to this study include the Education White Paper 6, which provides alternative methods such as concessions to support children who have difficulties in the school environment due to academic, emotional, or physical difficulties. However, applying for concessions often involves a lengthy process before children are granted concessions. Another huge concern is that a lot of schools do not have counsellors to support learners with difficulties. As has been noted above, the SIAS policy aims to provide a framework for children and adolescents in need of support, but the process involves long waiting lists and follow-up sessions.

The community and broader population must be educated on mental illness. Individuals in the community must be informed about the appropriate referral systems. Changes in one of the

systems have the potential to change other systems, which can have a positive influence on the child's development (Bronfenbrenner, 1979).

6.3 Limitations of the Study

The study has various limitations. It was carried out in one private practice in Northern KZN, and only a small sample of child cases was used. This is not a full representation of the population in the north of KZN, limiting the study's ability to generalise findings to the general population. Furthermore, cases from one private practice also limit the amount and type of information that was available. For example, most cases were referred for a psycho-educational assessment as the children were experiencing learning difficulties. This also limited the generalisability of the findings. As the cases analysed were drawn from private practice, they could be considered biased. They reflected individuals who did not have financial restrictions as they were covered by medical aid or could afford to make cash payments.

There was limited or missing information in some of the clients' files, and, as a result, some information could not be captured in the survey questionnaire. For example, several cases did not have information regarding the referrer's employment status and gender. Missing information in some of the cases and the questionnaire not being piloted limits the validity of the study's findings. Furthermore, although the researcher was careful when recording the information, there is a chance that some information was not recorded.

6.4 Recommendations for Further Research

Further research is recommended to gain more knowledge and an in-depth understanding of children and adolescents referred for psychological intervention. Given the limitations identified above, it is recommended that a more comprehensive quantitative study with a bigger sample be conducted. Such a study could include other private practices or regions within the KZN province or other provinces in South Africa. This would allow for greater generalisability of the findings and expand the trustworthiness of the results obtained.

The study found that only two healthcare professionals (a GP and a clinical psychologist) made referrals. It also found that mothers (as well as both parents) made only a few referrals. Given this, further research could investigate the referral system, and the roles played in managing child cases that have been referred for psychological services. In doing so, a more qualitative approach could be adopted through interviews with stakeholders at the DoE and the DoH to

investigate the arrangements for psychological service provision in schools and determine their views on the referral system. Moreover, interviews with stakeholders at the DoE could also explore issues around the application process for concessions to ensure that the learners are assisted and supported from an early stage.

6.5 Conclusion

This study served to better understand the child cases referred for psychological services in Northern KZN through the use of a quantitative method. It discussed the findings with reference to the literature reviewed in Chapter two and made use of Bronfenbrenner's Ecosystems theory. In relation to the study, Bronfenbrenner's theory suggests that the possibility of children receiving the support and intervention they need from CAMH services is largely influenced by multiple interconnected systems.

Most children referred for psychological services were of the African race, and this may be due to the country's demographics. The study revealed that children between grade R and grade 9 appear to be more likely to require psychological intervention. This led to most children receiving psycho-educational assessments to determine the nature and extent of their difficulties and provide the necessary support. Moreover, the study found that the highest numbers of children referred for academic difficulties were between 14 to 18 years.

Most of the cases referred were recommended for placement in a more specialised learning environment. It can also be said, based on the findings and literature and specifically with regard to teachers making referrals (as compared to school counsellors), that the school environment has insufficient support and an inadequate number of mental health service providers. This also suggests that parents often lack support, information, and knowledge regarding their child's condition as well as knowledge of appropriate referral pathways. Therefore, schools and communities need to develop education programmes to create awareness and knowledge of mental health problems and reduce the stigma associated with such problems.

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Appendices

Appendix A: Survey questionnaire

Survey Questionnaire

Please fill in the blanks with an X or check mark next to the word or phrase that best matches your response.

Case # _____

Office Use only

A. Recording information regarding the client (child)

1.	Age	□ 6-9 years_____	Aage □ 1
		□ 10 - 12 years_____	□ 2
		□ 13 - 15 years_____	□ 3
		□ 16 - 18 years_____	□ 4
2.	Gender	□ Male	Agender □ 1
		□ Female	□ 2
		□ Unknown	□ 3
		□ Other	□ 4
3.	Race	□ African/ Black	Arace □ 1
		□ Asian	□ 2
		□ Caucasian/ White	□ 3
		□ Coloured	□ 4

		□ Indian □Other: _____	□ 5 □ 6
4.	Disability	□Yes _____ _____ □ No	Adisabled □ 1 □ 2
5.	Known conditions/illnesses and specify	□Physical_____ _____ □Emotional_____ _____ □Psychological_____ _____ □Medical_____ _____ □Other:_____ _____	Aconditin □ 1 □ 2 □ 3 □ 4 □ 5
6.	Level of schooling	□ Foundation Phase □ Intermediate Phase □ Senior Phase □ Further Education and Training	ALevsch □ 1 □ 2 □ 3 □ 4
7.	Primary caregiver	□ Biological mother/father □ Sibling	Aprimcar □ 1 □ 2

	□ Grandparent		□ 3
	□ Aunt/uncle/cousin		□ 4
	□ Neighbour		□ 5
	□ Friend		□ 6
	□ Family friend		□ 7
	□ Stepmother/stepfather		□ 8
	□ Partner (girlfriend/boyfriend)		□ 9
	□ Adopted		□ 10
	□ Foster parent		□ 11
	□Other _____		□ 12

8.				Aparwork
	Parent employment status	Mother:	Father:	Mo Fa
		□ Employed	□ Employed	□ 1 □ 1
		□ Unemployed	□ Unemployed	□ 2 □ 2

9.			Atotlhom
	Total number of people living at home (including child)	□ 1 - 3	□ 1
		□ 4 - 6	□ 2
		□ 7 - 10	□ 3
		□ 11 - 15	□ 4
		□ 15+	□ 5

10.			Atotalshar
	How many children are in the clients' family?	□ 0	□ 1
		□ 1-2	□ 2
		□ 3-4	□ 3
		□ 5-6	□ 4

		□ more than 6	□ 5
11.			Atypdwel
	Type of dwelling	□ Homeless	□ 1
		□ Shack/informal settlement	□ 2
		□ Hostel	□ 3
		□ Room/garage	□ 4
		□ Flat/cottage	□ 5
		□ Shared house	□ 6
		□ House (not shared)	□ 7
12.			Alocation
	Location of residence	□ Rural	□ 1
		□ Urban	□ 2
		□ Semi-urban	□ 3
		□ Other	□ 4
13.			ATypeSc
	Type of school	□ Private school	□ 1
		□ Public school	□ 2
		□ Vocational school	□ 3
		□ Out of school	□ 4
14.			APayMet
	Payment method	□ Medical aid	□ 1
		□ Cash	□ 2
		□ Employer	□ 3
		□ Agent	□ 4
		□ Other	

		□ 5

Case # _____

Office Use only

B. Recording information regarding the referral source

15.			Bage
	Age	□ 25- 30 years_____	□ 1
		□ 31 - 40 years_____	□ 2
		□ 41 - 50 years_____	□ 3
		□ 51 - 61 years_____	□ 4
16.			Bgender
	Gender	□ Male	□ 1
		□ Female	□ 2
		□ Unknown	□ 3
		□ Other	□ 4
17.			Brace
	Race	□ African/ Black	□ 1
		□ Asian	□ 2
		□ Caucasian/ White	□ 3
		□ Coloured	□ 4
		□ Indian	□ 5
		□Other: _____	□ 6
18.			Bleveledu

	Highest level of education	□ Attended high school but did not finish	□ 1
		□ High School Diploma	□ 2
		□ Attended college but did not finish	
		□ Vocational/Technical degree or certificate	□ 3
		□ Associates Degree	□ 4
		□ Bachelor's Degree	□ 5
		□ Master's Degree	□ 6
		□ Doctorate Degree	□ 7
			□ 8
19.			Bcurrstat
	Employment status	□ Unemployed	□ 1
		□ Employed – Full Time	□ 2
		□ Employed – Part Time	□ 3
		□ Student	□ 4
		□ Retired	□ 5
20.			Brshipstat
	Relationship with client	□ Parent	□ 1
		□ Guardian	□ 2
		□ Teacher	□ 3
		□ Doctor/Health practitioner	□ 4
		□ Other	□ 5

21.	Reason for referring client	□ Attention problems □ Behavioural problems □ Learning difficulties □ Problems at home □ Other	Brefreaso □ 1 □ 2 □ 3 □ 4 □ 5

C. Recording information regarding the presenting problem

Office Use only

1.	Referral reason	□ Psychological counselling	CRefrea □ 1
		□ Psycho-educational assessment	□ 2
		□ Career assessment	□ 3
		□ Counselling, Attention and behaviour assessment	□ 4
		□ Examination concession	□ 5
		□ Other	□ 6
2.	Presenting problem	□ Physical	Cpp □ 1
		□ Medical	□ 2
		□ Emotional	□ 3

		□ Psychological	□ 4
		□ Direct trauma	□ 5
		□Other _____	□ 6
			CSym
3.	Symptoms	□ Physical/somatic	□ 1
		□ Psychological/emotional	□ 2
		□ Motivational	□ 3
		□ Cognitive	□ 4
		□ Other	□ 5
4.			CPrevInt
	Previous interventions about presenting problem	☐ Psychologist ☐ Medical doctor ☐ Medical specialist ☐ Traditional healer ☐ Other_____	□ 1 □ 2 □ 3 □ 4 □ 5
5.			CRprevInt
	Previous intervention reason	☐ Psychological counselling ☐ Educational assessment ☐ Career assessment ☐ Counselling, attention and behaviour assessment ☐ Examination concession	□ 1 □ 2 □ 3 □ 4

			□ 5
6.	Setting where previous intervention was received	□ Private practitioner □ Public institution □ Other_____	CSetting □ 1 □ 2 □ 3

Case # _____			**Office Use only**
D. Recording information regarding the status of the case			
1.	Interventions provided	□ Psychological counselling □ Psycho-educational assessment □ Career assessment □ Counselling, Attention and behaviour assessment □ Examination concession □ Other	DInteprov □ 1 □ 2 □ 3 □ 4 □ 5 □ 6
2.	Referrals made	□ Psychologist □ Medical doctor □ Medical specialist □ Traditional healer	DReferals □ 1 □ 2 □ 3

		☐ None ☐ Other	□ 4 □ 5 □ 6
3.	Outcome of the case	□ Referred to healthcare professional/specialist □ Referred to remedial educator □ Placement □ Ongoing □ None □ Other	D □ 1 □ 2 □ 3 □ 4 □ 5 □ 6

Case # _____ **E. Diagnosis Profile: Primary learning disorder that the child has been diagnosed with.**			**Office Use only**
4.	Reading Disorder	□ Yes □ No	EReaddis □ 1 □ 2
5.	Mathematics Disorder	□ Yes □ No	Bgender □ 1 □ 2
6.	Disorder of Written Expression	□ Yes □ No	Brace □ 1 □ 2

7.	Learning Disorder NOS	□ Yes □ No		Bleveledu □ 1 □ 2
8.	Attention-deficit disorder/ADHD	□ Yes □ No		Bcurrstat □ 1 □ 2
9.	Relationship with client	□ Parent □ Guardian □ Teacher □ Doctor/Health practitioner □ Other		Brshipstat □ 1 □ 2 □ 3 □ 4 □ 5
10.	Other	□ Attention problems □ Behavioural problems □ Learning difficulties □ Problems at home □ Other		Brefreaso □ 1 □ 2 □ 3 □ 4 □ 5

F. Recording additional information

Office Use only

1. Risk factors noted _____
_____
_____
_____
_____
_____
_____
_____

Frisk

Fprotctive

2. Protective factors noted _____
_____
_____
_____
_____
_____
_____
_____

3. Role of practitioners _____
_____
_____
_____
_____
_____
_____
_____

FPract

False

4. Anything else _____
_____
_____
_____
_____
_____
_____
_____

Appendix B: Information sheet

Date: 05 March 2018

Dear Ithubalethu Health and Wellness

My name is Sithembiso Mnguni, I am a Masters of Social Science student from the University of KwaZulu- Natal, Pietermaritzburg Campus.

You are being invited to consider participating in a study that involves research on analysing child cases referred for psychological services in private practice within the Northern KwaZulu-Natal region. The aim and purpose of this research is to identify the source of referrals, the reasons for referral and gain a better understanding of the role of psychological services in the private sector.

The study will help with the discovery of gaps in the literature as well as gaps in the access of psychological services. The data collection method that will be used is the face-to-face interview method, the researcher will go to the private psychologists practice and obtain responses by conducting a personal interview.

The client base for the practice comes from both the rural and urban areas of the Northern KwaZulu-Natal region. The researcher will profile and present information from clients (male and female) that are between 6-18 years old, which are learners of school going age. However, the clients' identities will remain anonymous.

Participation in this research is voluntary and participants may withdraw participation at any time, should they wish to do so. In the event of refusal to participate or withdraw from the study the participants will not incur penalty.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems/concerns or questions, you may contact any of the following:

Researcher: [redacted] or [redacted]

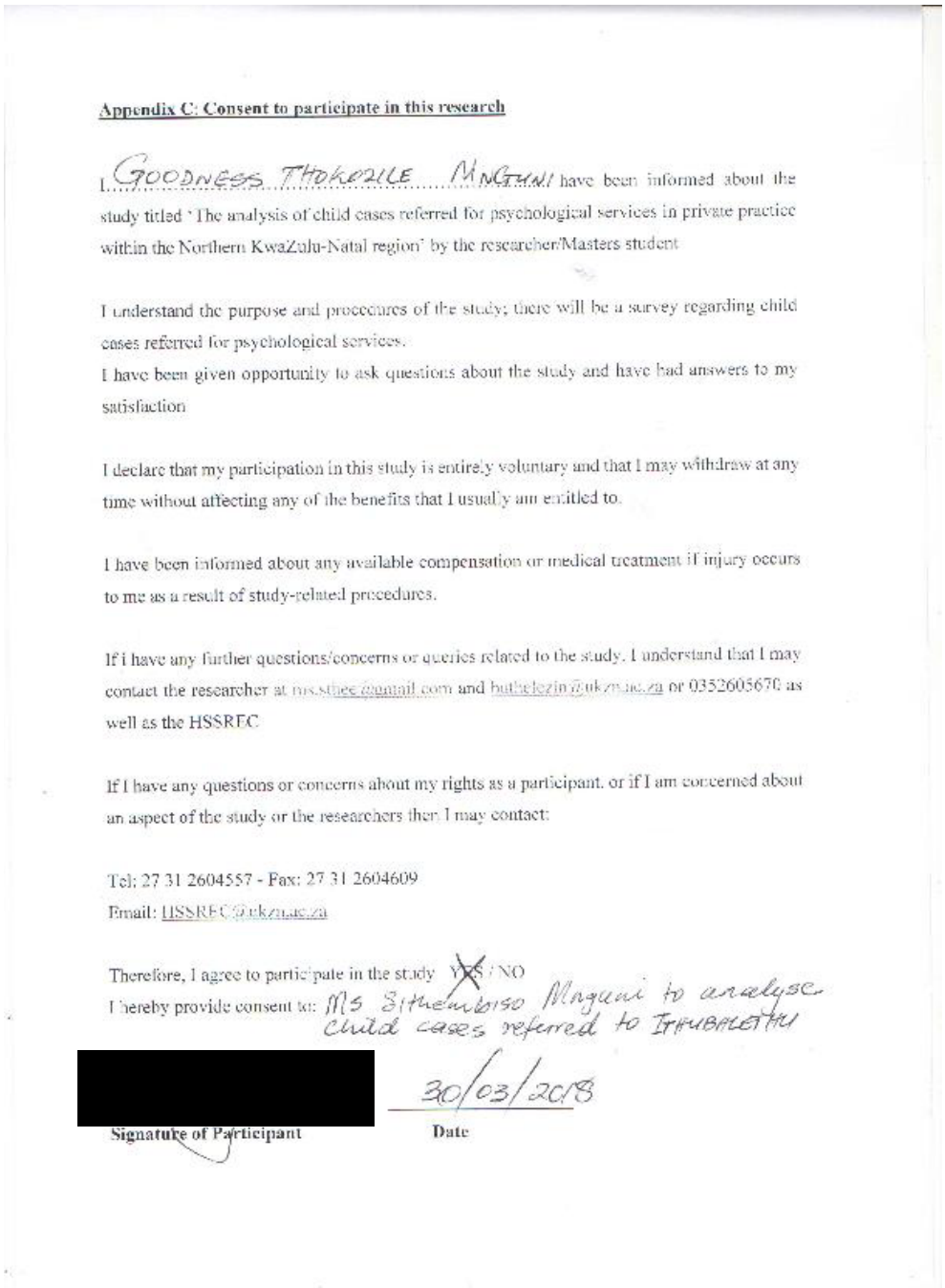
Supervisor: [redacted] or [redacted]

UKZN Humanities & Social Sciences Research Ethics Committee: 27 31 2604557 or HSSREC@ukzn.ac.za

The steps that will be taken to protect confidentiality of personal information:

1. Researcher and Supervisor will have access to the data collected from the private practice psychologist's records.
2. Collected data will be kept by the supervisor with access restricted to only the researcher.
3. The research data and research materials will be kept by the supervisor for a period of five years.
4. The questionnaires and all confidential data will be incinerated after five years
5. A copy of the findings will be made available at the university of KwaZulu-Natal library, Pietermaritzburg.

Appendix C: Consent to participate in this research



Appendix C: Consent to participate in this research

I GOODNESS THOKOZILE MNGUNI have been informed about the study titled 'The analysis of child cases referred for psychological services in private practice within the Northern KwaZulu-Natal region' by the researcher/Masters student

I understand the purpose and procedures of the study; there will be a survey regarding child cases referred for psychological services.
I have been given opportunity to ask questions about the study and have had answers to my satisfaction

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If i have any further questions/concerns or queries related to the study, I understand that I may contact the researcher at mssithee@gmail.com and buthelezin@ukzn.ac.za or 0352605670 as well as the HSSREC

If I have any questions or concerns about my rights as a participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Therefore, I agree to participate in the study YES / NO
I hereby provide consent to: Ms Sithembiso Mnguni to analyse child cases referred to IThubalethu

[redacted] 30/03/2018

Signature of Participant Date

Appendix D: Ethical clearance

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

13 December 2019

Miss Sithembiso Mnguni 212536702
School of Applied Human Sciences
Pietermaritzburg Campus

Dear Miss Mnguni

Protocol reference number : HSS/0890/018M
Project title: The analysis of child cases referred for psychological services in private practice within the Northern KwaZulu-Natal region

Full Approval – Expedited Application

In response to your application received 10 July 2018, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of one year from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

[redacted]

Professor Urmilla Bob
University Dean of Research

/dd

CC Supervisor: Mrs Nontobeko Dlutheleza
CC Academic Leader Research: Prof Jean Steyn
CC School Administrator: Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee
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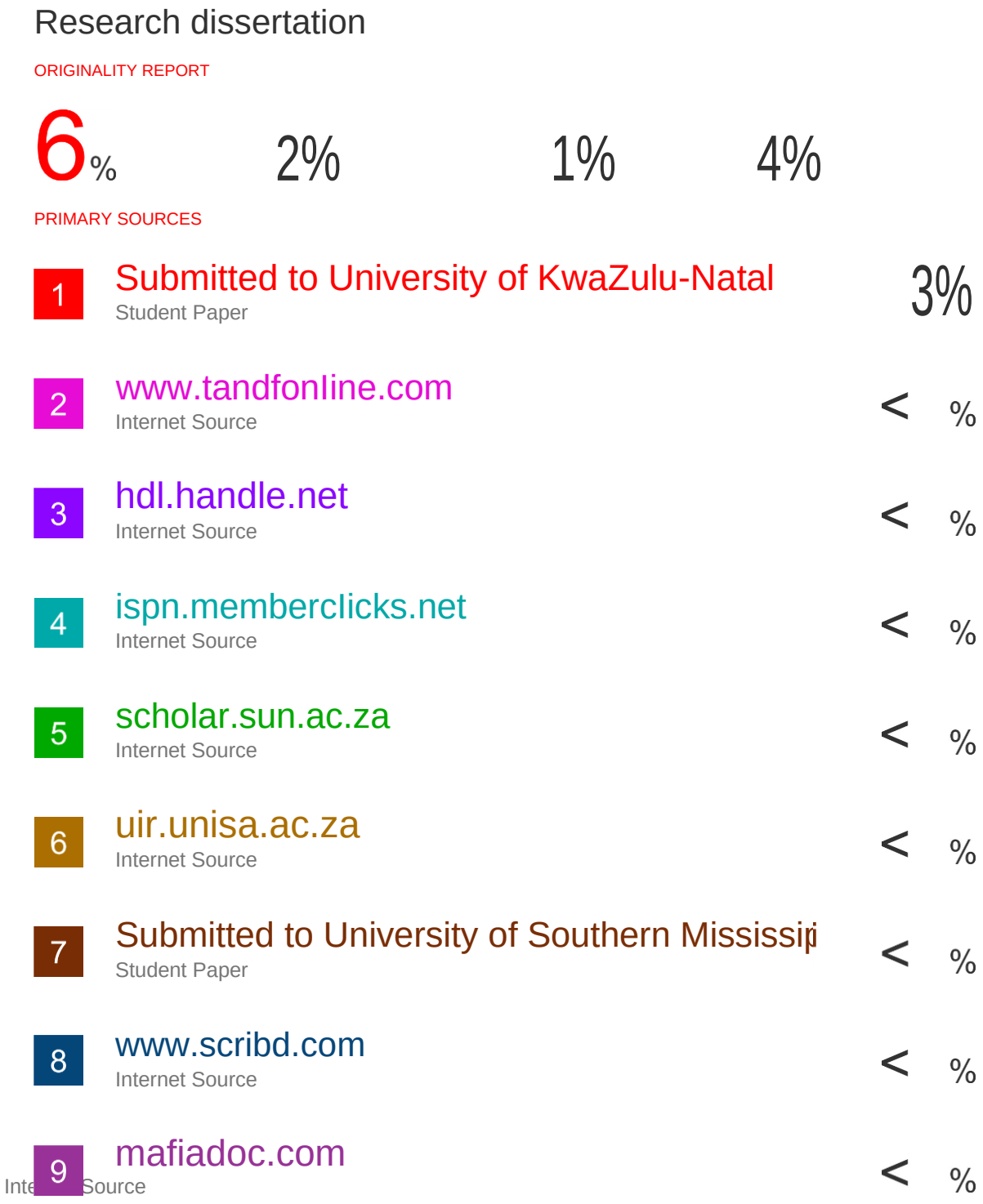
Appendix E: Turnitin report



10	Submitted to Da Vinci Institute Student Paper	0 o
11	"Mental Health and Illness in the Rural World", Springer Science and Business Media LLC, 2020 Publication	0 o
12	www.hst.org.za Internet Source	0 o
13	studydriver.com Internet Source	< %
14	www.ci.org.za Internet Source	< %
15	Submitted to University of Stellenbosch, South Africa Student Paper	On o
16	dx.doi.org Internet Source	0 o
17	Submitted to Adtalem Global Education Student Paper	0 o
18	www.dokumenty.hrebenar.eu Internet Source	0 o
19	Submitted to University of Witwatersrand Student Paper	< %
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