

An investigation into mental health care deficits in South Africa:
Exploring an alternative intervention strategy.



**Submitted in Fulfilment of the Requirements for
the Award of the Doctoral Degree in Social Work,
University of Cape Town, South Africa**

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Date: January 2018

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DECLARATION

I, **Ingrid Daniels**, hereby declare that this thesis is my own unaided work; that the assistance obtained has been only in the form of professional guidance and supervision; and that no part of this thesis has been submitted in the past for a degree at any other university; and that the information used in this thesis has been obtained by me while registered as a candidate for the degree of Doctor of Philosophy in Social Work, University of Cape Town.

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ABSTRACT

An investigation into mental health care deficits in South Africa:

Exploring an alternative intervention strategy.

This study investigates mental health care deficits in South Africa and explores an alternative intervention strategy that promotes an integrated community-based intervention model to reach the vulnerable majority living with the debilitating consequences of mental illness. The research is grounded in human rights, empowerment and human scale development theories. A mixed-methods research design consisting of a dominant quantitative methodology complemented by a qualitative methodology was adopted. The research design was carried out in three sequential phases. The first phase of the study involved an online survey with 19 mental health professionals employed at State psychiatric facilities and 90 social workers at 17 mental health non-government organisations. The second phase involved 5 focus group discussions with a total of 40 mental health service users from the Western Cape, Eastern Cape, KwaZulu-Natal, Northern Cape and Limpopo Provinces. The third and final phase of the study involved telephonic interviews with two key informants, using a semi-structured interview guide. Purposive sampling procedures were used to recruit respondents from all nine provinces in South Africa. Findings indicate that less than half of the mental health professionals (49%, $n=53$) reported that the National Mental Health Policy Framework and Strategic Plan 2013–2020 is a very good policy, whereas 42.6% ($n=46$) agreed that the policy is highly appropriate for a developing country. The Chi-square test showed a significant relationship between respondents' perceptions of a good policy and its appropriateness for mental health care in South Africa [χ^2 (9, $n=109$) = 120.5, $p < .000$]. The focus group findings indicated that only a few service users were aware of the policy as a 'strategic plan' whilst the majority of focus group participants were unfamiliar with the policy and thought that it should be summarised in clear language and disseminated. The issue of stigma experienced and confirmed by service users was regarded as a major barrier to mental health care – the majority (89.9%, $n=98$) of respondents indicated that mental illness remains one of the most highly stigmatised conditions in South Africa. There is a significant relationship between how well mental illness is understood and the stigma associated with mental

illness [χ^2 (16, $n=109$) = 40.7, $p<.001$]. The Chi-square test indicated a significant association between mental health professionals' perception about vulnerability and the discrimination against mental health service users [χ^2 (9, $n=109$) = 25.0, $p<.003$]. These findings were confirmed by the focus group participants who said: *“As long as there is stigma – we as mental health patients get judged by our community, by our families and people around you – then nothing will change”*. The majority (94.5%, $n=103$) of respondents agreed that people with mental illness are more vulnerable to abuse by society than those without mental illness. The majority (80.7%, $n=88$) of mental health professionals reported that the medical model is the dominant approach to diagnosis and treatment of mental illness in South Africa. The focus group participants were keenly aware that *“just taking your medication isn't always balancing out”*. The majority of mental health professionals (83.5%, $n=91$) agreed that poor socio-economic conditions increased mental illness, whereas 73.4% ($n=80$) agreed that there was a direct link between poverty and the increase in demand for mental health services. The Chi-square test indicated that there is a significant association between poor socio-economic conditions and the increased demand for mental health services in South Africa [χ^2 (16, $n=109$) = 199.2, $p<.001$]. Focus group discussions confirmed this link between poverty and mental illness with participants highlighting the constraints of meagre grants and their inability to find jobs. Findings from the key informants concur with the aforementioned main findings. Conclusions drawn from the triangulated findings show the major deficits in treatment; the lack of resources and funding; the lack of community-based mental health interventions and the exclusion of mental health service users as significant role-players. Finally this study both recommended and designed a comprehensive patient-centred, integrated community-based mental health service model that is aligned with South Africa's National Mental Health Policy. The proposed model took into account the perspectives of mental health professionals, mental health service users, and findings from the survey respondents, as well as ideas from 'best practice models' found in Zimbabwe, Uganda, Brazil and India – and was corroborated by key informants.

DEDICATION

This study is dedicated to all those who live courageously with mental illness.

“The flower that blooms in adversity is the rarest and most beautiful of all”.

Walt Disney Company

“The strongest people are not those who show strength in front of the world but those who fight battles and win battles no one knows about”.

Jonathan Harnisch

“You are not your illness. You have an individual story to tell. You have a name, a history, a personality. Staying yourself is part of the battle”.

Julian Seifter

“Your ordinary acts of love and hope point to the extraordinary promise that every human life is of inestimable value”.

Archbishop Emeritus Desmond Tutu

ACKNOWLEDGEMENTS

It is with deep appreciation that I extend gratitude and thanks to the many people who supported and encouraged me on this journey of rediscovery, humility and great learning.

I thank my God who promised never to leave me nor forsake me and who held my hand throughout this process. The things that are impossible with men and women are possible with God (Luke 18:27).

To my husband and anchor, Eugene, thank you for your unfailing love and support. Thank you for believing in my abilities and encouraging me when the hill was steep and the mountain top seemed unattainable. Reaching this destination was possible with you by my side, patiently inspiring and supporting me, and immersing yourself in every phase of this journey. To my children, Megan and Kyle, for your love and pride in me, and for constantly checking on my progress.

I am deeply appreciative and thank my supervisors, Dr Constance O'Brien and Prof. Johannes John-Langba, Department of Social Development, University of Cape Town, for their valuable academic guidance, knowledge and supervision. I have learnt and discovered much with their investment in supporting me to achieve this goal.

I wish to extend my sincere thanks to the Board and staff at Cape Mental Health for their encouragement and for backing me to achieve this milestone. In particular, I wish to express thanks to Brigitte van der Berg, my management secretary, friend and confidante, for her loyal support and for always being by my side. Sandra Ellis, thank you for your editing brilliance, support and counsel.

Special thanks are extended to the South African Federation for Mental Health and the Western Cape Government: Strategic and Health Support Unit for endorsing my research, to all the directors of the mental health non-profit organisation and psychiatric facilities in South Africa and key informants for participating in this study, and to all the mental health societies who assisted with the logistics, co-facilitation and arrangements for the focus groups.

I further wish to express my deep thanks to all service users who bravely told their stories and participated in this study. Your lived experiences were captured and to you especially I hope that my study will bring greater inclusion, mental health care, human rights protection and respect. May every day bring hope and good mental health on your recovery journey.

The best kinds of people who come into your life are the ones who make you see the sun. Thank you to all the amazing people who gave me sunshine on this journey.

*“Some people arrive and make such a beautiful impact on your life;
you can barely remember what life was like without them.”*

Anna Tylor

LIST OF ABBREVIATIONS AND ACRONYMS

ACT	Assertive Community Team
AIDS	Acquired Immuno-Deficiency Syndrome
HIV	Human Immuno-Deficiency Virus
LMIC	Low- and Middle-Income Countries
MHPF&SP	National Mental Health Policy Framework and Strategic Plan
MINMEC	Ministers and Members of Executive Councils Meeting
NGO	Non-governmental Organisation
NHI	National Health Insurance
NPO	Non-profit Organisation
OLM	Open Labour Market
PHC	Primary Health Care
PSR	Psychosocial Rehabilitation
TB	Tuberculosis
WHO	World Health Organization

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CHAPTER ONE: INTRODUCTION

1.1. Introduction

Mental health experts have identified a serious global mental health crisis due to the large and extremely worrying treatment gap, particularly in low- and middle-income countries (LMIC), which requires urgent redress (Lund, Breen, & Flisher, 2010; Mangham & Hanson, 2010; Eaton, Mc Cay, Semrau, Chatterjee, Baingana, Araya, Ntulo, Thornicroft, & Saxena, 2011; Patel, Boyce, Collins, Saxena, & Horton, 2011; Petersen & Lund, 2011; Raviola, Becker, & Farmer, 2011) and the World Health Organization (WHO, 2008, 2010, 2012, 2013).

This situation is no different in South Africa where mental health deficits are alarming and estimated to grow significantly over the next decade (Bradshaw, Norman & Schneider, 2007; Mkhize & Kometsi, 2008; Burns, 2009, 2010; Lund & Petersen, 2011; Lund, De Silva, Plagerson, Cooper, Chisholm, Das, Knapp, & Patel, 2011; Lund, Petersen, Kleintjies & Bhana, 2012; Janse van Rensburg, 2012; Freeman, 2013).

Mental health remains a low national health priority with a dominant bio-medical approach (Mkhize & Kometsi, 2008; Burns, 2009; National Mental Health Policy Framework and Strategic Plan, 2013–2014, 2013). This approach is fragmented and fails to provide integrated comprehensive mental health care to the majority of poor South Africans who cannot afford private mental health care (Mkhize & Kometsi, 2008; Motsoaledi, 2012; National Health Insurance for South Africa, 2015). The treatment gap is increased as a result of mental health services being located mainly in urban areas with limited or no services in rural communities across the country (Mkhize & Kometsi, 2008; Rural Mental Health Campaign Report, 2015).

The situation in South Africa is compounded by abject poverty and the serious lack of mental health resources (Mkhize & Kometsi, 2008; Lund, et al., 2010). Lund et al. (2011) stated the following:

There is growing international evidence that mental ill health and poverty interact in a negative cycle. This cycle increases the risk of mental illness among people who live in poverty and increases the likelihood that those living with mental illness will drift into poverty (p. 7).

Years of racial, economic, structural and resource discrimination during the Apartheid era has created and added to this dearth in mental health services to the majority of black South Africans. Despite a progressive South African Constitution, adequate mental health care for all has not, as yet, materialised.

Despite this glaring mental health crisis, the national health budget allocation for the provision of mental health services remains significantly disproportionately low compared to the allocation for general health (Mkhize & Kometsi, 2008; Burns, 2010; Rural Mental Health Campaign Report, 2015). Even though mental health is regarded as the third highest burden of disease in South Africa, it remains the most neglected aspect of health care, competing with medical conditions such as HIV/AIDS (human immunodeficiency virus / acquired immunodeficiency syndrome) and tuberculosis (TB) for a fair percentage of the health budget, resources and personnel (Bradshaw, Norman & Schneider, 2007; Mkhize & Kometsi, 2008; South African Stress and Health Study, 2008; Williams, Herman, Stein, Heeringa, & Moomal, 2008; Lund, et al., 2012; Freeman, 2013; Rural Mental Health Campaign Report, 2015). The Rural Mental Health Campaign Report (2015) stated that, on average, provinces spent 2.9% of their total budgets on psychiatric facilities in the 2015/16 fiscal year. The North West Province spent the highest proportion of its health budget on these facilities (viz. 4.6%), whereas Mpumalanga spent the least by some margin (viz. 0.37%). Section 27 Catalyst for Social Justice (2017) reporting on the budget for non-communicable diseases NCDs indicated the following:

While the mental health budget is not, itself, detailed in the health vote, the 2017 budget sees a decrease in the percentage of the Primary Health Care budget spent on NCDs from 10.8% to 8.2%. The NCD budget decreased by 5.4% from 2013/14–2016/17 and it's now increasing by 5.4% for 2017/18–2019/20. While we must wait for the Department of Health budget to establish what funding is being committed to mental health, we are concerned about a further shift of focus away from mental health and the tragic consequences that this could have for a particularly vulnerable population (p. 1).

The disparity between health and mental health funding and resource allocation remains large with no clear demarcation within the health budget for mental health services.

The National Health Insurance (NHI) in South Africa, which aims to radically re-engineer health care for all South Africans, has failed to prioritise mental health as a separate category; instead it has been grouped with other non-communicable diseases. It has taken nineteen years to finalise and formally adopt the first National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013). Despite this achievement, evidence of actual implementation and attainment of the targeted outcomes is lacking.

Community mental health services have been delivered primarily by non-government organisations (NGOs) (Lund, 2012; South African Federation for Mental Health Analysis Report on Annual Statistics for Financial Year 2014–2015, 2015). However, Primary Health Care (PHC) facilities and psychiatric hospitals remain unaware of the extent of the community-based interventions offered by these NGOs due to the lack of co-ordination between the Departments of Health and NGOs. NGOs offer the major portion of community-based mental health services, but remain seriously under-funded by government and are seen as the lesser partner in the mental health care plan. This is so, despite the promise of upscaling community mental health services to cope with the rapid process of de-institutionalisation in the 1990s (Mkhize & Kometsi, 2008; Lund, et al., 2012; National Mental Health Policy Framework and Strategic Plan, 2013–2014, 2013).

There is therefore a dire need to expand and improve mental health services in South Africa by designing cost-effective integrated interventions to reach the vulnerable majority of those living with debilitating mental illness.

At the World Congress of the World Federation for Mental Health themed “African Footprint in Global Mental Health” held in October 2011 in Cape Town, a clarion call was issued by service users, researchers, experts and service providers from across the globe to urgently prioritise mental health services. “If left untreated, mental disorders can result in worse treatment adherence and outcomes for commonly co-occurring diseases, such as tuberculosis, diabetes, cardiovascular disease, and cancer” (Prince, Patel, Saxena, Maj, Maselko, Phillips & Rahman, 2007, pp. 859 – 877).

The slow response to address the large gaps in mental health services in South Africa impedes recovery and people’s ability to live a dignified life despite their mental illness. The barriers operating in our health care system limit progressive and proactive care. Versteeg and Couper (2011) identified the lack of governance and leadership, weak provincial management, and inadequate comprehensive and equitable resources and skilled health workers as the major challenges and factors impeding adequate health care in the rural areas. The “Out of the Shadows: Making Mental Health a Global Development Priority” Conference in 2016 made the following statement:

The burden of depression, anxiety and other mental disorders calls for a concerted, multi-sectoral response that not only raises public awareness and political commitment about this often overlooked and stigmatized issue, but also puts in place an array of treatment and prevention strategies capable of reducing the large, and growing, human, social and economic losses attributable to them (The World Bank, 2016, p. 3).

1.2. Statement of the Research Problem

The provision of mental health services in South Africa is a developmental and human rights issue. People with mental illness are faced with multiple levels of discrimination on

structural, economic and social levels with limited access to appropriate mental health care (Tarantola, Byrnes, Johnson, Kemp, Zwi & Gruskin, 2009). Assurances to expand community-based mental health services with the advent of deinstitutionalisation – by using the savings incurred as a result of reduced beds, staff and facilities – have failed. These promises to mental health users were never met since other health conditions such as HIV/AIDS and TB were prioritised over mental health issues.

The first nationally representative psychiatric epidemiological study in sub-Saharan Africa reported the following:

There is a high level of unmet need for mental health services in South Africa. Irrespective of whether their mental disorder was classified as serious-moderate or mild, three out of four adults with a 12-month DSM-IV/CIDI disorder received no treatment in the year of the interview (Williams, et al., 2008, p. 6).

People with mental disorders often go untreated due to limited access to mental health care (Williams, et al., 2008; Raviola, et al., 2011; Patel, et al., 2011; WHO, 2012; Freeman, 2013). This lack of access to mental health care is a human rights violation and affects the most vulnerable who live in challenging and difficult socio-economic environments.

Deficits in community-based mental health services and the dire need to expand and improve mental health care in South Africa have been identified as requiring urgent intervention. The researcher is therefore of the opinion that an integrated community-based intervention approach is needed to reach the vulnerable majority living with the most debilitating consequences of mental illness. The current mental health packages of care remain fragmented, with pockets of excellence that serve the minority. The Department of Health's National Mental Health Policy Framework Strategic Plan 2013–2020 (2013) has had little impact on upscaling mental health care, while the lack of funding continues to exacerbate the problems experienced by mental health users.

1.3. Main Research Questions

The main research questions considered in the study are as follows:

- How do mental health professionals and service-users perceive the effectiveness of the present mental health policy with regards to the implementation of mental health services?
- How do mental health professionals and service-users perceive the major barriers preventing the effective expansion of community-based mental health services?
- What are the perceptions of mental health professionals and service-users about the financial and human resource allocations?
- What are the perceptions of mental health professionals and service-users about the present bio-medical approach and feasibility of an integrated community-based model?
- What are the perceptions of mental health professionals and service-users about the lack of or unavailability of mental health services and how this impacts on the human rights and dignity of persons with mental illness?
- What are the perceptions of mental health professionals and service-users about the kinds of critical partnerships (viz. carers, traditional healers, community leaders, etc.,) needed to implement a sustainable multi-sectoral integrated community-based mental health programme?

1.4. Aims and Objectives

The aim of this study is to investigate the current deficits, barriers and constraints in community-based mental health services and to suggest a model for effective community-based interventions in South Africa.

This research aims to put forward a model that promotes the strengthening of patient-centred recovery interventions, which is firmly grounded in human rights, empowerment and human scale development theories and social model approaches.

The proposed model aims to integrate bio-medical and psycho-social interventions with innovations to expand community-based mental health initiatives that rely heavily on local and traditional resources, non-government organisations, non-specialist human resources, and mental health service users who should be central to care and interventions at all times.

The research furthermore aims to give credence to South Africa's Bill of Rights and also significantly reduce the burden of mental health. The success of appropriate service delivery outcomes will have a positive impact on the burden of this disease.

The specific objectives of the study are as follows:

- To examine how mental health professionals and service-users perceive the effectiveness of the present mental health policy with regards to the implementation of mental health services;
- To ascertain how mental health professionals and service-users perceive major barriers preventing the effective expansion of community-based mental health services;
- To determine the perceptions of mental health professionals and service-users about the current allocation of financial and human resources and alternative measures required to facilitate effective community-based mental health programmes;
- To determine mental health professionals and service-users' perceptions about the present bio-medical approach and feasibility of an integrated community-based model;

- To explore the perceptions of mental health professionals and service-users about the lack or unavailability of mental health services and its impact on the human rights and dignity of persons living with mental illness;
- To explore the perceptions of mental health professionals and service-users about the critical partnerships (viz. carers, traditional healers, community leaders, etc.) needed to implement a sustainable multi-sectoral integrated community-based mental health programme.

1.5. Underlying Assumptions

The assumptions upon which the study is based are as follows:

- The structural and social impact of a racially defined fragmented health care system of an Apartheid regime prior to 1994 had dire consequences for black South Africans in need of mental health care.
- This backlog in mental health service provisioning, compounded by increasing poverty and inequality post 1994, has increased the burden of disease. Failure to address these deficits will escalate and exacerbate an already alarming mental health crisis in the country.
- Low prioritisation and failure to implement the National Strategic Plans 2013–2020 within the stipulated timeframes will limit access, escalate the hardships suffered by people with mental health needs and contribute to human rights violations. There appears to be a “disconnect” between the National Mental Health Policy Framework and Strategic Plan 2013–2020 and the implementation provisions of the NHI health reform plan.
- Current community-based mental health services or packages of care are limited, fragmented, inequitably distributed and inadequate in effectively addressing the growing population of people living with mental illness.

- Primary health care approaches favour the bio-medical model and fail to adequately consider holistic, social, community-based mental health models of care.
- Although much research and knowledge about the gaps in mental health services in LMICs have been identified, there has been limited research conducted in South Africa to examine cost-effective best practice community-based mental health interventions.
- Despite the high burden of mental illness, national and provincial governments have been ineffective in applying adequate, creative, innovative and alternative mental health care interventions due to financial constraints. A very small proportion of the health budget is assigned to mental health services. Furthermore, there is a scarce supply of mental health professionals/human capacity and resources, especially in remote rural areas.
- The inclusion of people living with mental illness, carers, communities and civil society partners is rarely considered in developing provincial/national mental health service strategies, leading to fragmented partnerships and uncoordinated comprehensive community mental health services.

All of the aforementioned assumptions underpin the rationale for this study.

1.6. Rationale and Significance of the Study

The mental health burden of disease is large and increasing across the world (World Health Organization, 2012; People's Charter, 2013; Whiteford, Degenhardt, Rehm, Baxter, Ferrari, Erskine, Charlson, Norman, Flaxman, Johns, Burstein, Murray & Vos, 2013). However, despite research to identify the serious gaps in treatment, alternative intervention strategies to address the alarming crisis remain limited. In South Africa, funding for community-based mental health interventions has not been a priority. There is agreement amongst the experts and researchers in the field that more research is required to implement evidence-based

interventions to upscale mental health services in resource-poor countries (World Health Organization, 2003; Mkhize & Kometsi, 2008; Petersen & Lund, 2011).

Petersen and Lund (2011) identified the progress and challenges in mental health care in South Africa, as well as the research priorities for future mental health services. They chose to systematically review mental health services research by completing literature searches. They concluded the following:

While there has been some progress in the decentralisation of mental health service provision, substantial gaps in service delivery remain. Intervention research is needed to provide evidence of the organisational and human resource mix requirements, as well as cost-effectiveness of a culturally appropriate, task shifting and stepped care approach for severe and common mental disorders at primary healthcare level (p. 751).

The reason for initiating this study is to make a contribution to transforming and accelerating decentralised community-based mental health services and practice in an attempt to alleviate “South Africa’s sick state of mental health” (Tromp, Dolley, Laganparsad & Govender, 2014, p. 1).

The slow pace of policy reform and development, inadequate decentralised community-based mental health interventions in response to rapid deinstitutionalisation of patients from psychiatric hospitals, low mental health service delivery priority, fragmentation in mental health care, insufficient mental health care professionals, and a leadership crisis, have all detrimentally affected those in serious need of mental health care. A significantly large proportion of persons with mental illness have no access to mental health services that has resulted in the violation of their human rights and impeded their recovery. Thus, the underlying theory of human rights underpins the study and will shape the values and principles of the proposed model for upscaling interventions.

Given the aforementioned, the researcher (who has worked in this field for close on 35 years) feels an ethical obligation to document the present-day South African reality with

regards to mental health care and to motivate for a model of service delivery that encompasses holistic community-based interventions.

This study has particular significance and value since it is the first major study in social work that proposes an original and new model for community-based mental health intervention.

The significance of this study is that it could influence mental health policy, community-based interventions, change funding priorities, give a voice to the most stigmatised and vulnerable mental health service users, and reduce the gap in mental health care.

1.7. Concept Clarification

1.7.1. Mental illness

In South Africa, the concept of mental illness is complex and has to be understood within the context of both Western diagnostic classifications of mental illness and traditional African understanding of mental conditions. South Africa is a largely plural society with eleven official languages and many cultures. The Western classification of mental illness is defined in the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM V) (2013) and our mental health professionals are all trained according to this DSM classification that sets out treatment interventions largely based on the bio-medical approach. However, South Africa is a diverse multi-cultural society in which the majority of black South Africans espouse various tribal traditions and customs that perceive mental illness very differently from a purely Western perspective. Treatment approaches that only adopt a bio-medical approach would be ineffective if the cultural nuances of these various tribes/religious groups with their varying beliefs are not taken into consideration. Interventions can only be successful once there is an understanding and respect for these cultural and belief systems. Thus traditional and cultural belief systems cannot be ignored when treating people with mental illness. We cannot apply Western diagnostic classifications alone without taking into

account how various communities, cultural perceptions and aetiological understandings and views have influenced the diagnosis of mental illness. According to Cheetham and Griffiths (1980), and Cheetham and Rzakowolski (1980), it is accepted globally that mental illness is relative to the culture concerned and mental illness concepts are based on beliefs regarding causation. Shezi and Uys (1997) added that “the African concept of illness embraces biological, social, religious and magical factors. Symptoms from disorders are generally shaped by local beliefs, norms and general patterns of living” (p. 83).

Of the participants in the Ensink and Robertson (1999) study, the majority of African patients had consulted traditional healers and explained more than one cause for their diagnosis. A combination of indigenous, psychosocial and religious components was frequently given as contributing factors. Sorsdahl, Flisher, Wilson and Stein (2010) highlighted that traditional healers in their study held multiple explanatory models to describe non-psychotic mental disorders. They noted the following:

A majority of the healers regarded non-psychotic disorders as a normal reaction to difficult life situations and as a relatively normal reaction to severe social and personal threats to losses. Therefore non-psychotic mental disorders would not be identified as a mental illness unless it acquires other characteristics such as severe behavioural disturbances (p. 289).

Indigenous categories or descriptions for mental illness such as *ukuthwasa* (calling to be a healer), *amafufunyana* (possession by evil spirits) and *ukuphambana* (madness) are usually portrayed as if they are clearly bounded entities. Ensink and Robertson (1999), and Shezi and Uys (1997) compared culturally bound syndromes with those compared in the DSM-IV. Some of these diagnostic disorders were described as *Amok* (dissociative episode), and *Thwasa* (characterised by anxiety and somatic complaints, and so forth).

The preferred diagnostic classification used in South Africa is the Diagnostic and Statistical Manual of Mental Disorders 5th edition, which is an American-influenced categorisation of mental disorders.

Stein, Phillips, Bolton, Fulford, Sadler, and Kendler (2010) noted that the American Psychiatric Association's task group working on the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM V) in its revised definition of mental illnesses or disorders indicated the following:

DSM-V Proposal for the Definition of Mental/Psychiatric Disorder Features

- A A behavioral or psychological syndrome or pattern that occurs in an individual
- B The consequences of which are clinically significant distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning)
- C Must not be merely an expectable response to common stressors and losses (for example, the loss of a loved one) or a culturally sanctioned response to a particular event (for example, trance states in religious rituals)
- D That reflects an underlying psychobiological dysfunction
- E That is not solely a result of social deviance or conflicts with society

Other considerations

- F That has diagnostic validity using one or more sets of diagnostic validators (e.g., prognostic significance, psychobiological disruption, response to treatment)
- G That has clinical utility (for example, contributes to better conceptualization of diagnoses, or to better assessment and treatment)
- H No definition perfectly specifies precise boundaries for the concept of either "medical disorder" or "mental/psychiatric disorder"
- I Diagnostic validators and clinical utility should help differentiate a disorder from diagnostic "nearest neighbors"
- J When considering whether to add a psychiatric condition to the nomenclature, or delete a psychiatric condition from the nomenclature, potential benefits (for example, provide better patient care, stimulate new research) should outweigh potential harms (for example, hurt particular individuals, be subject to misuse) (p. 1760).

The National Alliance on Mental Illness, America's largest grassroots organisation, defined mental illnesses as follows:

Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning. Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD) and borderline personality

disorder. The good news about mental illness is that recovery is possible. Mental illnesses can affect persons of any age, race, religion, or income. Mental illnesses are not the result of personal weakness, lack of character or poor upbringing. Mental illnesses are treatable. Most people diagnosed with a serious mental illness can experience relief from their symptoms by actively participating in an individual treatment plan. In addition to medication treatment, psychosocial treatment such as cognitive behavioral therapy, interpersonal therapy, peer support groups and other community services can also be components of a treatment plan and can assist with recovery. The availability of transportation, diet, exercise, sleep, friends and meaningful paid or volunteer activities contribute to overall health and wellness, including mental illness recovery (“National Alliance on Mental Illness”, 1996).

The Mental Health Care Act No. 17 of 2002 (2002:10) does not provide a specific definition, but instead offers a broad yet simple description of mental illness: “mental illness means a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis.” This definition was used in this study since it is one that all mental health professionals can agree to and one that service users tend to accept.

1.7.2. Mental health and Mental Well-being

Mental health and mental well-being is the opposite of mental illness. It is recognised that mental health is an integral and essential component of health. The WHO stated that “Mental health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2001, p. 1). An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities. “Mental health is a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (WHO 2001a, p. 1). Furthermore, the WHO (2004, p. 12) stated that “Mental health and mental illness are determined by multiple and interacting social, psychological and biological factors, just as health and illness in general”. Mental health and well-being are fundamental to our collective and individual ability as

humans to think, emote, interact with one another, earn a living and enjoy life (WHO, 2004). On this basis, the promotion, protection and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world (WHO, 2014). Sartorius (1990) stated that health and illness co-exist and neither exists on its own. He added that mental, physical, and social functioning are dependent on one another, none being mutually exclusive.

Taking into account different cultures, values and socio-economic backgrounds across the world, a new definition of mental health and mental well-being is proposed:

Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognise, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium (Galderisi, Heinz, Kastrup, Beezhold & Sartorius, 2015, p. 232)

This definition aligns itself with the recovery movement in which recovery after experiencing a mental illness is seen as a process aimed at living a fulfilled and valued life by building on the abilities and functions spared by the illness despite having active symptoms of the mental illness (Slade, Amering, Farkas, Hamilton, O'Hagan, Panther, Perkins, Shepherd, Tse & Whitley, 2014).

The concept “mental health and well-being” in this study will refer mostly to that cited by Galderisi, Heinz, Kastrup, Beezhold and Sartorius (2015) since South Africa is a diverse country with different cultures, socio-economic, religious and ethnic groups, and the proposed model is aligned with the recovery movement.

1.7.3. Community-based Mental Health Practice

It is understood that community-based mental health services are mostly rendered at decentralised community levels. The community-based approach presupposes an individual-

in-the-community environment perspective of community mental health. Thus, specific mental health needs of people living with mental health challenges are met within their own community environment and surroundings.

A definition of community mental health practice is as follows:

Community Mental Health Practice (CMHP) is a multidimensional intervention process that effectively meets a community's need for appropriate mental health services through both engaging available local, tertiary and national resources and capabilities and stimulating multiple stakeholder awareness and commitment. Within the broad framework of CMHP the manner in which the 'essential components' come together (or the process of CMHP) should remain flexible so as to adapt to the unique features of local implementation sites (i.e. resources, capacities, infrastructure and user needs). Community mental health programmes should be designed, planned and budgeted for by taking into account the strengths and weaknesses of local contexts. Close monitoring and evaluations by users and the management body are necessary to also recognise and adapt to changing condition (Basic Needs, 2009, pp. 10–11).

Community-based mental health practice is understood to be a treatment philosophy that is based on the social model of care and promotes a more holistic and comprehensive range of mental health service options that are readily accessible and available to persons with mental disability in the communities where they live.

1.7.4. Comprehensive Mental Health Services

Comprehensive mental health services could therefore be regarded as an expansion and extension of the aforementioned definition and can be defined as follows:

An integrated system of care designed to meet the health needs of individuals, families and communities in their local settings. It includes primary prevention, i.e. prevention of health problems and/or diseases before they occur (health promotion and disease prevention); secondary prevention, i.e. early detection of problems or diseases and intervention (curative care and support); and tertiary prevention, i.e. correction and prevention of deterioration, rehabilitation and terminal care (rehabilitative care). It is underpinned by the partnership between health workers, clients/patients and members of the local community. Community health based health care can be provided in numerous settings in the community, by various people including health professionals, care assistants, and non-formal caregivers such as volunteers and family members (World Health Organization, 2004, n.p.)

It could also be considered as an integrated model of decentralised mental health care and or other services for people with mental illnesses. It is a well-structured model that takes into account primary, secondary and tertiary intervention methods and includes a multi-disciplinary approach. It is a mental health service delivery approach that is less costly and aims to integrate and include persons with mental disability. The researcher believes that it should be the model of choice especially in LMICs.

1.7.5. Primary Mental Health Care (PHC)

The PHC model was developed during the late 1970s and early 1980s after the vertical (hospital-based care) approach to managing malaria was criticised as being largely ineffective in preventing the large number of deaths. Hospital-based health care was heavily criticised as it failed to consider prevention as a significant intervention approach that had the potential for much better health outcomes. The model was considered as a solution to dealing with half the world's population who lived in LMICs and who would never be able to access hospital-based care. PHC intervention empowers individuals and communities to actively participate in health care to facilitate significant health outcomes. The PHC model was therefore introduced as a radical approach to complement traditional medicine with the acceptance and understanding that traditional medicine, as it was practised in the 1970s, could not deal with the global health crisis in developing countries.

In response to this global crisis, The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care, Alma-Ata, in Russia in September 1978. It was a historic moment in the history of medicine as it called for urgent action from governments, all health and development workers, and the world community, to protect and promote the health of all the people of the world and ensure health equality for all.

PHC is commonly referred to as the first level of care. It is based on a patient-centred approach underpinned by strong human rights values and principles. Primary Health Care is defined by the World Health Organization (1978) as follows:

Essential health care; based on practical, scientifically sound, and socially acceptable method and technology; universally accessible to all in the community through their full participation; at an affordable cost; and geared toward self-reliance and self-determination. As a philosophy, primary health care is based on the overlap of mutuality, social justice and equality. As a strategy, primary health care focuses on individual and community strengths (assets) and opportunities for change (needs); maximizes the involvement of the community; includes all relevant sectors but avoids duplication of services; and uses only health technologies that are accessible, acceptable, affordable and appropriate. Primary health care needs to be delivered close to the people; thus, should rely on maximum use of both lay and professional health care practitioners (WHO, Declaration of Alma-Ata:1978, p. 1).

The ultimate goal of primary health care is based on the philosophy of health for all. It is a patient/person-centred approach in which the patient comes first and is included in the care plan. The researcher has adopted the WHO definition for PHC for this study. Primary health care is a feature of any comprehensive health service. When one considers comprehensive mental health services (Section 1.7.3., pp. 15–16) that should be the thrust of any mental health policy, then community-based mental health practice (Section 1.7.2., pp. 14–15) would be a natural outflow of such a policy. Psycho-social rehabilitation is a community-based intervention strategy.

1.7.6. Psycho-social Rehabilitation

Psychosocial Rehabilitation (PSR) is a community-based intervention model aimed at fostering recovery and independent functioning for persons with severe mental illness. This intervention model has reduced chronic and repeated relapse and readmission. Barton (1999) provisionally defined psycho-social rehabilitation as follows:

- Psychosocial rehabilitation is an organized set of psychosocial interventions that includes one or more of the areas of skills training, peer support, vocational rehabilitation, and consumer-community resource development.

- It is targeted to individuals who have major psychotic disorders and functional impairments equivalent to the federal definition of severe and persistent mental illness.
- It is oriented toward empowerment, recovery, and competency.
(p. 4)

PSR is regarded as the best practice model by the Department of Health as well as by NGOs for rehabilitating persons with psychiatric disabilities. PSR aims to change service users' environment, their ability to deal with their environment, and to facilitate the improvement and reduction of adverse psychiatric symptoms and personal distress. Individuals gain a sense of belonging through PSR, build their confidence and skills, and engage in meaningful activities that enhance their quality of life. This is achieved and facilitated through the four PSR focus areas of community living, learning, working and socialising.

1.7.7. Psychological and Mental Health First Aid

Psychological Mental Health First Aid is generally provided by non-professionals. These are interventions provided by members of the public who have received training in basic psychological first aid.

World Federation for Mental Health, Dignity in Mental Health Psychological & Mental Health First Aid for All manual (2016) cites Kitchener (2015) stating that:

Mental health first aid is the help offered to a person developing a mental health problem, experiencing a worsening of an existing mental health problem or in a mental health crisis. The first aid is given until appropriate professional help is received or until the crisis resolves.

The aims of mental health first aid are to:

1. Preserve life where a person may be at risk of harm
 2. Provide help to prevent the mental health problem from becoming more serious
 3. Promote recovery of good mental health
 4. Provide comfort to a person with a mental health problem
- (p. 12).

The Australian Red Cross defined Psychological First Aid (PFA) as follows:

Psychological First Aid is an approach to helping people affected by an emergency, disaster or traumatic event. It includes basic principles of support to promote natural recovery. This involves helping people to feel safe, connected to others, calm and hopeful, access physical, emotional and social support, and feel able to help themselves. Psychological first aid aims to reduce initial distress, meet current needs, promote flexible coping and encourage adjustment (Australian Red Cross and Australian Psychological Society, 2013, p. 5).

1.7.8. National Health Insurance

The Green Paper on the NHI policy is the South African government's plan to radically transform health care in South Africa. The NHI policy seeks to address the legacy of systematic denial of access to quality, accessible and appropriate health care to the majority of South African prior to 1994. "The NHI is intended to bring about reform that will improve service provision. It will promote equity and efficiency so as to ensure that all South Africans have access to affordable, quality healthcare services regardless of their socio-economic status" (Department of Health, [DOH], 2011, p. 4).

The NHI policy objectives are to address the inequities by allocating equitable funding and resources to the large majority currently receiving health care outside of the private health care sector and to level the playing field in which the privileged few have disproportionate access to health care.

1.7.9. Low- and Middle-Income Countries

In order to define and understand how a LMIC is determined the World Bank sets out to classify countries into four categories, based on wealth as a determinant. These economic factors are reviewed each year in July to determine the wealth classification of each country.

Economies were divided according to Gross National Income (GNI) per capita using the following ranges of income, classified according to World Bank estimates of 2015 GNI per capita:

Low income (\$1,025 or less)
Lower middle income (\$1,026–\$4,035)
Upper middle income (\$4,036–\$12,475)
High income (\$12,476 or more) (The World Bank, 2017, p. 1V).

The list of the least developed countries (LDCs) is decided in the following manner:

Low- and middle-income economies are sometimes referred to as developing economies. The term is used for convenience; it is not intended to imply that all economies in the group are experiencing similar development or that other economies have reached a preferred or final stage of development. Classification by income does not necessarily reflect development status (The World Bank, 2012, p. 1).

Furthermore, the development of a country is measured by using various indices and measurements, such as income per capita (per person), gross domestic product, life expectancy, the rate of literacy, and so forth. Developing countries are often regarded as countries that have not realised significant levels of industrialisation to support their citizens. These countries often present with above-average to high levels of population growth with low income and standards of living.

The term “developing country” is often criticised since it implies inferiority and underdevelopment in comparison to first world developed countries and under-values the strengths, resilience and traditional capacities that exist within these countries.

South Africa is regarded as an upper middle-income country with GNI of between \$4,036 and \$12,475 (The World Bank, 2017, p. V1). Even though it is classified as “upper middle income” this predominantly applies to a smaller cohort of the whole population.

1.7.10. Non-profit Organisations

A non-profit organisation (NPO), also known as a non-government organisation (NGO), is established and registered with the Non-profit Directorate and regulated by the RSA Nonprofit Organisations Act No. 71 of 1997. The Act defines a non-profit organisation as “a trust, company or other association of persons – established for a public purpose; and the income and property of which are not distributable to its members or office-bearers except as

reasonable compensation for services rendered” (RSA Nonprofit Organisations Act No. 71 of 1997, p. 2).

Organisations operating within this legal framework are part of civil society and are established not-for-profit or gain. NPOs function independently, but may deliver essential humanitarian services on behalf of, and in partnership with, State entities and may or may not receive State subsidies. These subsidies generally provide partial funding and do not necessarily consider annual inflationary escalations, resulting in the NPOs having to carry the cost and financial burden for the implementation of the services. In South Africa, the value of these subsidies varies from one provincial department to another and is inconsistently allocated. The NGOs referred to in this study are NGOs providing mental health services.

1.7.11. Service User

The term “service user” applies to people with mental disability who access and use mental health services offered by either State, private and non-profit organisation (NPO) sectors. The terms “user”, “consumer” or “survivor” are used interchangeably to refer to the above concept. Tait and Lester (2005) noted the following:

Users can also be seen as consumers, survivors and providers, all of which imply different notions of the roles and responsibilities of people with mental health problems and the relationship between them and mental health services. Users are increasingly seen as customers who can exercise an informed choice about the services they receive and can shop around, which means that if they are not satisfied, they can take their ‘business’ elsewhere (p. 168).

1.8. Summary

This chapter gave an overview of the mental health crisis and disparity in mental health care compared to other illnesses in South Africa. It provided a statement of the research problem, identified the main research questions, overall objectives, underlying assumptions, rationale for the study, and clarified the main concepts used.

The following chapter discusses the current state of mental health, providing an international, low- and middle-income country and South African perspective. Theoretical frameworks that underpin the study are also discussed.

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

Mental health service delivery needs to be understood and contextualised within the framework of international lower-and middle-income countries and specifically the South African context, medical and social model approaches, policy and legislation, and various theoretical frameworks that impact mental health care outcomes.

This chapter highlights the inadequate and inequitable provision of mental health care resources, and funding and human resource allocation to address the burden of mental health needs across the globe. The lack of political will and leadership to reduce the alarming and serious gap in mental health services will also become clear. A review of literature indicated inadequate provisioning of much-needed mental health services and the consequences of such an oversight.

This chapter considered the following key themes:

- Mental Health – An International Perspective
- Mental Health in Low-and Middle-Income Countries
- Mental Health in South Africa
- South African Legislation and Policy Framework
- Medical and Social Model Approaches to Mental Health Care
- Theoretical Frameworks

2.1.1. Mental Health – an International Perspective

Mental health care deficits are alarming and estimated to grow significantly over the next decade. It is recognised by mental health experts and the World Health Organization (WHO) that there is a serious global mental health crisis due to the large and extremely worrying

treatment gap particularly in low- and middle-income countries (LMICs) that needs to be urgently addressed.

WHO (2012) stated the following:

Mental disorders affect, and are affected by, other chronic diseases such as cancer, cardiovascular disease and HIV/AIDS. For example, there is evidence that depression predisposes people to developing myocardial infarction and diabetes, and conversely, myocardial infarction and diabetes increases the likelihood of depression. There is also substantial co-occurrence of mental disorders and substance use disorders. Taken together, mental, neurological and substance use disorders exact a high toll on health outcomes, accounting for 13% of the total global burden of disease. Depression alone accounts for 4.3% of the global burden of disease and is among the largest single causes of disability worldwide (11% of all years lived with disability globally). The economic consequences of these health losses are equally large: a recent study by the World Economic Forum estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US\$ 16 000 billion over the next 20 years (p. 3).

The World Health Organization, Zero Draft Global Mental Health Action Plan 2013–2020 warns that depression will be the number one global burden of disease by 2030, surpassing heart disease and cancer. “It is estimated that every year almost 1 million people die from suicide – 1 death every 40 seconds with an increase over the last 45 years of 60% worldwide” (People’s Charter, 2013, p. 12). Whiteford et al. (2013) added that “the burden of mental and substance use disorders increased by 37.6% between 1990 and 2010, which for most disorders was driven by population growth and ageing” (pp. 1575–1586).

Despite these concerns, mental health has received the lowest priority in budget allocations (compared to general medical conditions), inadequate resources and poor infra-structural development at community level, few medical supplies, as well as limited human resources. Over the past few decades enormous global attention has been directed towards reducing the burden of physical disease with little focus on addressing mental illnesses and neurological disorders. Ravishankar, Gubbins, Cooley, Leach-Kemon, Michaud, Jamison and Murray (2009) stated that “resources targeting HIV/AIDs, tuberculosis, malaria, maternal and child health have increased substantially. Development assistance for health grew from

US\$5.6 billion in 1990 to \$21.8 billion in 2007” (p. 2113). However, at a global level there has been little financial commitment towards mental health funding or towards that of treating neurological disorders (Patel, et al., 2011; The World Bank, 2016; Whiteford, et al., 2013; World Health Organization, 2010; World Health Organization, 2013). “It is known that neuropsychiatric disorders receive disproportionately low resource allocation – the average across countries is 4% of the health care budget” (Prince, et al., 2007, pp. 859–877).

WHO mhGAP Intervention Guide (2010) concurred that “The resources available to countries are insufficient – the vast majority of countries allocate less than 2% of the health budget to mental health leading to a treatment gap of more than 75% in many low-middle-income countries” (p. iii). The WHO, in its call for a comprehensive and co-ordinated response from the health and social sectors at country level, added the following:

Financing for treatment and prevention of mental disorders remain insufficient in member states. Globally, annual spending on mental health is less than US\$2 per person and less than US\$ 0.25 in low income countries. Median annual mental health expenditure per capita range from US\$ 0.20 in low income countries to US\$ 44.84 in high income countries (World Health Organization [WHO], 2012, p. 3).

Prominent mental health research activists stated that “If mental health is to be included in the future development targets beyond 2015, assessment of evidence based and feasibility on interventions that attempt to break the cycle of poverty and mental ill health becomes important” (Lund, et al., 2010, p. 8).

2.1.2. Mental Health in Low-and Middle-Income Countries

There is unease and concern within the global mental health movement that mental health services in LMICs seriously lag behind high-income countries. Large populations of persons living with mental illness receive limited, inadequate or no mental health services at all. The WHO (2012, p. 2) supported this statement and added that “ between 76%–85% of people

with severe mental disorders receive no treatment at all in LMIC, compared to high-income countries where the percentage drops to between 35%–50%”.

Patel et al. (2011) stated that “up to nine out of ten people with a mental problem do not receive even basic care in some countries” (p. 1). The authors highlighted the following:

This gap was not due to insufficient evidence about the effect of mental health problems or their effective treatments, but due to a range of barriers operating at all levels of the health system. This problem is particularly evident in LMIC’s where the gaps are the largest” (Patel, et al., 2011, p. 1).

The WHO, Executive Board 130th session confirmed the latter by stating that “The gap between the need for treatment of mental disorders and its provision are wide all over the world” (WHO, Executive Board 130th session, 2011, p. 1).

Raviola et al. (2011) stated that “Neuro-psychiatric disorders comprise a substantial share of the disease burden and disability – approaching 14% with depression the leading global cause of disability but receive a disproportionately low resource allocation – the average across countries is under 4% of the overall health care budget” (p. 4). The WHO Executive Board 130th session indicated that over 75% of patients in LMICs go untreated; that there are significant shortfalls in financial allocations to address mental health care needs, as well as a dearth of adequately trained mental health professionals. Raviola et al. (2011, p. 4) referring to the low funding of mental health care stated that “Even these dismal metrics do not fully convey the unconscionable neglect, social discrimination, and frequent abuse endured by the mentally ill, a situation aptly described as a failure of humanity”.

Mnookin (2016) highlighted that the poorer the country, the fewer the resources to address the competing priorities with the situation being further exacerbated by stigma attached to mental illness as well as policy and funding limitations.

2.1.3. Mental Health in South Africa

Prior to 1994, mental health services in South Africa focused largely on institutional care that was structured, designed, systematically engineered, developed, implemented and reinforced by the laws and policies of the Apartheid regime to promote racial discrimination and segregation. The Apartheid laws were structured and engineered in such a manner that mental health services were limited, scarce, withheld or totally unavailable to black South Africans with mental illness. The now repealed Mental Health Act, No. 18 of 1973, limited the rights and protection of person with mental disability and maintained the system that deprived their human rights. The Act defined people with mental illness as “mentally defective” and those with intellectual disability as “idiots or imbeciles” – terminology that sadly entrenched the stigma and discrimination against those with mental disability. Furthermore, persons of colour with a mental illness were doubly discriminated against with their human rights being severely violated especially in an Apartheid context. Prior to 1994, the Apartheid government had defied all international human rights declarations. Thus those who had a mental illness found their situation compounded by a context of gross human rights violations, political violence, torture, and increasing poverty. Civil society organisations tried to address the challenges of that time by advocating for mental health services for persons with mental disability, and for those who had suffered psychiatric breakdowns as a result of the Apartheid regime’s process of detention without trial, torture and the impact of security operations that destabilised communities. Community-based mental health services that tried to address those in need during this time of socio-economic and political turmoil had no policies or legislative frameworks to guide their practices. Community-based mental health services were implemented primarily by non-profit organisations while institutional care was the primary focus of the State mental health sector.

After 1994, the new democratic government of South Africa with its Reconstruction and Development Policy, the Constitution of the Republic of South Africa, No.108 of 1996, and Bill of Rights, paved the way for the rights of persons with mental disability to be safeguarded in the Mental Health Care Act, No. 17 of 2002. Despite this progressive piece of legislation, however, mental health needs have remained a low priority while mental illness continues to be one of the most marginalised, stigmatised and discriminated conditions.

Burns (2011) stated the following:

Despite South Africa's progressive mental health legislation (i.e. MCHA-2002), multiple barriers to the financing and development of mental health services exist, which result in: (i) psychiatric hospitals remaining outdated, falling into disrepair, and often unfit for human use; (ii) serious shortages of mental health professionals; (iii) an inability to develop vitally important tertiary level psychiatric services (such as child and adolescent services, psychogeriatric services, neuropsychiatric services, etc.); and (iv) community mental health and psychosocial rehabilitation services remaining undeveloped, so that patients end up institutionalised, without hope of rehabilitation back into their communities. This state of affairs remains unchanged despite the legislated commitments to reform mental health care in the MHCA (p. 104).

Mental illnesses have been increasingly recognised as a leading cause of disability worldwide including in South Africa (SA). Burns (2010) and the WHO (n.d.) indicated that “over 30% of disability adjusted life years are attributed to mental disorder” (p. 1).

As previously noted, 9 out of 10 people living in LMICs have no access to mental health services and this is not dissimilar in SA despite SA being an upper middle-income country. The provision of mental health services in SA is sparse in deep rural areas.

According to the Mental Health Poverty Study Policy Brief (2008) and Bradshaw et al. (2007), mental illnesses and neuropsychiatric conditions ranked the third highest in contributing to the burden of disease in SA, while Williams et al. (2007) found that 16.5% of South Africans suffer from a mental disorder – a staggering 75–85% have not had the benefit of receiving treatment. Freeman (2013), the Department of Health's Chief Director for Non-

communicable Diseases, in his address to Parliament's Portfolio Committee on Health reported on the following:

- About three quarters of South Africans with a mental disorder are currently not receiving any treatment.
- 9% of all unnatural deaths in SA are due to suicide, a high *age when compared with the 27% of deaths as a result of road accidents.
- A shortage of clinical psychologists (with only 14% of registered psychologists practising in the public sector) and only 3 psychiatrists, 11 psychiatric nurses and about 4 social workers for every one million people [in the state mental health sector], means that the majority of people with mental health disorders will not receive treatment.
- The cost of treating persons is considerably less than the cost of mental illness going untreated.

Briefing parliament's select committee on social services the Department of Health's Chief Director of Non-communicable diseases, Prof. Melvyn Freeman reported that "In the first nationally representative survey of mental disorders in South Africa, lost earnings among adults with severe mental illness amounted to R28.8-billion [in 2002]" (Williams, 2013, p1). He added that "direct spending on adult mental healthcare was only about R470-million". The situation in South Africa is compounded by abject poverty and the serious lack of mental health resources. Lund et al. (2011) stated that "There is growing international evidence that mental ill health and poverty interact in a negative cycle. This cycle increases the risk of mental illness among people who live in poverty and increases the likelihood that those living with mental illness will drift into poverty" (p. 7).

Petersen and Lund (2011) cited the published systematic services research in Africa, conducted from 1967 to 1999, by Thoms (2000), stating that Thoms recommended the need to shift from centralised institutional care, which characterised apartheid South Africa, towards decentralised, integrated and community-based services provided within human rights framework. Thoms further added:

The use of trained non-specialists to provide healthcare was also suggested as a strategy to increase access in the context of the shortage in specialists. Research gaps identified included the need

for accurate epidemiological studies; intervention studies demonstrating the efficacy of sustainable models of service delivery in line with policy imperatives for deinstitutionalised and integrated primary healthcare; and economic evaluation studies of service delivery models. The latter included cost-effectiveness, cost-benefit and cost-utility analyses. Policies and legislation in post-apartheid South Africa have been consistent with the suggestions emanating from this in a bid to increase access and quality care within a human rights framework (p. 751).

Currently, the mental health system in South Africa, under the auspices of the National Department of Health (DOH), differentially decentralises resources, capacity and budget allocations resulting in serious disparities and fragmentation. Burns (2010) confirmed this by stating the following:

It is a sad reality that budget allocations to psychiatric hospitals over a 5-year period, range from 8–25% with a mean 5-year increase of 19% and a mean annual increase of 3.8% while the increase for general hospitals over the same period ranged from 29–54% with a mean annual increase of 10.2%” (p. 104).

This bleak budget outlook does not address the fact that large populations of persons with mental illness living in outlying communities remain without or receive limited mental health services. Budgets and services are decentralised to the nine provinces in South Africa with vastly varying degrees of provincial governance, capacity and or expertise to advise or implement appropriate and innovative community mental health services, leaving some provinces to be grossly under-funded or under-resourced, e.g., there is only one psychiatrist in Mpumalanga.

The National Minister of Health, Aaron Motsoaledi in a keynote address stated that “We know that there continues to be over-reliance on psychiatric hospitals as the model to care, treatment and rehabilitation” (DOH, National Mental Health Summit: 2012). He added that “South Africa has continued to follow the colonial, ‘hospi-centric’ approach and in doing so neglecting critical aspects of primary health care” (Ibid). He concurred with Thoms (2000) and challenged delegates:

To meet the need, we must increase the production and employment of other mental health professional categories. At the same time, we must ensure that mental health does not become the sole domain of dedicated mental health practitioners, but that mental health becomes integral to the training of all health professionals, especially those that work in primary health care services.

Mental health professionals are considered “scarce resource skills” in South Africa (Burns, 2010; Burns, 2011; Jack, Wagner, Petersen, Thom, Newton, Stein, Kahn, Tollman & Hofman, 2014; and National Mental Health Policy Framework and Strategic Plan, 2013–2014, 2013). This is confirmed by Petersen and Lund (2011) who noted that “63.9% of designated general hospitals in the province reported inadequate resources, including insufficient designated beds, specialist staff and seclusion rooms to deal with the demand and challenges of caring for disruptive patients” (p. 752). The lack of trained staff requires creative and innovative strategies if we are to close the treatment and service delivery gap. There is little collaboration with traditional structures – for many living with mental illness consulting traditional healers would be their first treatment preference.

Service user participation in policy planning and development is seldom considered. Patient-centred approaches in current Primary Health Care (PHC) ignore the principles of the Alma Ata Declaration 1978 that promote the full participation of patients in planning of mental health services. (WHO, 1978).

Shingange (2012), a mental health care user who presented the service users’ perspective at the National Mental Health Summit, said the following:

... people with mental illness were always considered as ‘useless.’ However, times had changed, thanks in part to new technology, and people with mental illnesses should no longer be bystanders to their personal journeys or allow other people to speak on their behalf... We have potential and can make a great contribution to the world. We believe in an Africa where all people are treated with dignity. We want to be listened to and fully participate in decisions concerning our lives ... No one can speak for us (DOH, National Mental Summit, 2012).

The DOH requires strategically focused interventions to upscale services at community level to reduce the burden of disease nationally. At present, the community outreach responses are limited, superficial, and needs to implement well-researched, best practice intervention options. Motsoaledi (2012) indicated that “We need to scale up investment in our community-based mental health services and reverse the trend of institutionalised care. We must examine how mental health can be integrated into general health care and particularly into primary health care” (p. 1).

For the latter to be realised, the South African government needs to align its budget allocations to appropriate levels of funding to give credence to the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) with the objective of upscaling mental health services. This will facilitate appropriate staffing, resources and implement cost-effective community-based intervention strategies. Motsoaledi (2012) further stated that “South Africa's mental health services are fragmented, unfairly distributed and inadequately resourced” (p. 1). He added that many challenges still prevail requiring intervention:

These include continuing high prevalence of mental disorders (linked to social determinants such as poverty, unemployment, violence, substance abuse and other adversities that increases the vulnerability of South Africans to mental disorders); high co-morbidity between mental and other diseases; a substantial gap between demand and supply of mental health services; inequity of services and mental health system weaknesses (DOH National Mental Health Policy Framework and Strategic Plan 2013–2020, 2013, p. 3).

At the World Congress of the World Federation for Mental health, themed “African Footprint in Global Mental Health”, held in October 2011 in Cape Town, delegates from across the globe issued a clarion call to urgently prioritise mental health services. The South African response to this call has been weak. The barriers operating in our health care system limit progressive and proactive care. The lack of governance and leadership, weak provincial management, inadequate comprehensive and equitable health resourcing and skilled health

workers are major challenges and factors impeding the right to appropriate mental health care (Versteeg & Couper, 2011; Burns, 2010; Mkhize & Kometsi, 2008).

2.2. South African Legislation and Policy Framework

Over the past few decades, many statutes have been passed concerning mental health care and human rights of persons with mental illness in South Africa. The RSA Mental Health Act, No. 18 of 1973, was repealed as the country entered its new democracy in 1994.

According to Mc Crea (2013):

Scholars and psychiatrists have noted that the Mental Health Act 18 of 1973 did not have an individual rights concern. Rather, its primary focus was on patient control and treatment, along with the “welfare and safety” of the society. The fact that this Act was propelled during the Apartheid era cements the view that the human rights of the patients were not necessarily the priority. Specifically, (i) the Mental Health Act 18 of 1973 has been criticized because it only required a reasonable degree of suspicion to be certified to a mental institution; (ii) individuals could be denied their freedom and placed in a mental facility based on prejudices and vendettas. In fact, finding someone mentally incapable was sometimes utilized solely for political means in the apartheid era. Freedom fighters were often silenced by being placed in a mental facility; (iii) once deemed mentally ill and certified, patients went without the assistance of the law, and could spend a considerable amount of time in the mental institutions against their will; and (iv) patients did not have a significant right of appeal or representation (p. 1).

The RSA Mental Health Act, No. 18 of 1973, facilitated and entrenched disproportionate and fragmented mental health care based on race, with blacks receiving the least care.

In effect, the Mental Health Act 18 of 1973 provisions did not promote personal autonomy, dignity or justice for individuals with mental illness. Instead, it highlighted a paternalistic principle which allowed mentally ill patients to be alienated, stigmatized and disempowered. It became apparent that the Mental Health Act (1973) needed to be reconsidered and changed (Mc Crea, 2013, p. 1).

The Constitution of the Republic of South Africa, No. 108 of 1996, is the cornerstone of democracy in South Africa. This Constitution safeguards the rights of all people in our country and affirms the democratic values of human dignity, equality, freedom and non-discrimination. The State must respect, protect, promote and fulfil the rights of individuals as

identified in the Bill of Rights. These fundamental constitutional principles and human rights values are therefore underpinned in the RSA Mental Health Care Act, No. 17 of 2002, which was promulgated to replace the flawed RSA Mental Health Care Act, No. 18 of 1973.

The RSA Mental Health Care Act, No. 17 of 2002, was a positive milestone in the development of mental health legislation in South Africa and a victory for persons living with mental illness. Despite this ground-breaking legislation and approval given by Ministers and Members of Executive Councils Meeting (MINMEC) in 1997, South Africa's National Mental Health Policy remained in draft form for a long time and other laws including the RSA Criminal Procedures Act, No. 51 of 1977 were not sufficiently amended to comply with the human rights protection given by the RSA Mental Health Care Act, No. 17 of 2002.

It is acknowledged that policy development is a slow process requiring the involvement of different role-players and actors, but such delays impact severely on actual implementation of treatment and the monitoring thereof. Furthermore, resource allocation and budgetary allocations are also stymied due to the sluggishness of the process. Thus, despite the growing body of research, summit meetings, consultations and several calls for reprioritising, mental health services, service users and NPOs have found themselves not only without a coherent national mental health policy but having to contend with major challenges in trying to implement policy.

Thoms (2004) stated that "It would appear that most people involved in the mental health services field are aware of, and grappling with obstacles to policy implementation. These obstacles are predominantly economic, resources-related and attitudinal" (p. 36).

In June 2013, the National Department of Health adopted the first National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) based on the feedback given at the Mental Health Summit and Ekurhuleni Declaration on Mental Health adopted in April 2012.

The adoption of a National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) was a commitment by the national government to guarantee the prioritisation of the national mental health implementation plan. It is the blueprint for equitable distribution of mental health financing across all provinces, human resources allocation and resources within a specific timeframe. Speedy resource allocation, implementation, monitoring and evaluation will be required to give credence to the plan. Omar, Green, Bird, Mirzoev, Flisher, Kigozi, Lund, Mwanza, and Ofori-Atta (2010) stated that:

Mental health policies signal a government's intent to address the mental health needs of its citizens. However, many countries either lack such a policy, or have non-operational, inappropriate policy. For example, 53% of African countries have a mental health policy, and many of these are outdated (p. 24).

The major challenge facing the implementation of the currently proposed National Health Insurance (NHI) plan is that the need for comprehensive mental health services at primary health care (PHC) level competes with the disease burden of HIV/AIDS, tuberculosis (TB), injuries and other non-communicable. This is evident in the NHI Green Paper in which mental illness, despite being the third highest burden of disease in South Africa, is grouped with non-communicable diseases in a manner that camouflages the seriousness of the prevalence of mental illness in South Africa:

Non-communicable diseases such as high blood pressure, diabetes, chronic heart disease, chronic lung diseases, cancer and mental illnesses contributed to 28% of the total burden of disease measured by disability adjusted life years in 2004. They are largely driven by three risk factors, namely smoking, poor diet, and lack of exercise (DOH, NHI, 2011, p. 8).

Even though mental illness is a non-communicable disease, it is essential that it is ring-fenced and categorised as a priority area, with clear policy and implementation strategies to reduce this particular burden of disease. The risk factors identified for non-communicable diseases do not encompass the complexity of factors that give rise to mental illness. The poor synchronisation of the National Mental Health Policy Framework and Strategic Plan 2013–

2020 (2013) and the NHI (2015) plans will further marginalise mental health services and compromise accessibility to much-needed treatment. The providers of mental health services would need to actively lobby so that treatment gaps can be addressed. Despite the issues raised about a “policy disconnect” between the National Mental Health Policy Framework and the NHI plan, mental health activists would need to focus on implementation of the positive aspects of the policy framework if they are to serve the needs of mentally ill persons in South Africa.

The quality of mental health care in South Africa varies greatly from district to district and province to province. Rigorous implementation of the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) and the NHI (2015) would need to be implemented if there is to be real commitment to addressing the mental health service delivery gaps in South Africa.

2.3. Medical and Social Model Approaches to Mental Health Care

Various models or approaches are used in the treatment of mental illness and form the basis for understanding “impairment”. Policy specialists within government devise strategies for treatment interventions that are guided by their preferred approach. Often these approaches limit creative and innovative actions for treatment outcomes. These models are valuable and beneficial for understanding and creating frameworks for mental disability interventions, often informed by research done by academics in the field of mental health. They also explain society’s attitudes towards people with disabilities. Although societal attitudes to mental illness have undergone some changes over the years, there is still much stigma attached to this disability compared to other forms of disability. The two most common approaches to disability are best defined within the medical and social models that are underpinned by particular philosophies, principles and values. The medical model views people with disabilities as being dependent and reliant on society, often receiving paternalistic responses

to care, with limited commitment to ensuring inclusion in society. The social model, on the other hand, focuses on inclusion, integration and empowerment, with strong human rights values embedded in the approach.

More specifically, the medical model of care is generally regarded as:

Viewing disability as a problem of the person, directly caused by disease, trauma, or other health condition which therefore requires sustained medical care provided in the form of individual treatment by professionals. In the medical model, management of the disability is aimed at a "cure," or the individual's adjustment and behavioral change that would lead to an "almost-cure" or effective cure. In the medical model, medical care is viewed as the main issue, and at the political level, the principal response is that of modifying or reforming healthcare policy ("Disabled World": 2010, p. 1).

The medical model is a traditional approach to the diagnosis and treatment of illness as practised by medical doctors in the Western world – this model is applied to general medical conditions and in the treatment of persons with psychiatric conditions. According to Sullivan, (2011):

In this model, also known as the individual model, the problems associated with disability are seen as lying solely within the individual and his or her medical condition or impairment. The desired solution to these problems is often the cure or rehabilitation of the individual, in order to fix the "defect" so that he or she can become closer to "normal" (p. 30).

Within this frame of reference, mental disorders are also attributed to physiological factors and should thus be treated as one would a physical disease. This medical model has underpinned most research in the field of disability in the past and the theories that emanate from such research have informed policies as well as treatment interventions. Such theories have also formed the basis for understanding both causation and remediation with regards to disabilities.

Under the medical model, disabled people are defined by their illness or medical condition. They are disempowered: medical diagnoses are used to regulate and control access to social benefits, housing, education, leisure and employment.

The medical model promotes the view of a disabled person as dependent and needing to be cured or cared for, and it justifies the way in which disabled people have been systematically excluded from society. The disabled person is the problem, not society. Control resides firmly with professionals; choices for the individual are limited to the options provided and approved by the 'helping' expert.

The medical model is sometimes known as the 'individual model' because it promotes the notion that it is the individual disabled person who must adapt to the way in which society is constructed and organised ("The Open University", 2006, p. 1).

The medical model is regarded within the disability movement as a model that often infringes on the rights of persons with disability. The causes of disability are believed to be as a result of impairments, defects or abnormalities related to disease. Within this approach, people with disabilities are regarded as incapable and rendered worthless rather than citizens who can participate equally within their homes, community and society (Brisenden, 1986; Disabled World, 2010; Sullivan, 2011).

Such an approach to disability suggests that persons with a disability have to adjust to their circumstances. These circumstances may be blatant violations of their human rights and may deter them from functioning at all. The medical model is thus perceived as being rather prescriptive in defining boundaries for functioning and prohibitive in allowing "agency" to the individuals with the disability. Thus the institutional and structural barriers are being reinforced by this medical model that entrenches attitudinal barriers resulting in stigma and unequal service delivery. Even though the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) favours a more integrated and progressive model of care that includes the primary health care and community-based care philosophy, the focus remains bio-medical (Mkhize & Kometsi, 2008). Whilst it is agreed that the treatment of mental illness does require "aspects of a medical approach," especially when one considers the use of psychotropic drugs and in certain cases elements of restraint to protect both the

individual and others, a combination of a medical model together with a social model is needed.

The social model of care in contrast to the medical model is a holistic approach and sees the individual as part of society with very specific needs. Persons with disability view the barriers that exist within society and the way in which society is organised as disabling factors that limit their full participation, inclusion and involvement. These barriers are considered as factors that discriminate against their right to self-determination and fulfilment.

Paley (2002) stated the following:

The **social model** of disability is a reaction to the dominant medical model of disability which in itself is a functional analysis of the body as machine to be fixed in order to conform to normative values. The social model of disability identifies systemic barriers, negative attitudes and exclusion by society (purposely or inadvertently) that mean society is the main contributory factor in disabling people. While physical, sensory, intellectual, or psychological variations, may cause individual functional limitation or impairments, these do not have to lead to disability unless society fails to take account of and include people regardless of their individual differences. The origins of the approach can be traced to the 1960s; the specific term emerged from the United Kingdom in the 1980s (p. 189).

However, according to Burns (2009):

The British medical sociologist, Michael Bury, adheres to what he calls a socio-medical model of disability in which he reaffirms the reality of impairment in contributing to disability. In addressing the “causality” of mental disability, I am inclined to agree with Bury. Research has largely discredited a strict social model view of the causality of serious mental disability associated with such conditions as schizophrenia and bipolar illness to instead support a significant role for genetic and other biological factors in conferring vulnerability to these conditions. Importantly, this integrated, or multifactorial, view of the genesis of mental disability does not support the traditional medical or individual model either. In other words, a critique of the social model does not imply a return to the strict medical model that it superseded. Instead, what is consistent with current evidence from both the biological and sociological fields of research is a model of mental disability that integrates biological and social (as well as cultural and political) factors in establishing cause for these conditions (p. 21–22).

The National Mental Health and Policy Framework and Strategic Plan 2013–2020 (2013) aims to integrate the philosophies of both these models into its service delivery pyramid of care by 2020.

Thus one could conclude that a comprehensive, integrated approach is needed. The following section will discuss some central theoretical approaches that constitute the conceptual underpinning of this study.

2.4. Theoretical Frameworks

The following theoretical frameworks underpin this research:

- Human Rights Theory
- Human Scale Development
- Empowerment Theory

2.4.1. Human Rights Theory

People with mental illness suffer some of the harshest forms of discrimination and stigma (Mkhize & Kometsi, 2008; Burns, 2009; WHO, 1996; WFMH, 2016). In many under-resourced LMICs they are exposed to some of the most inhumane forms of treatment and hospitalised in conditions unfit for any mental health recovery (Mkhize, 2007).

People with mental disability are often exposed to some of the harshest forms of human rights abuses. In some parts of South Africa, traditional beliefs still abound and people with mental illness are perceived to be “demon–possessed” and are consequently flogged and badly treated as a result. Recently 1 397 (one thousand three and ninety-seven) mentally ill patients were discharged from the Life Esidimeni facility, a subsidiary of the Life Healthcare group with public/private partnerships in South Africa, due to the termination of the funding contract by the Gauteng Department of Health. Of those discharged, more than one hundred patients lost their lives. These patients were discharged into the care of unregistered non-

government organisations (NGOs) who had no mental health knowledge or skilled personnel. Mental health service users lost their lives due to gross neglect, starvation and poor medical management and general care (Makgoba, 2017).

The WHO, citing Clarence and Rosenthal, (2004) indicated the following:

Much of the hardship experienced by people with mental disabilities, however, is caused by discrimination and the absence of legal protections against improper and abusive treatment. People with mental disabilities are often deprived of liberty for prolonged periods of time without legal process; subjected to peonage and forced labour in institutions; subjected to neglect in harsh institutional environments and deprived of basic health care; victimized by physical abuse and sexual exploitation; and exposed to cruel, inhuman or degrading treatment. People with mental disabilities are often denied opportunities to receive an education, to work, or to enjoy the benefits of public services or other accommodations. In many cases, the laws do not actively discriminate against people with mental disabilities, but they may place improper or unnecessary barriers or burdens on individuals with mental disabilities. In some countries, people with mental disabilities are subject to de jure discrimination – the arbitrary denial of rights that are afforded to all other citizens. Improper discrimination may also take place against people with no disability at all – if they are improperly viewed as having a mental disorder, or if they once experienced a mental disorder earlier in life. In a number of countries, there are no domestic laws that address the support, care or treatment of people with mental disabilities or that ensures people have an opportunity to participate fully in the community. Notwithstanding the absence of a specialized convention on the rights of people with mental or physical disabilities, there is in fact a growing body of international human rights law that requires governments to take action in these areas (p. 2).

It is a known fact that there is a lack of mental health care programmes and that mental health remains the “Cinderella” of health care provisioning. Thus one may question whether the South African government needs to be held accountable for its lack of mental health care provisioning to almost 75% of its population who are burdened with this disease in one form or the other. Does this not constitute a human rights violation? The lack of adequate care at community level certainly runs contrary to the Bill of Rights enshrined in the Constitution of the Republic of South Africa, No. 108 of 1996, and the United Nations Convention on the Rights of Persons with Disability (2006). Despite the fact that South Africa became a

signatory to the United Nations Convention on the Rights of Persons with Disabilities and its Optional Protocol in 2007 and committed itself to a radical new approach to ensure that persons with disabilities (including mental disorders) are afforded equal opportunities, many barriers still operate in the environment and limit the right to access proper health care, education, and employment.

Several international treaties and declarations protect the human rights and dignity of persons. The Universal Declaration of Human Rights (1949) was adopted by the United Nations General Assembly in 1948 after the Second World War in response to the atrocities committed to Jews and, in particular, people with disabilities in Germany. The Declaration became the foundation for all future human rights treaties and conventions, and became the benchmark for setting human rights standards across the globe. The Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993), adopted by the UN General Assembly, was among the major outcomes of the Decade of Disabled Persons in 1993. Although not a legally binding instrument, the Standard Rules represented a strong moral and political commitment by governments to take action to offer equal opportunities for persons with disabilities. The rules served as an instrument for policy-making and as a basis for technical and economic cooperation. The Standard Rules consists of 22 rules, summarising the message of the World Programme of Action. The Universal Declaration of Human Rights, UN Standard Rules on Disability, and the Constitution of the Republic of South Africa, No. 108 of 1996, became the foundation for the adoption of the National and Provincial Integrated Disability Strategy in South Africa in 1997. The rights of persons with mental illness are further protected in the United Convention on the Rights of Person with Disability. In aligning itself with such international human rights instruments and policies, the South African Government committed itself to removing discriminatory barriers that

prevent people with mental disabilities from full participation and integration in their communities.

According to Tarantola et al. (2009) human rights, health and development are reciprocal in nature and are interdependent sets of values, aspirations and disciplines. These authors note that there is “a strong causal link between human rights, health policies and programmes” (p.5). Thus governments have a duty to create the conditions necessary for good health. The response to the development of appropriate mental health care interventions has to be considered within a human rights framework. Mental health policies and service provision should therefore subscribe to universal goals that seek to attain physical, mental and social health for all. The core of the triangular interdependence framework of health, human rights and development proposed by Tarantola et al. (2009) is a rights-based approach that should uphold the principles of “indivisible and inter-relatedness of rights, non-discrimination, participation and accountability” (p. 16). According to Burns (2009):

Structural factors such as poverty, inequality, homelessness, and discrimination contribute to risk for mental disability and impact negatively on the course and outcome of such disability. A human rights based approach to mental disability means affirming the full personhood of those with mental disabilities by respecting their inherent dignity, their individual autonomy and independence and freedom to make their own choices (p. 1).

As alluded to earlier on, there is a link between human rights, health polices and development. The following section highlights the importance of considering the development needs of an individual.

2.4.2. Human Scale Development Theory

Human Scale Development recognises that people including those with mental illness are key actors and have fundamental human needs such as Subsistence, Protection, Affection (or love), Understanding, Participation, Idleness, Creation, Identity and Freedom that need to be satisfied (Max-Neef, Elizalde & Hopenhayn, 1991). This theory supports the values of

respect, personal autonomy and dignity as advocated by the human rights theorists (Burns, 2009; Tarantola, et al., 2009).

In applying Human Scale Development theory to the life situation of persons with mental illness, they become protagonists and central characters to determining and shaping their future. Human Scale Development creates a new praxis in development that is focused and “based on the satisfaction of fundamental human needs, on the generation of growing levels of self-reliance, and on the construction of organic articulations of people with nature and technology, of global processes with local activity, of the personal with the social, of planning with autonomy and of civil society” (Max-Neef, et al., 1991, p. 8). Within such a development framework individuals with mental illness are central to their recovery and have a significant role in articulating their needs, providing recommendations for interventions and being actively engaged planning. Thus there would be the ultimate transformation of the mentally ill person being viewed as an “object-person into a subject-person in the process of development” (Max-Neef, et al., 1991, p. 8).

Human Scale Development theory is cognisant of the fact that opportunities for active participation may be limited in complex hierarchically structured systems (especially for the mentally ill person) and that these could be structural, human rights and developmental barriers (Max-Neef, et al., 1991; Burns, 2009; Tarantola, et al., 2009).

Human Scale Development advances and promotes participatory democracy (Max-Neef, et al., 1991). This form of democracy can transform the traditional, semi-paternalistic and hierarchical structures of mental health care. Thus mental health users themselves gain a “voice” and are able to bring about change from the bottom up.

Human Scale Development provides a model that removes restrictive participation that ultimately limits access to fundamental constitutional rights of persons with mental illness.

The following theory complements human scale development and the human rights approach in that it focuses on the empowerment of the individual.

2.4.3. Empowerment Theory

Empowerment theories place the individual at the centre of any decision-making that impacts on their lives. At an individual level empowerment is a process by which individuals obtain control and some measure of independence over their lives, and a critical understanding of their environment (Berger & Neuhaus, 1977; Kieffer, 1984; Rappaport, 1984; Swift & Levin, 1987; Cornell Empowerment Group, 1989; Schulz & Israel, 1990; Zimmerman, 1990).

Theory also provides an understanding of the nature of power and powerlessness.

Zimmerman et al. (1992) noted the following:

The “intrapersonal component” refers to how people think about their ability and capacity to influence social and political systems important to them. It is a self-perception that includes domain-specific perceived control, self-efficacy, motivation to exert control, and perceived competence. It may also include perceptions about the difficulty associated with trying to exert control over community problems” (p. 708).

According to Zimmerman et al. (1992) being empowered also means having knowledge about resources to achieve one’s goals and includes the interactional components of problem-solving and decision-making capacities to influence the environment. The behavioural component refers to the specific actions the individual will take to influence the social and political environment through participation. All three components also form part of human scale development and underscore central values of the theories previously discussed. The intrapersonal capacity of persons with mental illness is often constrained by discrimination, bias and stigma that negatively affect self-esteem and the ability to interact with the necessary role-players to influence specific actions in complex hierarchical systems that impact on their lives. It is therefore clear that the psychological empowerment of persons with mental illness is critical to provide them with the necessary skills and capacity to participate in matters that

affect their lives. Interventions that foster empowerment of mental health users are important in addressing power imbalances in mental health care. It is essential that persons with mental illness do have a say in decision-making that impacts on their lives and that they are respectfully dealt with at all times. Much more work needs to be done with mental health professionals and service providers who are not always empowering in the way they provide treatment. At the same time mental health service users need to be made aware of their rights and be empowered in gaining access to the necessary resources that will make a difference to their lives.

Empowerment theory suggests that there is a process through which the individual identifies their goals and can be central to influencing the outcome.

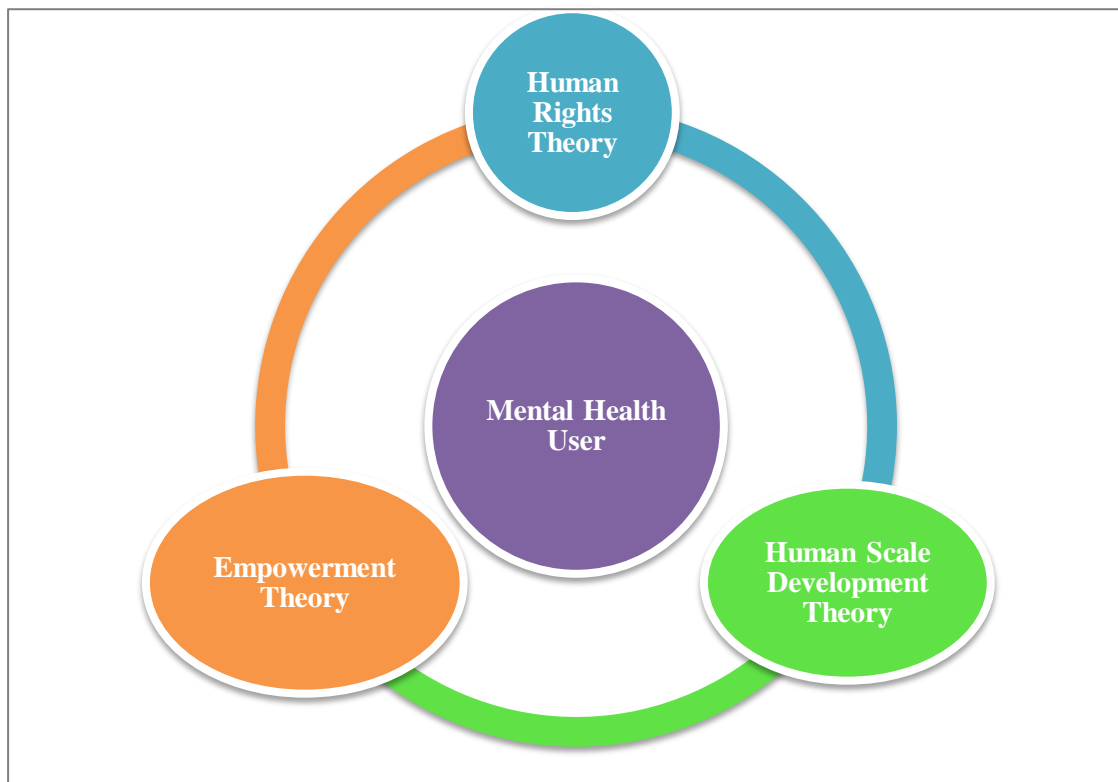
2.4.4. Convergence of Theories

It should become clear at this stage that human rights theory, human scale development and empowerment theory coalesce into a holistic theoretical framework that should inform policy makers as well as mental health professionals in the way they conceptualise their treatment plans and carry out their interventions. Whilst the rights of those with mental illnesses are enshrined in South Africa's Bill of Rights, they have not been translated into action on the ground. The fundamental human needs of the mental health service user are not being met in our South African context at many levels and mental health professionals and policy-makers may only be paying lip service to the notion of empowerment. Despite this clear understanding of theoretical discourses that impact on the mental health of persons, there is still a long way to actual implementation. The one theory that is not dependent on those in "power" to implement but is an actual resource that is owned by the "powerless" is resilience.

What a difference it would make if policies could be driven by a values-based framework that incorporates aspects of all these frameworks in an integrated manner – not just as a "progressive document" but as a statement of intent with action plans that translate into

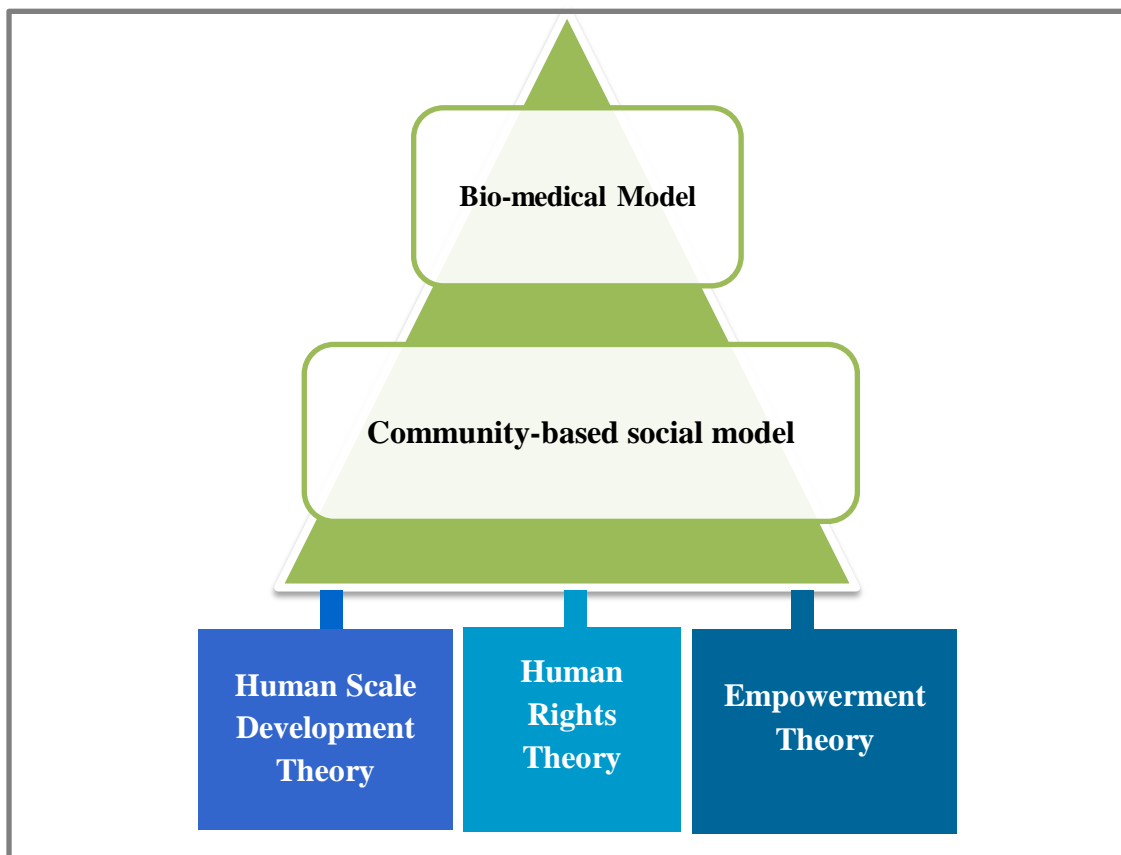
monitored interventions. Figure 1 diagrammatically places the mental health users at the centre of their own recovery, which is facilitated by interventions that are based on values that respect their rights, recognise and build on their resilience, enhance their development through addressing their fundamental human needs, and that provide scope for empowerment.

Figure 1: Convergence of Theoretical Frameworks



Integrating these values into a model for mental health care could go a long way in transforming mental health practice as well as making a difference in the lives of service users. The following diagram in Figure 2 (p. 49) illustrates the shift from a bio-medical to a social model that reconceptualises a new framework that rests on the convergence of the values of the theories that underpin this study and the proposed model for community-based mental health interventions.

Figure 2: Reconceptualised New Framework for Mental Health



2.5. Summary

This chapter focused on key themes, mental health legislation and policies in South Africa, medical and social approaches, and theories that underpin this study. The following chapter discusses the research methodology employed in this study.

CHAPTER THREE: METHODOLOGY

3.1. Introduction

This chapter discusses the research design and rationale for the research methodology, presents the research design flow chart, discusses the exploratory and descriptive nature of the research, outlines the processes adopted for the mixed methodology approaches [quantitative and qualitative methods], describes the population and sampling of both methods, data collection, data analyses, triangulation, data verification, ethical considerations, and potential limitations of this study.

3.2. Research Design

Babbie and Mouton (2002) provided a useful definition of research design, indicating that it is “a plan or blueprint of how you intend conducting the research” (p. 74). Creswell (2003) stated that “Research designs are plans and the procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis” (p.3). He added that “The selection of a research design is also based on the nature of the research problem or issue being addressed, the researchers' personal experiences, and the audiences for the study” (p. 3).

In this study, a mixed methods research design was chosen, using both quantitative and qualitative methods that are both descriptive and exploratory methodologies. This study furthermore adopted a quantitative dominant design that was supplemented by a secondary qualitative approach.

Thus data gathered using an online questionnaire [quantitative] was triangulated with data gathered from the focus groups [qualitative].

3.3. Rationale for a Mixed Methodology Approach

A combination of quantitative and qualitative research methods was chosen to provide a more complete and in-depth perspective of the problem (Creswell & Plano Clark, 2007; De Vos, Strydom, Fouché, & Delport, 2011; Creswell, 2014). De Vos et al. (2011) confirmed the value of this approach as follows:

Mixed method research provides the opportunity for greater assortment of divergent views and perspectives and makes researchers alert to the possibility that issues are more multi-faceted than they may have initially supposed. Mixed methods research eliminates different kinds of bias, explains the true nature of the phenomenon under investigation and improves various forms of validity or quality criteria (p. 436).

This mixed methods approach enabled the researcher to obtain both “hard data”, as well as “soft data”. An analysis of the survey findings provided descriptive statistical evidence of the current mental health position in South Africa from the perspective of mental health professionals in both public psychiatric facilities and the non-government sectors in all nine provinces in South Africa. An analysis of the focus groups’ data provided exploratory “thick descriptions”, insights and opinions based on the perceptions of the mental health beneficiaries that offered a holistic account of mental health deficits in South Africa.

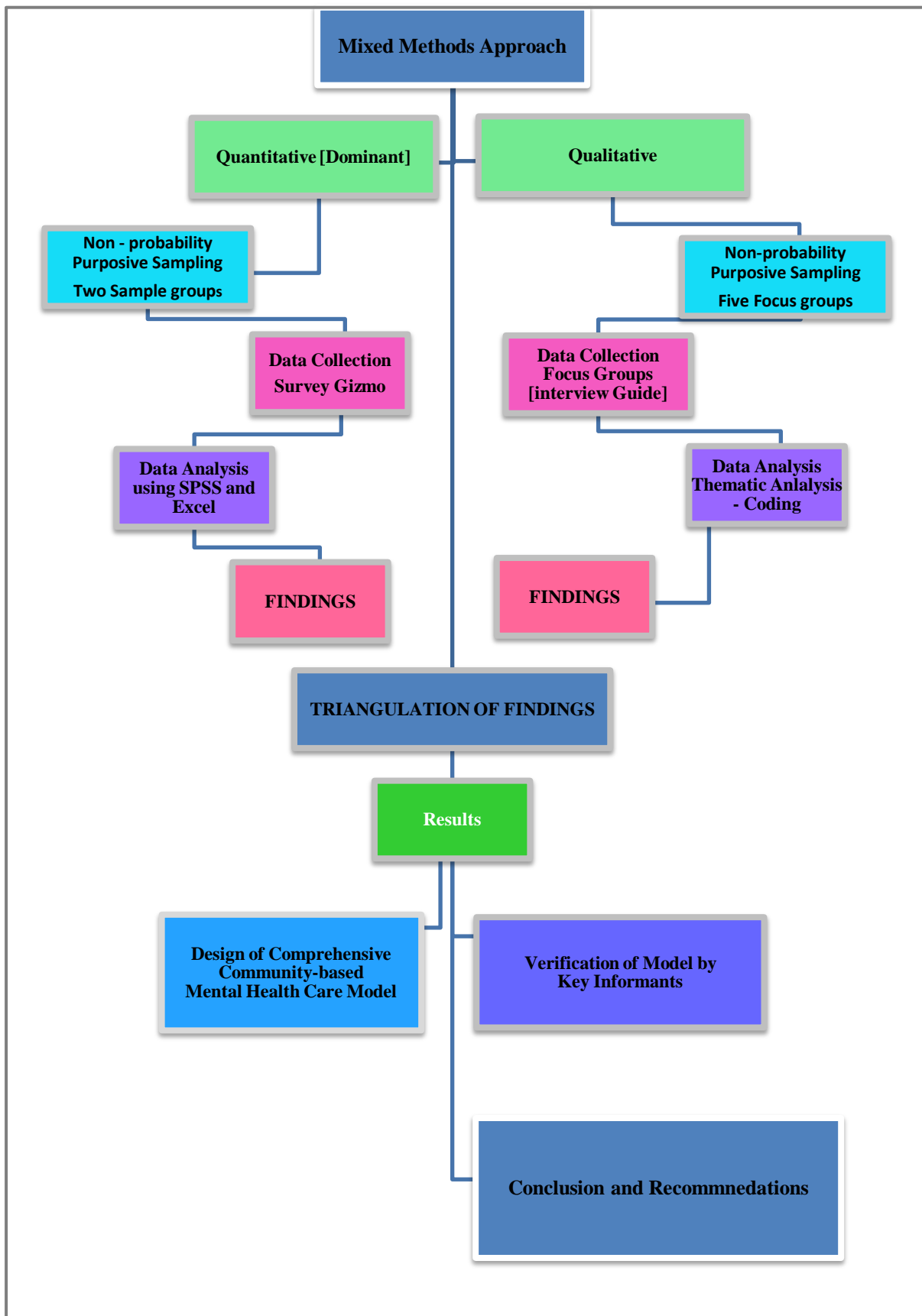
Thus the philosophical assumptions using the mixed methods were grounded in the worldview or epistemological paradigm that brings together post-positivism (quantitative method) and constructivism, advocacy/participatory and pragmatism (qualitative method), thus adding multiple methods and assumptions to the research. (Creswell, 2007).

The quantitative and qualitative methodologies were employed in a sequential manner. The survey was designed, administered and analysed before designing the qualitative component which included the interview schedule, data collection and analysis. This was done to reduce any potential conflicts and tensions between the two approaches, while simultaneously ensuring that the integrity of both approaches was maintained. The methodologies were initiated as two separate approaches rather than parallel processes to

ensure that the broad research questions were addressed by mental health professionals and mental health service users. The model for comprehensive and integrated community-based mental health services was designed based on the insights gleaned from data gained from this mixed methodology approach as well as best practice models in low-income, resource-poor countries such as Zimbabwe, Brazil, India and Ghana. Data gained from the key informants confirmed the need for such a model as well as its feasibility given the South African context.

The following research design flow chart illustrates the conceptualisation of the research plan.

Figure 3: Research Design Flow Chart



3.4. Population and Sampling for the Survey

The population from which the sample was selected for the survey were all mental health professionals at psychiatric facilities and social workers employed at non-profit organisations providing mental health services across the nine provinces in South Africa. Some judgement had to be exercised in the selection of these facilities in order to maximise the integrity of the data. Hence a non-probability sampling approach was used.

3.4.1. Non-probability Sampling for Survey Respondents

Probability sampling would have been the sampling strategy of choice, but the researcher placed great store on gaining a maximum response rate from respondents who were actively involved in the mental health care field and thus adopted a non-probability approach to sampling.

The non-probability purposive sampling method, also known as selective and or judgemental sampling, was employed. Etikan, Musa, and Alkassi (2016) defined purposive sampling as follows:

The purposive sampling technique, also called judgment sampling, is the deliberate choice of a participant due to the qualities the participant possesses. It is a non-random technique that does not need underlying theories or a set number of participants. Simply put, the researcher decides what needs to be known and sets out to find people who can and are willing to provide the information by virtue of knowledge or experience (p. 2).

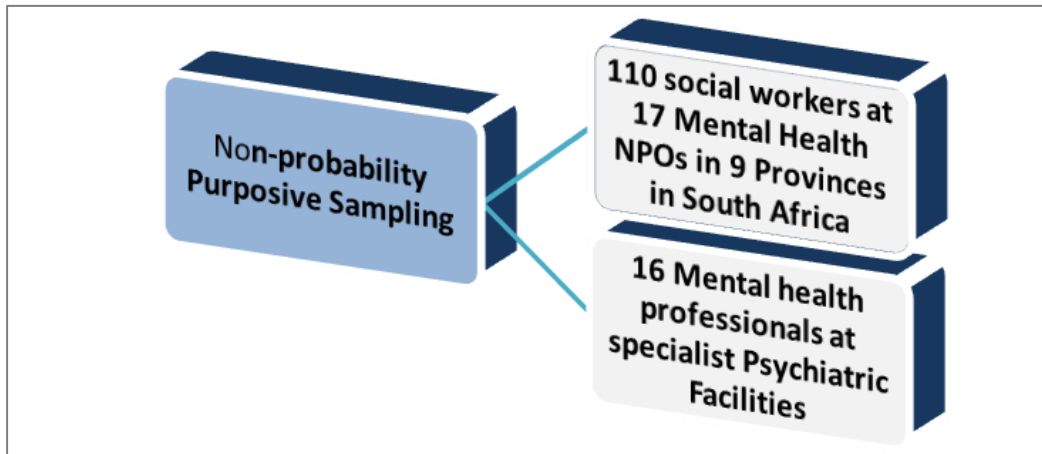
The following respondents in all nine provinces in South Africa were selected in the mental health sector in South Africa:

- Heads of social work departments, social workers, psychologists and psychiatrists at 16 specialist psychiatric hospitals in South Africa were selected from the 23 psychiatric hospitals.

- 110 social workers employed at 17 Mental Health NPOs affiliated to the South African Federation for Mental Health across nine provinces in South Africa.

The above is graphically represented in Figure 4.

Figure 4: Survey – Sample Groups

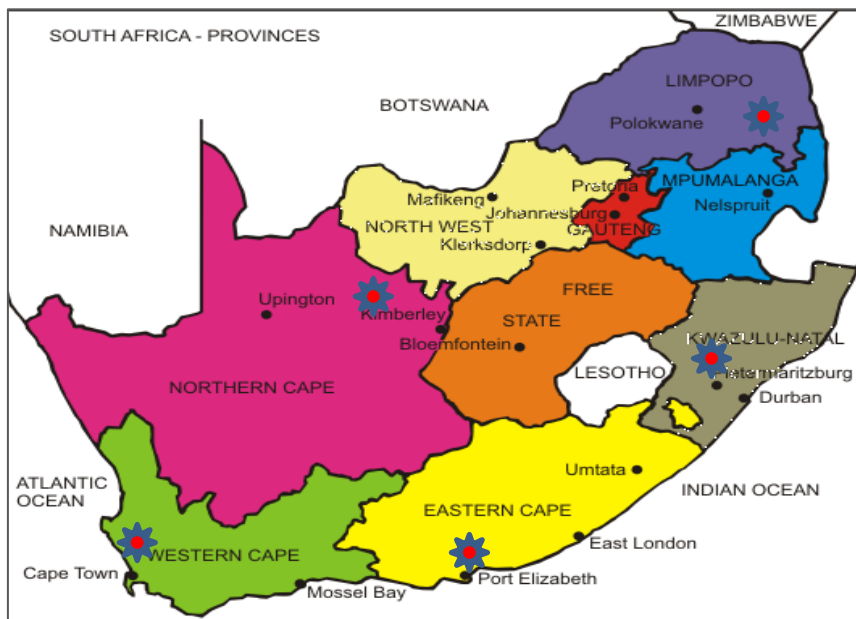


3.4.2. Population and Sampling for the Focus Groups

The population for the focus groups consisted of mental health service users across the nine provinces. Five provinces were purposively chosen to ensure representation from rural, peri-urban and urban areas as depicted in the map (Figure 5) and Table 1 (p. 57):

Figure 5: Map of South Africa

 = Five provinces selected.



(South Africa Map of Provinces Picture, n.d.)

Purposive sampling was employed to select 5 focus groups. These groups consisted of 6 to 11 mental health service users – a total of 40 adults with a positive diagnosis of mental illness in five provinces in South Africa. Service users who had had an admission within 6 months prior to the study and/or displayed active symptoms of mental illness were excluded.

Purposive sampling was used to ensure relative homogeneity in the composition of the focus groups' members with regards to their mental illness and their ability to convey their experiences of mental health care. During the sampling process often heterogeneity versus homogeneity had to be considered. Richie (2003) stated that “There needs to be a degree of commonality in how they relate to the research topic – something similar in their experience of it or their connection with it” (p. 190).

The focus groups were selected to represent service users living in urban, peri-urban and rural communities in South Africa as depicted in Table 1.

Table 1: Focus Group Sampling

Provinces where Focus Groups were held:	Mental Health NPO Service User Groups	Urban	Peri-Urban	Rural	Participant Numbers	Date
1 in Eastern Cape Province	Port Elizabeth Mental Health Society	✓	✓		6	16 March 2016
1 in Western Cape Province	Cape Mental Health	✓	✓		7	17 March 2016
1 in KwaZulu-Natal Province	Pietermaritzburg Mental Health Society	✓	✓	✓	11	06 April 2016
1 in Northern Cape Province	Northern Cape Mental Health Society	✓	✓	✓	6	08 April 2016
1 in Limpopo Province	Limpopo Mental Health Society			✓	10	21 April 2016

Attempts were made to include the service user representatives of the nine provincial advocacy group structures across South Africa who participated in the national advocacy group known as the South African Mental Health Service User Advocacy Movement (SAMHAM). Unfortunately, they convene their meetings annually in September of each year and could therefore not be included due to the research time frames. The service user group in the Western Cape was by far the largest and thus random sampling was used to achieve an appropriate sample.

3.4.3. Non-probability Purposive Sampling of Key Informants

Purposive sampling was used to select two key informants respectively from the Mental Health Review Board and National Mental Health Advisory Board who are knowledgeable about the mental health policy and mental health service delivery in South Africa, to ascertain whether the implementation of an alternative model for mental health care in South Africa would be feasible.

3.5. Data Collection

Data was gathered in three phases. Firstly, the quantitative data was gleaned from responses to the online questionnaire; secondly, qualitative data was gathered from the participants of the focus groups. Data from the survey and the focus groups were then triangulated. Thirdly, the feasibility of an alternative mental health care model was assessed through telephonic interviews with key informants.

Thus data was gathered from five major sources, namely psychiatric facilities, mental health non-government organisations (NGOs), focus groups, key informants, and literature review on alternative models of intervention.

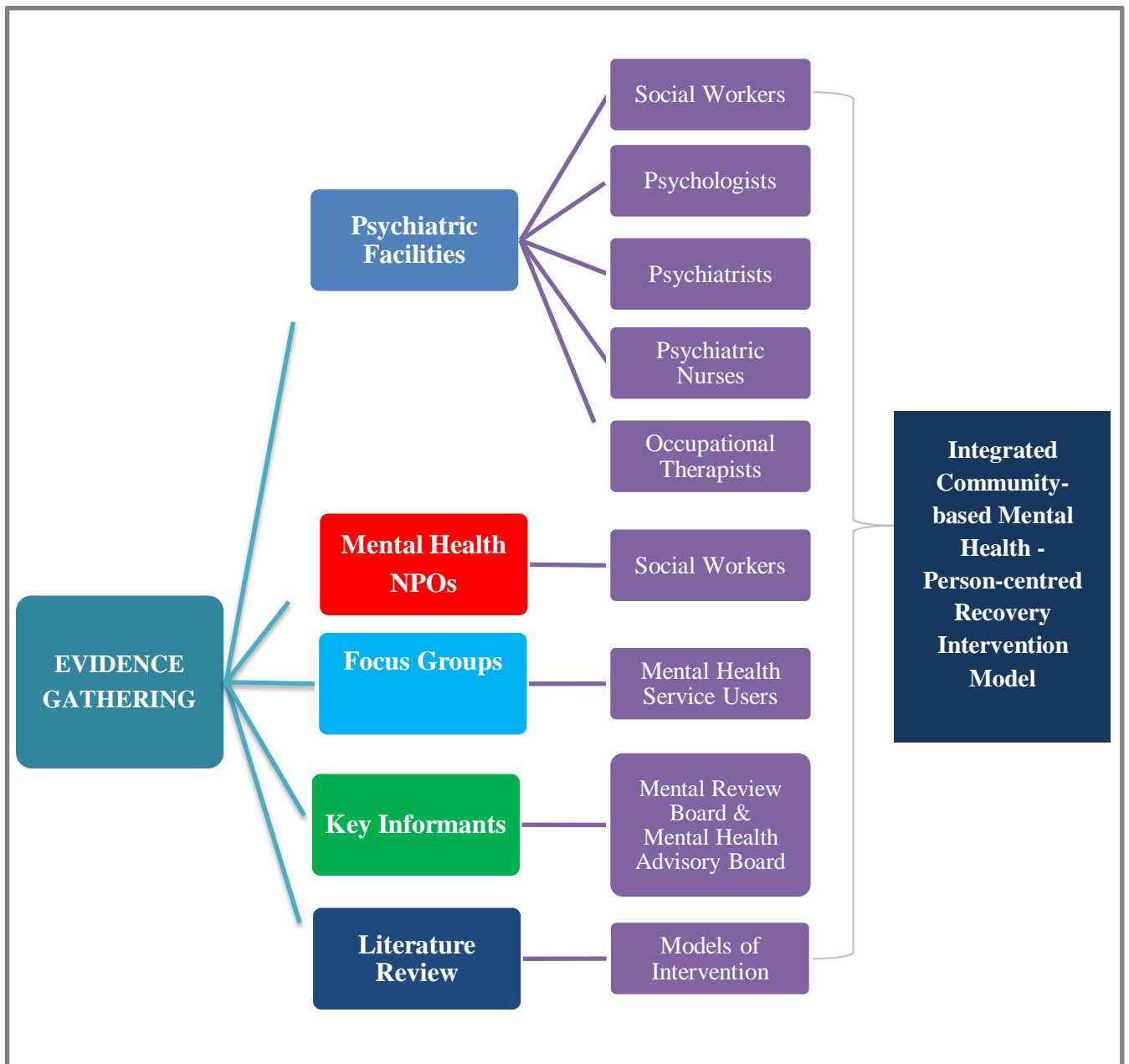
In designing the survey, the researcher gave careful consideration to the research questions. Some of the challenges that were experienced included ensuring that the questions were sufficiently clear, that there was no ambiguity, and that they were understood by the respondents; the choice of questions also had to be sufficiently comprehensive and provide a range of possible alternative responses to ensure that no bias was introduced. Even though the survey was comprehensive, the researcher had to take into account the length of the survey due to the time constraints of mental health professionals (Alford, 2011).

The interview schedule for the focus groups was designed after the completion of the survey data collection and data analysis. The researcher had to ensure that the ethical considerations and protective measures were strictly applied in designing the questions for mental health service users while at the same time ensuring that the open-ended questions would elicit their opinions and responses. Thus, in designing the interview schedule for the focus groups, the researcher was challenged to structure the questions clearly and logically, and to allow the participants time to deal with the more challenging questions at a later stage once trust had been developed in the group. The interview schedule with the key informants could only be administered after the design of the Model for Comprehensive and Integrated

Community-based Mental Health Services which had been forwarded in advance of the telephonic interviews. The researcher had to ensure that the questions were sufficiently open-ended to receive unbiased and honest responses.

The following diagram (Figure 6) presents this evidence-gathering process:

Figure 6: Data Collection – Evidence-Gathering Process



3.5.1. Data Collection Process

Data was collected via an online survey, focus groups, as well as through telephonic interviews.

3.5.1.1. *Quantitative Data Collection*

The online survey-questionnaire (Appendix A, pp. 274–287) was piloted with social workers at one of the non-profit mental health organisations to address issues of comprehension and ambiguity and was amended accordingly. The electronic questionnaire was presented in the Survey Gizmo format that was forwarded individually to 17 mental health NPOs and 16 psychiatric facilities respectively. The official request to participate in the research was emailed to the directors of the mental health non-profit organisations and the chief executive officer or head of the psychiatric facilities in all nine provinces. Background information and the objectives of the study including a hyperlink to the survey were inserted in the email with the option to request a copy of the proposal or to contact the researcher or supervisor. (See Appendices B, pp. 288–289, and C, pp. 290–291.)

The anonymity of the mental health professionals was safeguarded to ensure that individuals would respond without fearing reprisal, and to facilitate open and honest responses. Respondents could return to the questionnaire if interrupted, as the incomplete survey would be saved with simple prompts built into the survey. Weekly electronic targeted reminders were built into the software programme including telephone call reminders to enable a good response. The highest response rate was received in the first two weeks of the study.

In instances where access to computers was a barrier, self-administered hard-copy non-electronic surveys were completed to improve the response rate. Hard copies of the -

questionnaires were sent via courier services and responses were manually captured onto Survey Gizmo.

Survey Gizmo reports were regularly provided to update provincial response rates. Low response rates were indicated and corrective measures could be applied. This was seen particularly in the case of Gauteng and Mpumalanga provinces and enabled the researcher to enquire about their difficulties and challenges. It was clear that, in the case of Gauteng Mental Health Society, they had difficulty accessing computers, whilst in the case of Mpumalanga Mental Health Society the director had resigned and had not forwarded the email to the social workers.

The deadline was extended to increase the response rate and to accommodate Valkenberg Hospital, one of the major mental health facilities in the Western Cape.

The quantitative survey was used to assess the current state of mental health service delivery in South Africa by gathering mental health professionals' views and perceptions on six themes that are related to the study objectives, namely:

1. National Mental Health Policy Framework and Strategic Plan 2013–2020
2. Major barriers preventing expansion of community-based mental health services
3. Financial and human resource allocation in mental health
4. Bio-medical approach and integrated community-based model
5. Human rights and dignity of mental health service users.
6. Critical partnerships for multi-sectoral community-based mental health

The key focus areas guided the development of the proposed model for improving community-based mental health services.

Information gathered provided nationwide data on the state of mental health in South Africa. The study was endorsed by the South African Federation for Mental Health and the Department of Health, Western Cape Government: Health Research Sub-Directorate, Health Impact Assessment who formally approved the research. (See Appendix D, p. 292 and Appendix E, p. 293).

3.5.1.2. *Qualitative Data Collection*

The focus group interview schedule (See Appendix F, pp. 294–299) was used to obtain the perceptions of mental health service users about their experiences of mental health care in South Africa, barriers in resource allocation, current state of community-based interventions, attitudes of mental health professionals, and to elicit their recommendations to re-engineer and prioritise mental health services with the view to closing the mental health treatment gap.

Kitzsinger (1995) stated that “Focus groups are a form of group interview that capitalises on communication between research participants in order to generate data” (p. 299).

A focus interview guide consisting of semi-structured and open-ended exploratory questions was used in conducting the focus groups (See Appendix F, pp. 294–299). The focus group interview guide was tested and piloted on 11 September 2015 with six mental health service user participants who are all members of Fountain House South Africa.

The researcher’s general impressions after the pilot focus group were as follows:

- Fewer breaks were required than originally expected.
- Participants were spontaneous and very responsive.
- They valued speaking about their experiences, particularly about their hospitalisation. Some respondents noted that they had not spoken about this before.
- Feedback about mental health services at clinics and psychiatric hospitals was more positive than originally anticipated for this group.

Focus groups were conducted by the researcher, a qualified clinical social worker. The co-facilitator was a social worker employed by the mental health NPOs where the focus group was held. The co-facilitator also assisted with translation in the various focus groups where translations were required in Zulu, Sotho, Xhosa or Tswana. Interviews were recorded with permission granted by the participants. Co-facilitators arranged pre-focus group sessions with participants to complete the consent forms and ensure that they understood the purpose of the study as well as how ethical considerations would be applied.

Focus groups are less intrusive, less threatening and containing, particularly for people with mental illness. The individuals were more comfortable and confident to speak in the presence of their peers rather than be exposed to the pressure of individual interviews. The focus groups were chosen as the preferred method since they provide the opportunity for richer responses as participants build on one another's insights and also confirm or negate responses in a group context. Debriefing took place at the end of each focus group and participants were informed that they could have further counselling sessions if needed to deal with any issues that arose from these focus groups.

Telephonic interviews consisting of semi-structured questions (see Appendix G, pp. 300–307) were administered to the key informants from the Mental Health Review Board (Western Cape) and the National Ministerial Advisory Board respectively to assess the feasibility of an alternative mental health care model.

3.6. Data Analysis

3.6.1. Quantitative Data Analysis of the Survey

The Statistical Package for the Social Sciences (SPSS), Version 24 (IBM, 2016) and Microsoft Office Excel (2010) computer-assisted software were used to analyse more complex and advanced data. SPSS was utilised to assist with bivariate non-parametric tests.

Bivariate analysis using Pearson's Chi-square to test for independence between two categorical nominal variables was done. McHugh (2013) stated:

The Chi-square test of independence (also known as the Pearson Chi-square test, or simply the Chi-square) is one of the most useful statistics for testing hypotheses when the variables are nominal, as often happens in clinical research. Unlike most statistics, the Chi-square (χ^2) can provide information not only on the significance of any observed differences, but also provides detailed information on exactly which categories account for any differences found (p. 143).

Mc Hugh (2013) added the following:

Like all non-parametric statistics, the Chi-square is robust with respect to the distribution of the data. Specifically, it does not require equality of variances among the study groups or homoscedasticity in the data. It permits evaluation of both dichotomous independent variables, and of multiple group studies. Unlike many other non-parametric and some parametric statistics, the calculations needed to compute the Chi-square provide considerable information about how each of the groups performed in the study (p. 143).

Chi-square is a non-parametric measure that explores the relationship between two or more variables (Engel & Schutt, 2009; Mc Hugh, 2013). Coakley (1996) stated that "Nonparametric statistics may be viewed as the collection of statistical methods that either (i) do not relate to specific parameters (the broad definition) or (ii) maintain their distributional properties irrespective of the underlying distribution of the data (distribution-free methods)" (p. 1).

This descriptive test was performed in the central study categorical variables to assess the difference in positive and negative perceptions of mental health professionals, including the test for independence between two categorical variables. These frequency tests were performed to assess the perceptions of mental health professionals and their positive and negative responses to the following: Mental Health Policy, Major Barriers Preventing Expansion of Community-based Mental Health Services, Financial and Human Resource Allocations, Biomedical Approach and Feasibility of an Integrated Community-based Model, Human Rights and Dignity, and Critical Partnerships.

Data from SPSS, Version 24 (IMB, 2016) was exported to Microsoft Office Excel (2010) to convert various frequency variables into various bar charts, line graphs and tables. Microsoft Excel offers various methods to analyse and present data through pie, bar, column, squatter, line, area, bubble, doughnut, radar and other methods including the statistical overview.

3.6.2. Qualitative Data Analysis of the Focus Groups and the Key Informants

Data analysis consisted of all tape-recorded focus group interviews transcribed onto Audacity, a software recording programme, to facilitate the manual transcription of each group discussion. Once all the focus group interviews were transcribed, the data was consolidated into one transcript. Six main themes emerged from the data. These were colour coded and verbatim responses from participants were systematically placed into 38 sub-categories across these themes and placed in a consolidated spreadsheet. The latter resulted in the classification of the thematic codes aligned with the objectives and categories as represented in Table 2 (p. 66).

The responses of the key informants were also analysed thematically. However, this data was collected only after the triangulation of the survey and focus group and after a literature search had been done on alternative models of mental health care (See Chapter 6, pp. 215–242).

Table 2: Classification of Thematic Codes and Categories

THEMES	OBJECTIVES	CATEGORIES
1. Perceptions and attitudes of health professionals toward mental health and mental health service users	3.3.2.	1.1. Attitudes of Professional Staff 1.2. Involuntary Admissions – treatment by staff
2. Current state of mental health services in province	3.3.2. 3.3.3.	2.1. State of Mental Health Services 2.2. Long Waiting Periods 2.3. Staff Shortages 2.4. Long Distances to Clinics 2.5. Inadequate Infra-Structure and Poor Conditions 2.6. Involuntary Admissions – Fear of Other Patients 2.7. Separate Waiting Rooms in Clinics 2.8. Medication – Primary form of Treatment 2.9. Medication Stock Outs
3. Mental health and human rights	3.3.6.	3.1. Community Attitudes 3.2. Involuntary Admission Violations 3.3. Medication Access – Disempowerment 3.4. Sexual, Physical, and Emotional Abuse 3.5. Financial Exploitation 3.6. Diagnosis – Right to Information 3.7. Accommodation Discrimination 3.8. Employment Discrimination 3.9. Protection Against Abuses 3.10. Ineffective Mental Health Review Board
4. National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013)	3.3.1.	4.1. Policy Knowledge, and Awareness 4.2. Policy Disillusionment
5. Improving comprehensive community-based mental health services at a primary health care level	3.3.5. 3.3.7	5.1. Increase Mental Health Professionals 5.2. Mental Health Information/Education and Awareness 5.3. Service Users role in Psycho-education 5.4. Support Groups 5.5. Accommodation 5.6. Community-based Treatment Options 5.7. Infrastructure Upgrades/Improvements 5.8. Financial Resources and Skilled Management
6. A proposed model for strengthening comprehensive community-based mental health services. [Additional recommendations to the proposed model]	3.3.5. 3.3.7.	6.1. Community Health Workers 6.2. Mental Health Volunteers 6.3. Community Education 6.4. Alternative Therapies 6.5. Psycho-social Rehabilitation Support Groups 6.6. Family Support Groups 6.7. Village Mental Health Centre

The analysis of the focus group data included the examination of raw data through the transcripts; labelling/coding, categorising and tabulating the data. Tesch (1990) suggested the following steps while coding the data in qualitative research methods. These steps were adapted for this particular study as follows:

1. To get a sense of the whole the researcher read all the transcriptions carefully and wrote down some ideas as they came to mind.
2. The researcher picked one document (i.e., one focus group interview and went through it, asking, "What is this about?" The researcher had to also think about the underlying meaning and thereafter wrote comments in the margin.
3. After completing this task for several focus group interview sessions, a list of all themes or topics was made with a list of all the sub-topics or categories of these topics which were colour coded using a spreadsheet.
4. Themes and categories were revisited (coding) to develop an organising scheme or framework.
5. New categories (codes) emerged.
6. The most descriptive wording for the categories was found and grouped by reducing them together. Lines were drawn between categories and colour coding used to show interrelationships.
7. The classification of thematic codes and categories was finalised bearing in mind how this relates to the objectives of the study.
8. This organising scheme was used to write up the qualitative findings in a systematic way, critically comparing it with other studies done in this field.
9. For purposes of this study these qualitative findings were triangulated with the online survey findings.

3.6.3. Triangulation of Data

Flick, von Kardorff, and Steinke (2004) explained the triangulation metaphor as “triangulation as a cumulative validation of research results, and triangulation as an enlargement of perspectives that permit a fuller treatment, description and explanation of the subject areas” (p. 174). They further noted that:

Qualitative and quantitative research results may:

1. converge, that is, tend to agree;
2. constitute a complementary relationship, that is, reciprocally supplement each other; or
3. diverge, that is, contradict each other (p. 174).

Flick et al. (2004) added the following:

The linking of qualitative and quantitative methods may serve to illuminate different aspects of social phenomena being investigated. Using quantitative methods the meaning of social-structural factors of context can then be investigated, and qualitative methods may be used to study the way in which these contextual factors are interpreted by the actors. Unlike many quantitatively oriented methods (p. 176).

In this study the survey findings were part of the dominant data collection strategy. The mental health professionals responded to the survey. However the voices of the mental health service users were captured in the focus groups and the findings that emanated from this qualitative process “gave flesh” as it were to some of the survey findings. In some instances it confirmed or even contradicted the survey findings, thus allowing for a more nuanced data analysis strategy. Thus the overall research design was aligned with an “empowering perspective” that allowed mental health service users to give voice to their concerns about mental health care deficits as well as shape ideas about an alternative model of care.

3.7. Data Trustworthiness, Validity, Reliability

3.7.1. Trustworthiness of the qualitative data

With regards to qualitative data the “trustworthiness” of such data can be confirmed in various ways. According to Creswell (2009) the following eight strategies could be adopted:

1. Triangulate
2. Use member checking to determine the accuracy
3. Use rich, thick description to convey the findings.
4. Clarify the bias the researcher brings to the study.
5. Also present negative or discrepant information
6. Spend prolonged time in the field.
7. Use peer debriefing.
8. Use an external auditor (pp. 191–192).

The researcher tried to increase the trustworthiness of the qualitative data by specifically engaging in data triangulation. This was achieved by analysing the responses to the research questions from multiple perspectives including the responses from the focus group participants as well as those of the key informants. Triangulating the qualitative data

with the quantitative data further enhanced the overall trustworthiness. Member checking occurred within the actual focus groups where participants were able to corroborate and clarify responses. The narrative responses from the focus groups as well as the two key informants provided rich, thick descriptions which could be transcribed and thematically analysed. Supervisory guidance ensured that the coding of the raw data in the transcripts did not exclude negative or discrepant information. Since the researcher is a mental health professional, she brought a unique “insider perspective” to the study and was clear about her biases and the need to “bracket” her strong advocacy leanings in order to be open to contradictory views. She engaged in constant comparisons and review of data. Negative or discrepant information that ran counter to the dominant emergent themes were not excluded but presented in the data analysis. The researcher had had thirty years of extensive engagement in the mental health field prior to the actual study. Gathering the actual qualitative data for this research spanned only a year. Debriefing was also carried out within the focus groups for ethical considerations. The two thesis supervisors assisted with debriefing the researcher and also adopted the role of ‘external auditors’.

3.7.2. Reliability of the Quantitative Data

Heale and Twycross (2015) defined reliability in quantitative data as follows:

Reliability relates to the consistency of a measure. A participant completing an instrument meant to measure motivation should have approximately the same responses each time the test is completed. Although it is not possible to give an exact calculation of reliability, an estimate of reliability can be achieved through different measures (p. 66).

The three attributes of reliability (or accuracy of an instrument) are **homogeneity** (internal consistency), which is the extent to which all items on the scale measure one construct, **stability** (consistency of results using an instrument for test), and **equivalence** (consistency among responses of multiple users of the instrument). Reliability therefore assesses the extent to which a research instrument consistently has the same results if used

and repeated in a similar context (Heale & Twycross, 2015). Thus the quantitative research instrument, viz. the online questionnaire, was consistently applied with all mental health professional respondents at psychiatric facilities and mental health non-profit organisations (NPOs) to ensure homogeneity, stability and equivalence. However, the instrument was self-designed by the researcher and thus the research instrument was not measured or used in any other research. Consistency, replicability and degree of measurement error over time were therefore not tested. The three attributes of reliability were therefore not assessed outside of this study.

3.7.3. Validity of Quantitative Data

Heale and Twycross (2015) defined validity as follows: “Validity is the extent to which a concept is accurately measured in a quantitative study” (p. 66). Winter, G (2000) stated:

The traditional criteria for 'validity' find their roots in a positivist tradition, and to an extent, positivism has been defined by and bolstered along by a systematic theory of 'validity'. Within the positivist terminology, 'validity' resided amongst, and was the result and culmination of other empirical conceptions: universal laws, evidence, objectivity, truth, actuality, deduction, reason, fact and mathematical data to name just a few (p. 9)

Heale and Twycross (2015) further identified three major types of validity in quantitative data as follows: **context validity** (the extent to which a research instrument accurately measures all aspects of a construct), **construct validity** (the extent to which a research instrument measures the intended construct), and **criterion validity** (the extent to which a research instrument is related to other instruments that measure the same variables) (p. 66).

In this study measures have been applied to ensure that the online survey questions results or scores created the opportunity to deduce, assess, infer and draw conclusions. The researcher was able to ensure that efficacy of the survey questions or tool tested the mental

health professionals' knowledge of mental health care in South Africa from which inferences could be derived.

3.8. Ethics Considerations

The researcher is registered with the South Africa Council for Social Service Professions and is therefore bound by the ethical code governing social workers. Social work ethics and practice require clients' and community interest to be safeguarded at all times. The researcher will ensure that the principles of respect, justice and beneficence are applied to all participants in this study. The National Association for Social Work (NASW) Code of Ethics (2008) stated that "Social workers engaged in evaluation or research should protect participants from unwarranted physical or mental distress, harm, danger, or deprivation". The University of Cape Town's Research Ethics Code for Research Involving Human Participants aims to promote high quality research excellence in the interests of South African society and the human condition as a whole. It requires students and academics to fulfil research with:

Scholarly integrity and excellence
Social sensitivity and responsibility
Respect for the dignity and self-esteem of the individual and for basic human rights
Reference to clearly specified standards of conduct and procedures ensuring proper accountability (University of Cape Town, 2013).

Key attempts to address some of the ethical issues that were considered in this study are as follows:

No harm, No Coercion – Voluntariness

- "Do no harm" guided the way in which this research was conducted. This principle was applied to mental health professionals as well as mental health service users.
- No service user was coerced to participate in the study. Service users participated of their own free will.
- Every identified participant had the right to refuse participation.

Equity

- Mental health professionals and service users' informed consent to participate in the research was sought and obtained in writing. (See Appendix A, pp. 274–287, Appendix G, pp. 300–307, and Appendix H, p. 308.)
- In the case where service user participants were illiterate, recorded verbal consent or fingerprints were obtained.
- Particular steps were taken to ensure that service users comprehended the questions.
- Interpretation was used where English was not understood.
- Mental health professionals and service users had the right to withdraw from the study at any time without penalty of any kind.
- Service users with active or florid symptoms of psychosis or who had been hospitalised within the past 6 months were excluded from the study.

Protective measures

- Every effort was made to protect this cohort of service users and appropriate steps would have been taken if the need arose to withdraw a participant from the study.
- The focus group method was specifically chosen for the cohort of mental health services users since they feel more at ease in a group setting.
- Every measure was taken to ensure that participants were mentally able to participate, were medication compliant, and had been functioning optimally for the previous 6 months.
- Co-facilitation enabled greater tracking and containment.
- Reasonable accommodation measures were applied to the cohort of service users to ensure sufficient breaks during the focus group interviews to guard against mental fatigue and additional mental stress.

- No intrusive questions pertaining to mental state, family history, predisposing factors for the diagnosis and/ or any personal information were required or probed.
- The questions focused on their lived experience as recipients of mental health services.
- Any service user participant who, during the study, identified a need for ongoing supportive services would be referred accordingly.

Transparency

- Findings and recommendations will be shared with communities and participants without censorship. However, no identifying details of focus group participants or the personal details of the survey respondents will be disclosed.
- No false promises will be made regarding the recommendations pertaining to the intervention strategies.

Privacy and Confidentiality

- The selection of focus group co-facilitators were social workers employed at the mental health NPOs and they were made aware of the ethics relating to this research especially with respect to confidentiality.
- All focus group data will be securely stored and accessible only to the researcher and supervisors.
- The participants were made aware of respecting the privacy /confidentiality of others in the group and the venues were carefully selected.

Anonymity

- Aliases were used to ensure anonymity of service user participants in the focus groups and key informants whereas mental health professionals were not required to identify themselves.

Dissemination

- The findings of this research will be submitted to the South African Federation for Mental Health, the Departments of Health and Social Development, relevant Portfolio Committees and other relevant stakeholders. The document will be written in a fair unbiased way. However, the above ethical considerations will be taken into account.
- The researcher will take into account the university's ethical requirements pertaining to the following: social values, scientific merit, respect for persons, privacy and confidentiality, fair subject and community selection, fair balance of benefit and harms, collaborative partnerships; particular emphasis will be placed on sensitivity towards the vulnerable group with mental illness. Ethical approval was obtained from the Department of Social Development, University of Cape Town. (See Appendix I, p. 309)

3.9. Limitations of the Study

- The quantitative survey: A shortcoming in the quantitative component of this study has been the non-probability sampling strategy adopted in selecting the respondents for the survey. The researcher opted for this approach, given the fact that she wanted to cover professionals from all nine provinces in the most feasible way. The quantitative online questionnaire was sent via the mental health non-profit organisations' directors and chief executive officers or head of psychiatric facilities, which meant that there were limitations in following up directly with mental health professionals. The researcher was therefore dependant on the goodwill of senior management to forward the survey.
- The completion of the electronic surveys was dependent on having access to computers, internet and emails, which was the case with most of the facilities that

were targeted. Nevertheless the response rate was surprisingly high. Alternative remedial options were the provision of self-administered hard-copy questionnaires. The data was then later captured and uploaded onto Survey Gizmo.

- Basic descriptive and bivariate analysis was done on the survey data that for purposes of this study could be deemed sufficient.
- Whilst this study cannot be generalised in the statistical sense of the word, the fact that there was widespread representation (albeit purposive/judgemental sampling) across all provinces suggests that these triangulated findings have some integrity.
- Whilst mental health intervention options for LMICs were investigated through the literature reviews as well as telephonic interviews with key informants, no cost analysis was done to ascertain the financial feasibility of an alternative mental health care model.

3.10. Summary

A mixed methodology approach was adopted that included quantitative data (dominant) and qualitative data completed in two separate phases and thereafter triangulated. Furthermore, a literature review was conducted on alternative models of mental health care and key informants were asked to give their perspectives on this alternative model. The research tools consisted of a survey designed to be uploaded and used electronically, as well as two semi-structured interview schedules (one for the focus groups and one for the key informants' telephonic interview). Data was analysed appropriately for both the quantitative and the qualitative components and the issues of trustworthiness, reliability and validity were addressed. The ethics of this study were duly considered and some limitations were discussed.

The following chapter presents and discusses the findings.

CHAPTER FOUR: PRESENTATION AND DISCUSSION OF FINDINGS

4.1. Introduction

This chapter presents the findings from the survey and the focus groups. The quantitative data collected from the survey respondents included mental health professionals at mental health non-profit organisations and State psychiatric facilities across all nine provinces in South Africa, and the qualitative data was gained from five focus group sessions with mental health service users who had a positive diagnosis of mental illness.

For the quantitative data, non-parametric statistical analysis was used to examine the relationships between categorical variables by administering Pearson's Chi-square – Bivariate Analysis. The presentation of the data focused on the comparison and triangulation of findings derived from both the quantitative and qualitative data. Thus, the quantitative findings are presented using appropriate graphs, charts, tables and other numerical illustrations, whilst the qualitative data presented uses actual participants' quotations.

This chapter will firstly provide a descriptive analysis of the socio-demographic characteristic of various categories of mental health professionals who responded to the survey, including an overview of the participants in the focus groups. Secondly, these findings will then be presented according to the six themes related to the study objectives, detailing the quantitative and qualitative responses of mental health professionals across all nine provinces and mental health service users as follows:

1. National Mental Health Policy Framework and Strategic Plan 2013–2020.
2. Major barriers preventing expansion of community-based mental health services.
3. Financial and human resource allocation in mental health.
4. Bio-medical approach and integrated community-based model.
5. Human rights and dignity of mental health service users.
6. Critical partnerships for multi-sectoral community-based mental health.

4.2. Socio-demographic Information

This section provides the socio-demographic information of participants in the survey and the focus groups as illustrated in Table 4.

Table 3: Socio-demographic Information of Participants

Sample Characteristic	Frequency (<i>n</i>)	Percentage (%)
Mental Health Professionals		
MHS/NPO	90	82.6
Psychiatric Facilities	19	17.4
Indication of profession		
Nurse	1	.9
Occupational Therapist	2	1.8
Psychiatrist	6	5.5
Psychologist	1	.9
Social Worker	90	82.6
Other	9	8.3
Geographic Location		
Rural	9	8.2
Urban	90	82.6
Peri-Urban	10	9.2

At the time of commencing the study there were 110 social workers across the 17 mental health non-profit organisations, affiliated to the South African Federation for Mental Health, operating across all nine provinces in South Africa. It was anticipated that all 110 social workers would respond; however, 82.6% ($n=90$) social work participants at the mental health non-profit organisations responded. Vacancies and those on leave during the period of the research at the mental health non-profit organisations were not taken into account and could therefore account for the lower than anticipated response.

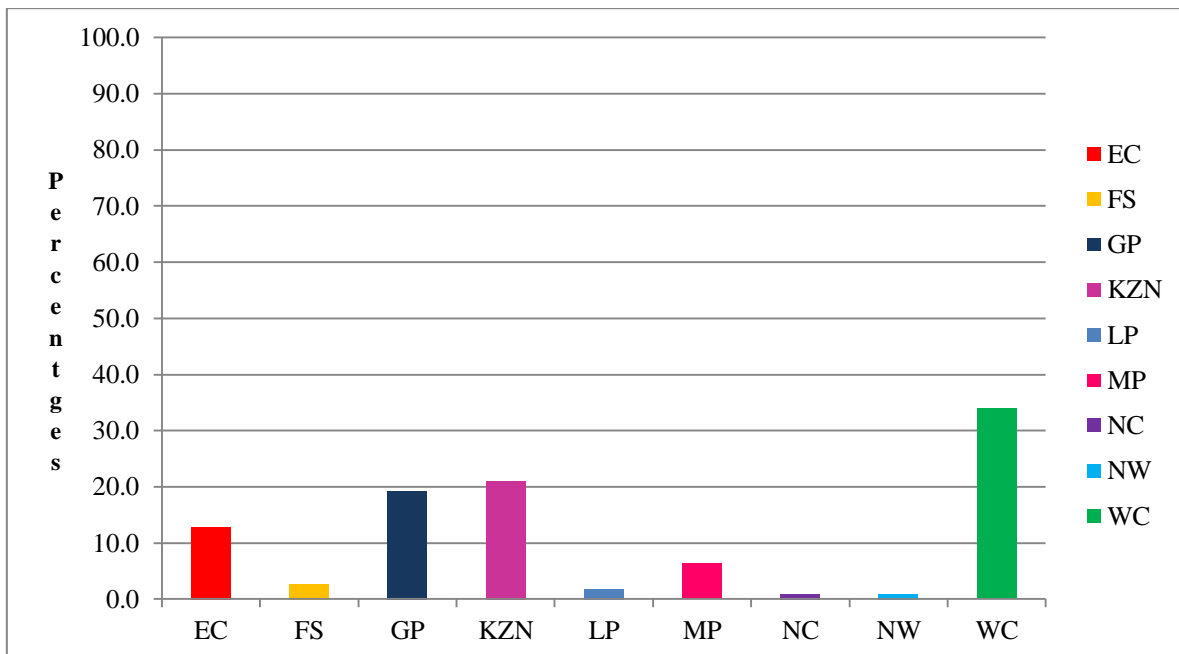
Twenty-three State psychiatric facilities were also identified to participate in the study. Only 16 of the 23 State psychiatric facilities were included in the research after the verification and filtering process, since the others were rehabilitation facilities or care centres. The researcher had envisaged that a minimum of at least four mental health professionals at each of the 16 psychiatric hospitals would respond, as this would result in a total response

rate of 64 mental health professionals. However, due to workload and other constraints, only 17.4% ($n=19$) participants responded as identified in Table 3 (p. 77).

All respondents ($n=109$) who participated in the survey indicated that they had participated voluntarily and understood the ethical implications of the study. The survey yielded a response rate of 63.2%, which is significantly higher for electronic surveys.

The mental health professionals who responded included nurses, occupational therapists, psychiatrists, psychologists, social workers and other professionals such as social auxiliary workers, life coaches and facilitators, as illustrated in Table 3 (p. 77). The majority of respondents were social workers (82.6%, $n=90$) mainly from mental health non-profit organisations, whereas the second largest group of respondents was obtained from the category other (8.3%, $n=9$) followed by psychiatrists (5.5%, $n=6$). The lowest response rate was received from psychologists and nurses (0.9%, $n=1$) respectively.

Figure 7: Provincial Response -- Mental Health Professionals



As illustrated in Figure 7, the largest response from the survey came from the Western Cape Province, namely 33.9% ($n=37$) respondents. This could largely be attributed to the fact that

the largest mental health non-profit organisation and three psychiatric hospitals are based in the Cape Peninsula area. The South African Stress and Health Survey (a 12-month and lifetime prevalence of common mental disorders, the first large-scale population-based study of common mental disorders in the country) found that “Significant differences in lifetime prevalence of mental disorders occurred across the nine provinces, with the Western Cape having the highest rate at 42% and the Northern Cape the lowest at 29%” (Herman, Stein, Seedat, Heeringa, Moomal, & Williams, 2009, p. 340). This could therefore also account for the larger concentration of mental health facilities in the Western Cape.

The second largest response was from KwaZulu-Natal (21.1%, $n=23$), followed by the Gauteng (19.3%, $n=21$) and the Eastern Cape (12.8%, $n=14$). The lowest response came from the Northern Cape (1%, $n=1$) and North West (1%, $n=1$), followed by Limpopo Province (1.8%, $n=2$). This could be attributed to very few social workers being employed at these three mental health non-profit organisations in these provinces.

Geographic distribution of responses received and location of services reflected that the largest concentration of mental health services was located in urban areas (82.6%, $n=90$), followed by peri-urban communities (10%, $n=9.2$), with the lowest concentration being in rural areas (9%, $n=8.2$).

This data confirms that the lowest concentration of mental health services is located in rural communities and peri-urban communities in South Africa. A recent report noted that “Services have been centralised in tertiary hospitals in the main cities of South Africa, while most people living with mental health-related issues in smaller towns and rural settings are confronted with unsupportive and inadequate desert-like mental health care services” (The Rural Mental Health Campaign Report – A call to action, 2015, p. iv). Burns (2011) confirmed this by stating that there is “limited availability of mental health services leaving large rural regions of the country without such services. For example, of the 32 psychiatrists

working in the public health sector in KwaZulu-Natal Province, only 6 are located outside of the major cities” (pp. 105–106). It further supports the finding that 75% of people living with mental illnesses have no or little access to mental health services (Williams, Herman, Stein, Heeringa, Jackson, & Moomal, 2008, pp. 211–220).

Statistics South Africa’s Mid-year report (2015, p. 1) estimated South Africa to have a population of 54.96 million persons. Almost fifty percent of South Africans live in poverty, while two-thirds of those living in poverty are found in rural communities where mental health services are sparse. Statistics South Africa’s Poverty Trends in South Africa: An examination of Absolute Poverty between 2006 and 2011 noted that 45.5% of South African’s lived in poverty (2014, p. 12). The report further highlighted that “In 2011, more than two-thirds (68,8%) of rural dwellers were still living in poverty as compared with less than a third (30,9%) of residents in urban areas” (Statistic South Africa, 2015, p. 33).

There is a strong link between mental illness and poverty. Lund (2012) stated that “poverty is strongly associated with mental illness in a vicious cycle that affects millions of people throughout their life course. The social conditions of poverty increase the risk of mental illness and, conversely, people living with mental illness are more likely to drift into, or remain in, poverty as a result of their disability and the associated stigma” (p. 1).

Focus group interviews were held after the completion of data collection and analysis of the electronic surveys. The perceptions of mental health service users were compared with those of the mental health professionals. The focus groups were held in five provinces in South Africa, namely Western Cape (WC), Eastern Cape (EC), Northern Cape (NC), KwaZulu-Natal (KZN) and Limpopo (LP) Provinces. Focus group interviews were held from 16 March to 21 April 2016 and a total number of 40 mental health service users participated as depicted in Table 4 (p. 81).

Table 4: Focus Group Response Rate

Provinces	Eastern Cape	Western Cape	KwaZulu-Natal	Northern Cape	Limpopo	Total
No. of Participants	6	7	11	6	10	40

4.3. Descriptive Findings

For the purpose of analysis, participant responses in each of the sections indicating “agree” is a combination of “strongly agree” and “agree”, and likewise where stated “disagree” is a combination of those who “disagree” and “strongly disagree”.

4.3.1. Perceptions of Mental Health Policy and Legislative Limitations

This section presents the findings related to perceptions of the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013), knowledge, experiences and opinions; Provincial Department of Health response to policy; policy relevance; implementation competence; capacity to implement the policy; the integration of mental health in National Health Insurance; role-players' participation in policy implementation; service user role in policy and legislation and finally, institutional capacity to implement this policy.

4.3.1.1. Perceptions of Mental Health Policy Knowledge, Experiences and Opinions

This section assessed the mental health professionals and service users' knowledge, experiences, opinions and perceptions of the mental health policy.

Figure 8: Mental Health Professionals’ Knowledge of the Policy

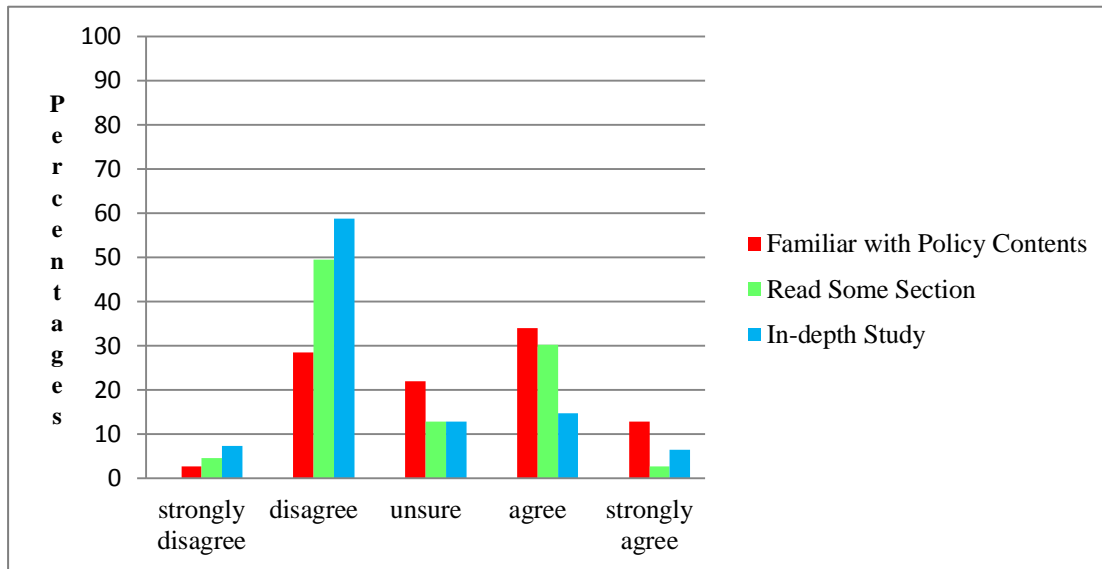


Figure 8 depicts mental health professionals’ knowledge of the mental health policy and highlights that 46.7% ($n=51$) of mental health professionals agreed that they were familiar with the contents of the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) (MHPF&SP), whereas 54.1% ($n=59$) agreed that they had read only some sections of the Policy. Only 21.1% ($n=23$) of respondents had done an in–depth study of the policy. These findings are disconcerting since this is the first official mental health policy in South Africa, and only a minority (21.1%, $n=23$) of respondents were conversant with it whilst the majority of mental health professionals (54.1%, $n=60$) had read only some sections.

Focus group participants related the following:

I never read it, but I heard about it through Cape Consumer Advocacy Body (*WC Service-user, MC, March 2016*).

No, we have not heard about the policy (*WC Group response, March 2016*).

Yes, I have seen it. No, I have not read it (*NC Service-user JVZ, April 2016*).

No [I have not seen it.] Most people [NC] are not familiar with the policy (*NC Service-user, April 2016*).

Service users in KwaZulu-Natal and Limpopo confirmed that they had not heard of the policy at all.

This policy had been widely influenced by a comprehensive provincial consultative process. This process had included both services users and professionals, and culminated in the first National Mental Health Summit held in 2012. This Policy Framework and Strategic Plan sets out clear objectives, deliverables and timeframes for implementation so as to measure the implementation progress.

4.3.1.2. Perceptions of the Policy Relevance

Mental health professionals' and service users' perceptions of the relevance of the policy and its appropriateness are depicted in Figure 9.

Figure 9: Assessment and Appropriateness of Policy

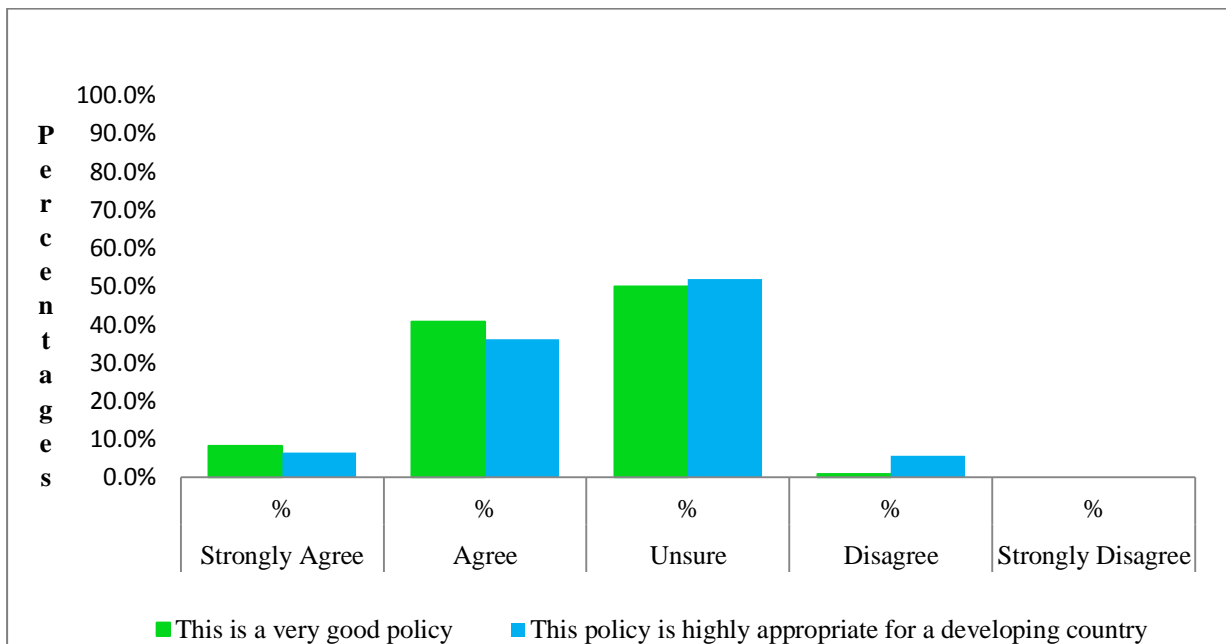


Figure 9 highlights that 49% ($n=53$) of the mental health professionals agreed that the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) was a very good policy. However, what is concerning is that 50% ($n=55$) were unsure. A similar response was noted with regards to their assessment as to whether this policy was

appropriate. Forty-three percent (42.6%, $n=46$) of respondents agreed that the policy was highly appropriate for a developing country, whilst at least 51.9% ($n=57$) of respondents indicated that they were unsure. A focus group participant appraised the policy as:

A strategic long-term plan between stakeholders and government as to where we want to go and to make a plan for us. There is a lot of meat in it and there is also a lot of stuff in that is really not being done (*EC Service user, RS, March 2016*).

This trend appears to indicate that mental health professionals were not sufficiently familiar with the contents of the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) and this could therefore have implications for the manner in which mental health care is implemented. Furthermore, their perceptions about the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) would be influenced by their limited knowledge of the policy.

4.3.1.3. Perceptions of the Provincial Policy Implementation Competence

Figure 10 (p. 85) relates to the respondents' perceptions of the competence of the Provincial Department of Health (DOH) to implement the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013).

Figure 10: Perceptions about the Provincial Department of Health Response to Policy

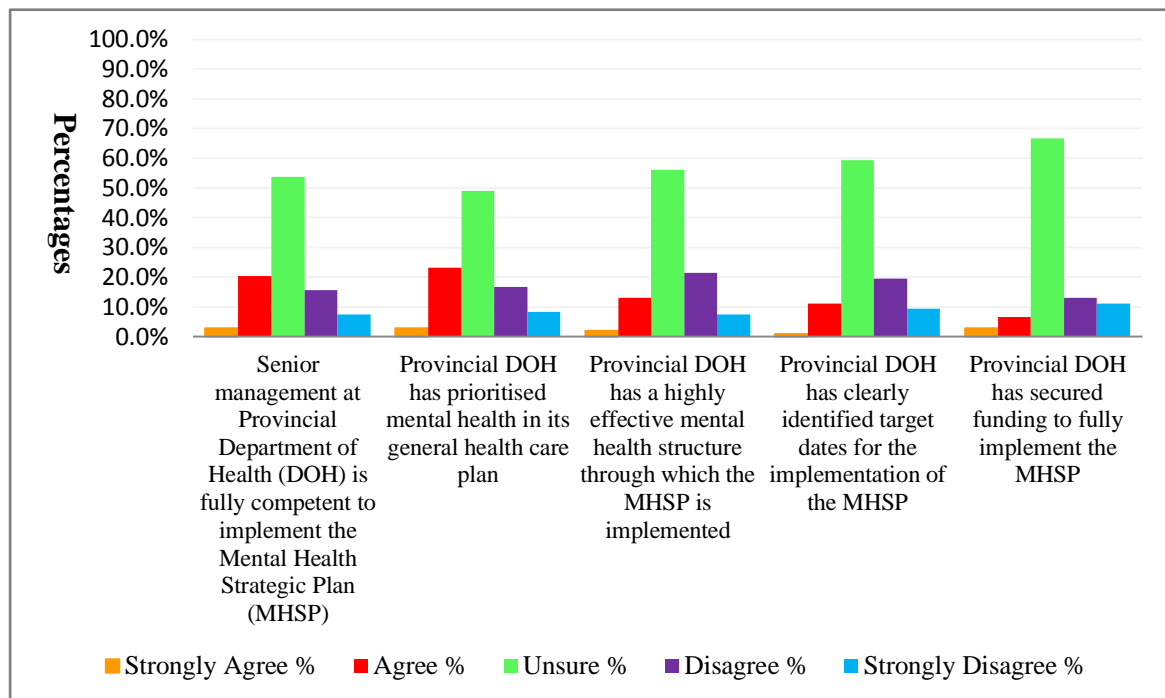


Figure 10 illustrates that 53.7% ($n=59$) of the mental health professionals were unsure, whilst 23.1% disagreed and 23.2% agreed that the senior management at the Provincial Department of Health (DOH) was fully competent to implement the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013). Figure 10 also shows that 49.1% of respondents ($n=54$) were unsure, whilst a quarter (25%) disagreed and the balance (25.9%) agreed that their Provincial DOH had prioritised mental in its general health care plan.

Only 13.1% ($n=14$) of respondents agreed, whereas 56.1% ($n=61$) were unsure that the Provincial DOH had a highly effective mental health structure through which to implement the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013).

Even though the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) set clear targets for implementation, only 11.1% ($n=12$) of mental health professionals agreed, whilst 59.3% ($n=65$) were unsure that the targets for implementation had been set. The majority of the respondents (66.7%, $n=73$) were unsure that the Provincial

DOH had secured funding to fully implement the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013).

Figure 10 (p. 85) reveals a high degree of uncertainty among mental health professionals as to whether the DOH was able to implement the mental health strategic plan. Some focus group participants were also sceptical about the policy plans being carried out:

When it comes to people with mental illness there is negligence on us as patients and the way we get treated. I can write down a plan, but if I don't meet the date by when the plan was set out to be working then it is a big joke. They like taking from us for their own – they think we stupid. We're not stupid. You can set goals for ourselves, but if those goals aren't implemented then that book [policy] means nothing. (*EC Service –user CMS, March 2016*).

So I am very disappointed in the government's plan and using people with disability to gain points – to score votes and talk and not carry it through is an insult to us. (*EC Service -user RS, March 2016*).

4.3.1.4. Perceptions of the Human Resource Capacity to Implement the Policy

This section focuses on the respondents' perceptions of the human resources required to implement the policy.

Figure 11: Perceptions of the Human Resource Capacity to Implementation the Policy

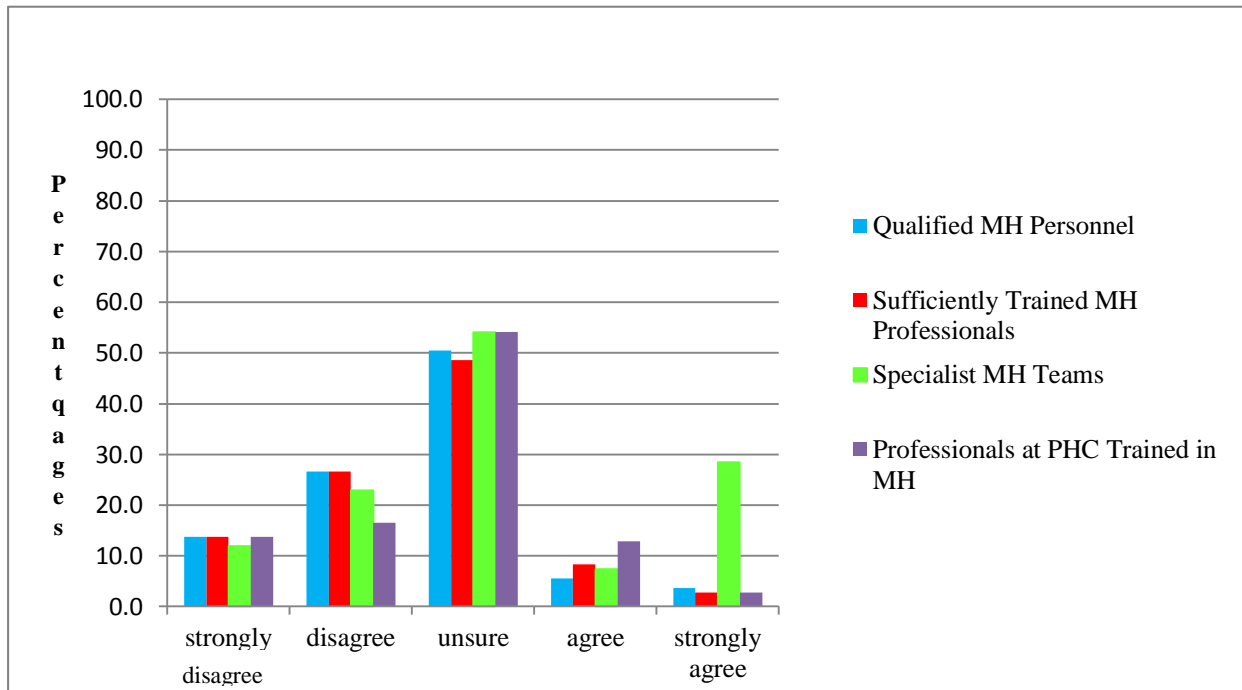


Figure 11 shows that a significant number of mental health professionals were unsure as to whether there were human resource capacity to implement the policy.

There were 50.5% ($n=55$) of mental health professionals who were unsure about whether there was a sufficient number of qualified mental health personnel employed in their province to implement the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013), whereas only 40.4% ($n=40$) disagreed that there were sufficient numbers of qualified mental health personnel employed in their province to implement the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013).

Figure 11 further highlights that 40.4% ($n=40$) of respondents disagreed, whilst 48.6%, ($n=53$) were unsure as to whether there were sufficiently trained mental health professionals who could implement the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013). There was further uncertainty by 54.1% ($n=59$) of mental health professionals who indicated that they were unsure as to whether the number of mental health

specialist teams had increased significantly in districts because of the new policy. A significant percentage (54.1%, $n=59$) of respondents was unsure that health professionals had been adequately trained in mental health at Primary Health Care (PHC) facilities to give effect to the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013).

The World Health Organization (WHO) Comprehensive Mental Health Action Plan 2013–2020 (2013) highlighted that the number of specialist mental health staff operating in lower- and middle-income countries was grossly inadequate to address and reduce the disease burden. The National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) identified an urgent need to train general health staff and primary health care (PHC) nurses in mental health. This would ensure, firstly, the integration of mental health in PHC and, secondly, that health professionals were knowledgeable and adequately equipped to provide adequate care to mental health services users.

The policy furthermore identified the need for specialist mental health teams to be established to support non-specialist PHC staff including community-based workers. However, we know that the implementation of these specific deliverables was particularly slow and had been fully discussed in the Rural Mental Health Campaign Report (2015).

4.3.1.5. Perceptions of the Integration of Mental Health in National Health

Insurance

Mental health professionals and service users' perceptions about the integration of mental health into the National Health Insurance's eleven pilot sites were largely inconclusive.

Figure 12: Integration of Mental Health in the National Health Insurance (NHI) Programme

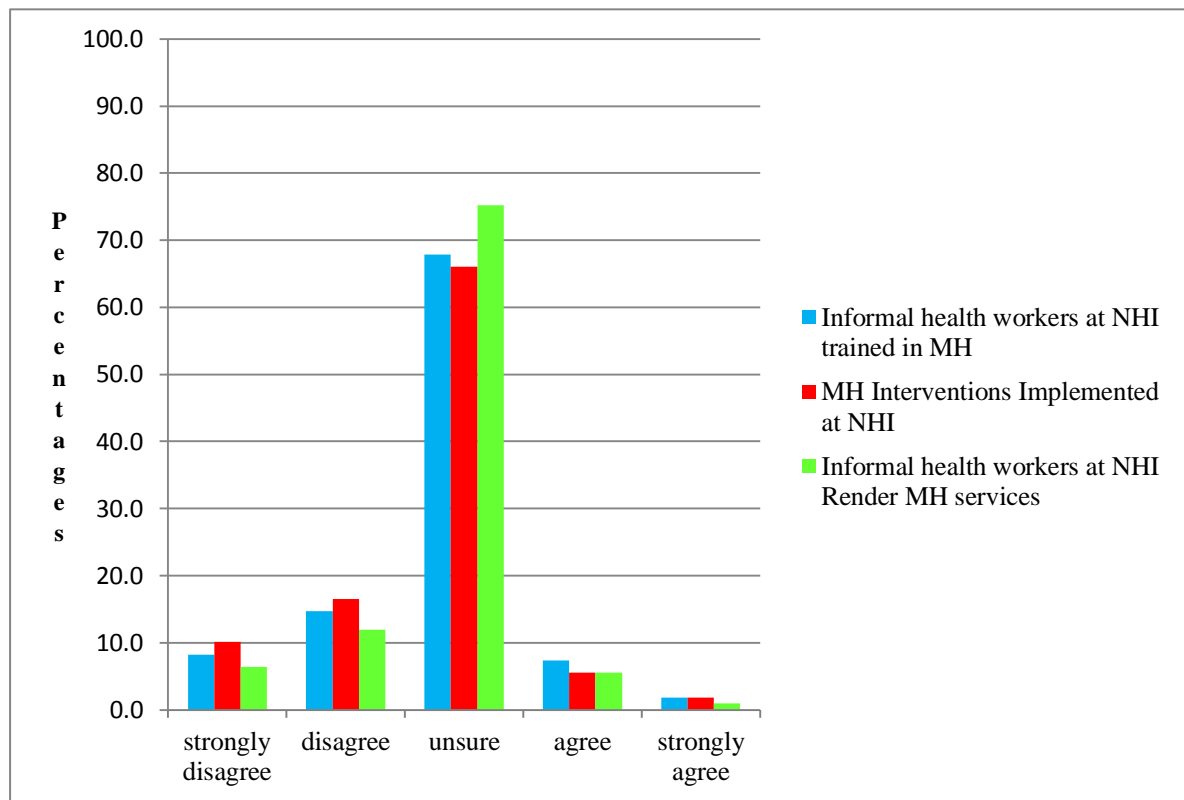


Figure 12 illustrates that the majority of respondents (67.9%, $n=74$) were unsure as to whether informal health workers at NHI sites had been adequately trained in mental health with the view to implementing the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013).

As depicted, a significant number (66.1%, $n=72$) of mental health professionals was unsure, whilst 26.6% ($n=29$) disagreed that mental health interventions were fully implemented at NHI pilot sites as set out in the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013).

An even larger percentage (75.2%, $n=82$) was unsure about whether informal health workers employed in NHI sites were actively rendering mental health services. Figure 12 highlights a particular trend in the peak, which illustrates that many of the respondents were unsure about whether mental health services were integrated into health services in the eleven

NHI pilot programmes in South Africa. These findings suggest a lack of engagement of mental health professionals with the broader mental health policy frameworks.

The vision of the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) is to improve the mental health of all South African by 2020. The objectives, as stated in the policy, is to increase access to mental health services by decentralising and integrating mental health into PHC by adopting a multi-sectoral approach, and to strengthen the district mental health system.

The National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) noted that “In the financing of the National Health Insurance system, mental health will be given parity with other health conditions, in proportion to the burden of disease and evidence for cost-effective intervention” (p. 25). Both the NHI policy and the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) aim to reduce the fragmentation in South Africa’s two-tier health system and ensure that the maldistribution of health care is addressed so that 83.8% of South Africans who are currently receiving public health care have access to services. The NHI White Paper (2015) highlighted the following:

A major characteristic of the South African health system is in the fragmentation of funding pools within and between the public and private sectors. In the private sector, there are 83 medical schemes, 15 funding the health needs of only 16.2%, (8.8 million lives) of the population (p. 15).

Despite the progressive position statement and objectives of the NHI programme, the reality is that progress in the pilot sites has been slow. Some of the challenges in implementation relate to weak human resource capacity in districts, bureaucracy, and technical challenges in finalising business plans. Other challenges relate to the lack of appointment of District Health Management Teams in some provinces and delays in budgets being communicated to some sites (RSA Parliamentary Monitoring Group [National Council of Provinces Appropriations], 2013). Many health workers employed within the NHI pilot sites currently focus mainly on treating patients with HIV/AIDs and tuberculosis (TB). These

health workers are often overburdened by the demand for care and, as a result, mental health has not been prioritised in NHI pilot sites. In the Eden Karoo NHI Pilot site, no specialised mental health training has been undertaken by these health workers. Pessimism about the current economic climate has raised questions about whether the NHI could realistically be implemented over the next 14 years. Delays in funding the NHI programmes will result in delays in funding and implementing the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) deliverables.

4.3.1.6. Perceptions regarding Role-Players’ Participation in Policy Implementation

The respondents’ perceptions of the various role-players that should be involved in the mental health implementation were identified.

Figure 13: Perceptions regarding Other Role-Players’ Participation in Implementing the Policy

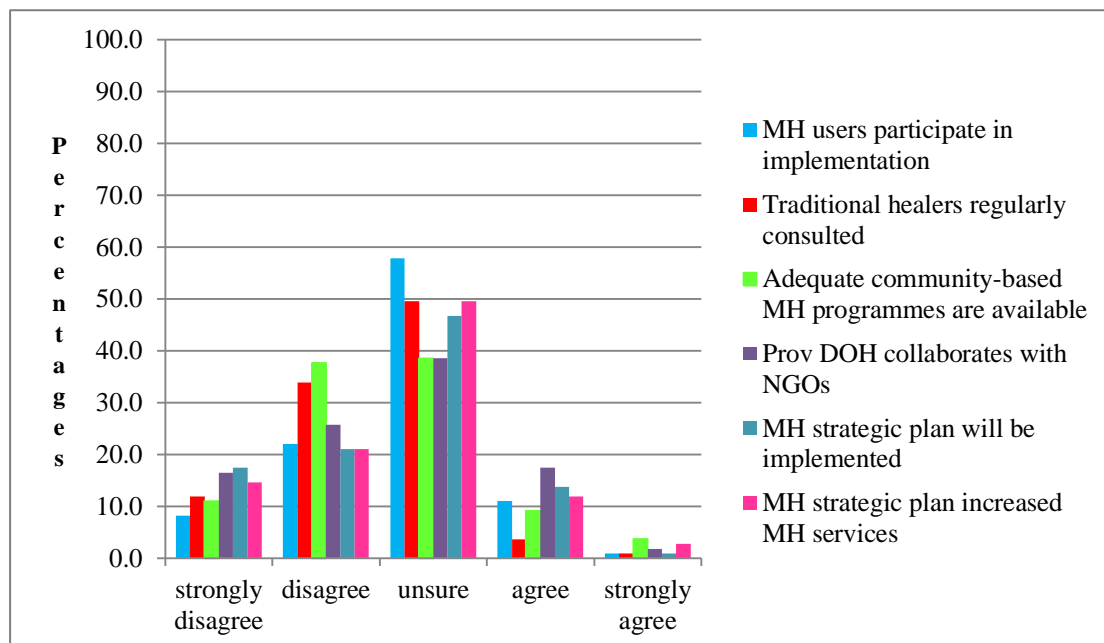


Figure 13 highlights that the majority of mental health professionals (57.8%, $n=63$) were unsure whilst (30.3%, $n=33$) disagreed that mental health service users actively participated

in the successful implementation of the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013). The National Mental Health Policy Framework and Strategic Plan 2013-2020 (2013) recognises the role of service users specifically, to provide appropriate self-help and peer-led services and support groups.

Even though studies mentioned previously highlighted the role of traditional healers in South Africa, Figure 13 (p. 91) shows that 45.8% ($n=50$) of respondents disagreed that traditional healers are regularly consulted in patient case management plans, whereas 49.5% ($n=54$) were unsure. The intent and objective of the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) are to foster more meaningful relationships and partnerships with traditional and faith healers. The policy encourages the implementation of the Traditional Health Practitioners Act No. 22 of 2007 by facilitating links and referral pathways at district level between mental health services and traditional healers and faith healers. Even though this is the intention, there is little evidence from these findings that the latter has been operationalised.

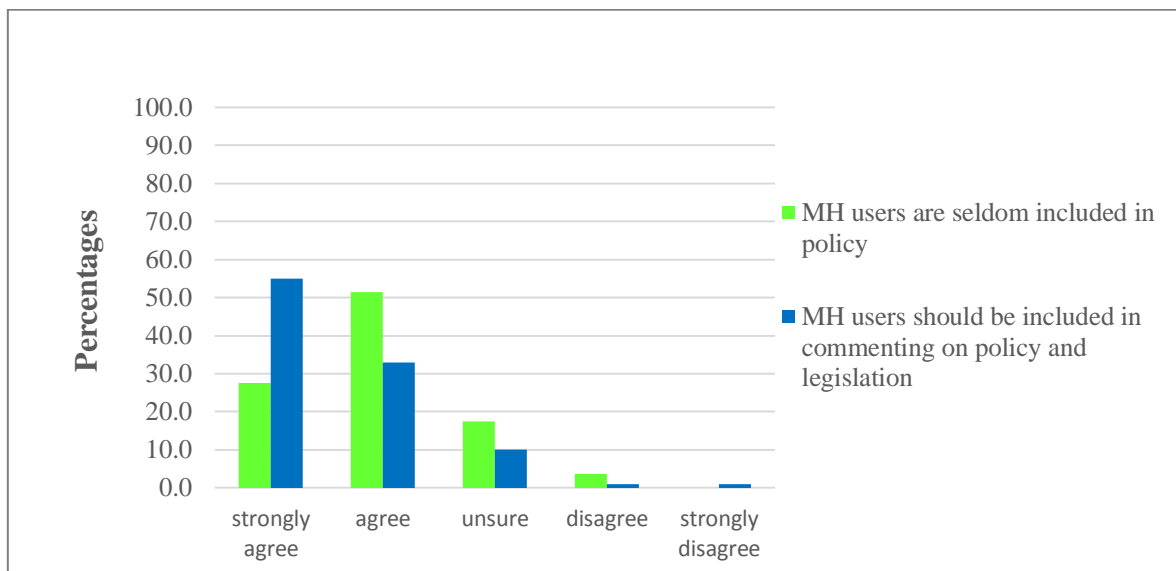
Figure 13 (p. 91) further highlights that 49.5% of mental health professionals ($n=54$) disagreed that adequate community-based mental health programmes were available to give effect to the policy, whereas 38.5% ($n=42$) were unsure. Studies by Burns (2011) confirmed that “community mental health and psychosocial rehabilitation services remain undeveloped, so that patients end up institutionalised, without hope of rehabilitation back into their communities” (p. 104).

Figure 13 (p. 91) indicates that 42.2% ($n=46$) respondents disagreed, whilst 38.5% ($n=42$) were unsure as to whether their Provincial DOH actively collaborated with mental health non-profit organisations (NPOs) to give effect to the policy. There were 46.8% of respondents ($n=51$) who were unsure, whilst a further 38.5% ($n=42$) disagreed that all health professionals were confident that the National Mental Health Policy Framework and Strategic

Plan 2013–2020 (2013) would be implemented within the given timeframes. The findings regarding the latter highlight the uncertainty and low confidence in the DOH’s ability to implement the deliverables in the given timeframes identified in the policy.

Almost half the respondents (49.5%, $n=54$) were unsure and a further (35.8%, $n=42$) disagreed that the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) had substantially increased mental health services in their province. These findings are not definitive considering that almost half of the mental health professionals in this study had not fully engaged with the contents of the mental health policy.

Figure 14: Mental Health Service User Role in Policy and Legislation



As depicted in Figure 14, the majority of mental health professionals (78.9%, $n=86$) agreed that mental health service users were seldom included in mental health policy development, whereas 88% ($n=96$) respondents indicated that mental health service users should be fully included in commenting on legislation that affect their lives.

The United Nations Convention on the Rights of Persons with Disability (2006) Article 12 – Equal Recognition before the Law stipulated that people with disability (inclusive of persons with mental disability) should enjoy legal capacity on the same basis as others and

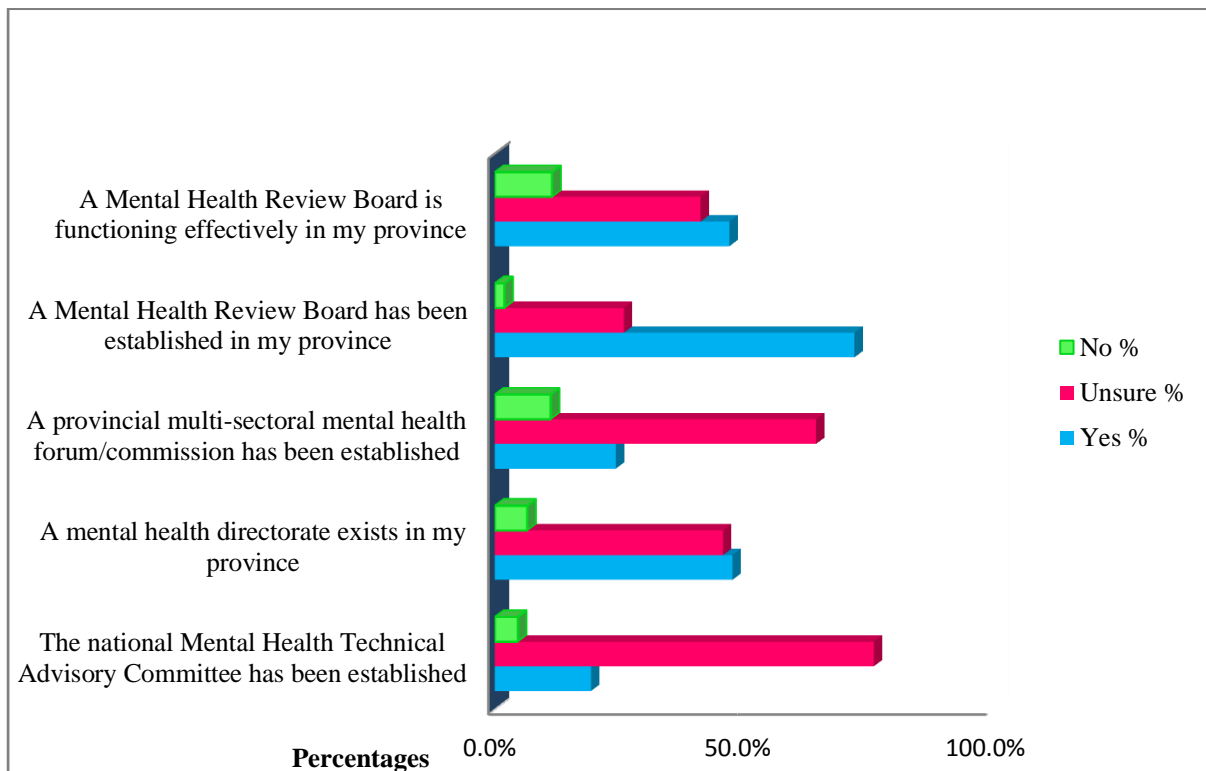
should take appropriate measures to provide access by persons with disabilities and the support they might require in exercising their legal capacity. Figure 14 (p. 93) highlights that mental health professionals overwhelmingly agreed that service users were often excluded from contributing towards policy development and legislation. They confirmed that service user advocacy was central to treatment. The disability movement's motto is "**Nothing about us Without Us**". Thus this principle of inclusion is central to all persons, and more so to those whose lives are affected by mental illness.

Only 39.5% ($n=43$) of social workers agreed that the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) clearly identified the role of the mental health NPOs in their province, whilst almost a similar percentage (53.2%, $n=58$) were unsure. The National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) did, in fact, refer to some limited roles and responsibilities of the NPOs. Some of the best practice award-winning programmes implemented by NPOs had been largely overlooked.

4.3.1.7. Institutional Capacity to Implement the Policy

This section highlights the perceptions of mental health professionals regarding the institutional capacity required to implement the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013).

Figure 15: Institutional Capacity to Implement the Policy



The National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013), recognised that institutional capacity at national, provincial and district levels would be required to provide structure and a framework for governance, to ensure the successful implementation of the strategy and the upscaling of mental health services by 2020. The National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013, p. 34) identified that the first national Mental Health Technical Advisory Committee in terms of Health Care Act No.17 of 2002 should be established by 2013/2014. The inaugural meeting of the Mental Health Technical Advisory Committee was held on 1 October 2015 in Kempton Park, Johannesburg. However, as shown in Figure 15, a significant number of the respondents (76.1%, $n=83$) were unsure as to whether the Mental Health Technical Advisory Committee had been established. Only 19.3% ($n=21$) of the mental health respondents indicated that they knew that the Mental Health Ministerial Advisory Committee had been established.

The National Mental Health Policy Framework and Strategic Plan 2013-2020 (2013) highlighted the plan to establish a Mental Health Directorate in each province in South Africa by 2013/2014. However, only two Mental Health Directorates are currently in operation. Forty-eight percent of respondents (47.7%, $n=52$) agreed that a Mental Health Directorate operated in their province, whilst 45.8% ($n=50$) were unsure. Currently, the only two Mental Health Directorates operating in South Africa are found in the Western Cape and Gauteng Provinces.

The National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) identified the need for inter-sectoral collaboration and plans to establish a multi-sectoral health commission that includes mental health by 2013/2014. Thus far, no such national commission has been established.

Despite the need to strengthen inter-sectoral collaboration at provincial and district levels in order to reduce the fragmentation in mental health services delivery, only 24.3% ($n=26$) of respondents indicated that a multi-sectoral provincial forum/commission has been established, whilst 64.5% ($n=70$) were unsure and 11.2% ($n=12$) noted that no forum/commission had been established.

The National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013:34) also emphasised the plan to establish functioning and resourced Mental Health Review Boards in all provinces by January 2013. The majority of mental health professionals (72.2%, $n=79$) indicated that Mental Health Review Boards had been established in their provinces. These findings concur with Figure 50 (p. 175), which highlights that 62% ($n=68$) of respondents agreed that they had fully functioning Mental Health Review Boards in their provinces. Even though the majority of the respondents indicated that a Mental Health Review Board had been established in the province, fewer than half the respondents (47.1%,

$n=51$) indicated that they had a Mental Health Review Board that functioned effectively, whilst 41.3% ($n=45$) were unsure.

4.3.2. Major Barriers or Constraints Preventing the Effective Expansion and Improvement of Community Mental Health Services

Major barriers or constraints preventing the effective expansion and improvement of community mental health services in South Africa explored were:

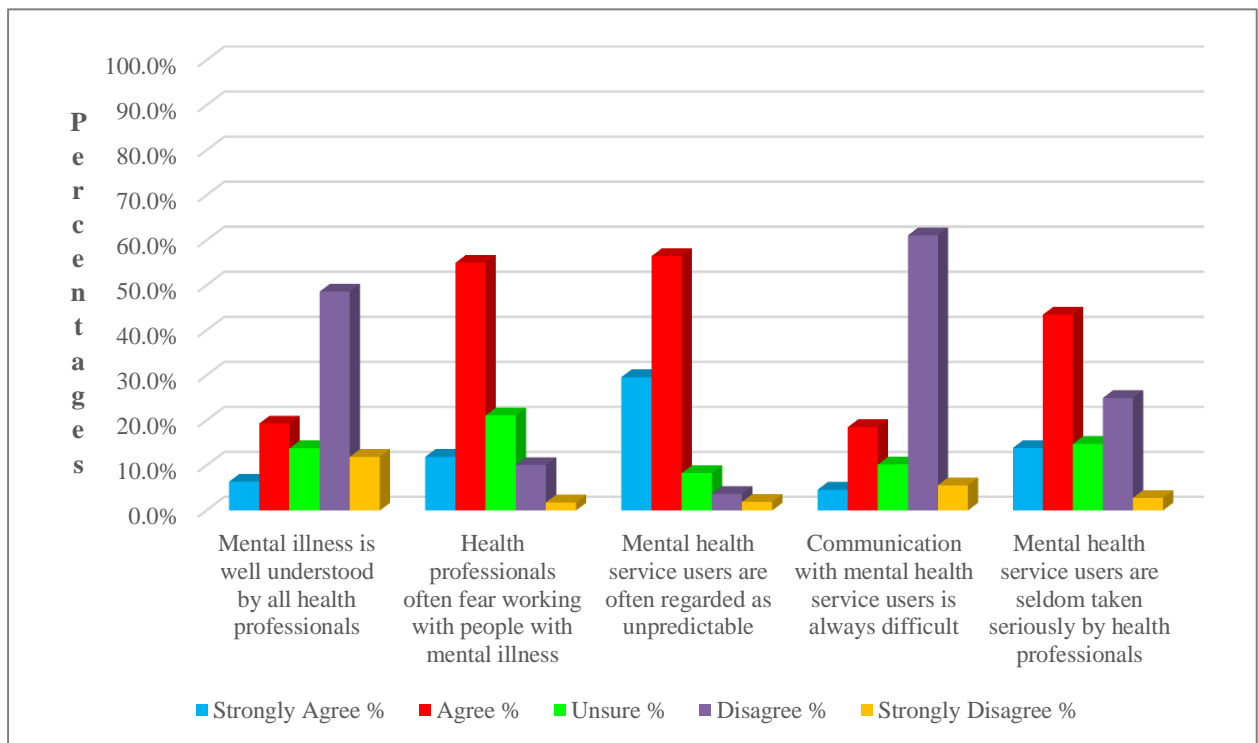
- Mental health professionals' opinion of the perceptions and attitudes of health professionals towards mental health and mental health users
- The current state of mental health in provinces in South Africa
- Limited human resource capacity and challenges faced by non-government organisations (NGOs)

The findings below attempt to highlight in detail these barriers and limitations:

4.3.2.1. Perceptions and Attitudes of Health Professionals

Figure 16 (p. 98) reflects mental health professionals and service users' opinions about the perceptions and attitudes that health professionals have towards mental health and mental health users.

Figure 16: Perceptions and Attitudes of Health Professionals towards Mental Health and Mental Health Service Users



The survey revealed that 60.5% ($n=66$) of the respondents disagreed that mental health and mental health service users were well understood by health professionals. Sixty-seven percent agreed that health professionals often feared working with people who have a mental illness.

Focus group findings confirmed this:

They are afraid of you (*KZN Service-User -MM & LD, April 2016*).

Yes, I was also locked up – there are securities all over the place – you can't go no-where. If you wanted to go to the shop you had to be escorted to the shop you see. It was not a nice thing (*EC Service User, March 2016*).

A significant number of respondents (86.1%, $n=94$) agreed that mental health service users were often regarded as unpredictable by health professionals. According to Kapungwe, Cooper, Mayeya, Mwanza, Mwape, and Sikwese (2011, p. 293), a Zambian study, clinical officers and psychiatrists saw people with mental illness as unpredictable and 38% of clinical

officers thought them to be dangerous. Gateshill, Kucharska-Pietura, and Wattis (2011) found, however, that non-mental healthcare professionals were more inclined to regard people with a mental disorder as more dangerous and unpredictable than did mental healthcare professionals.

In the present study, at least 66.7% ($n=73$) respondents disagreed that communication with service users was difficult. However, despite the fact that most respondents agreed that communication with service users was not difficult, 57.5% ($n=63$) agreed that service users were often not taken seriously by health professionals.

Service users who participated in the focus groups, particularly, in the Eastern Cape, appeared to have had the most negative experiences. They indicated as follows:

Well, I have my own experiences which are very disgusting. There are normal people who come to the clinic – there are things that I see for myself. The way professional health care workers speak and the way they get treated. The way they talk to these patients is disgusting because you don't even talk to your dog at home like that. The sister's attitude at the West End Clinic is – this you can write to the newspaper – I'm not scared – that is their attitude. What does their code of ethic say – treat all patients the same (*EC Service-user CMS, March 2016*).

Without doubt, the general clinic that I go to the problem there is that the nurses and the staff are extremely rude. They don't care (*EC Service-user RS, March 2016*).

However, some service-users from the Western Cape had more positive experiences:

I found the psychiatrist that I went to yesterday to be very professional (*WC Service-user AF, March 2016*).

4.3.2.2. Perceptions regarding Attitudes and Perceptions of Mental Health Service

Users

This section deals with the attitudes and perceptions of health professionals towards mental health service users as a major barrier to providing effective treatment.

Figure 17: Perceptions regarding Attitudes and Perceptions of Mental Health Service

Users

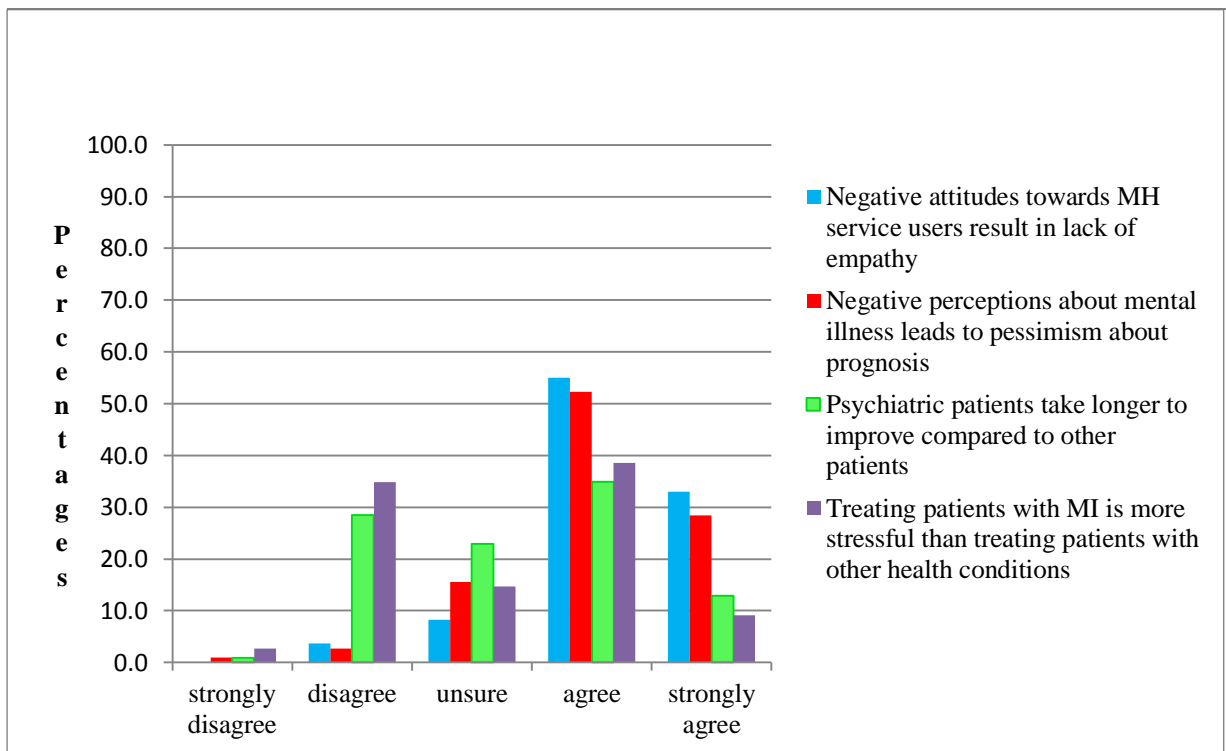


Figure 17 highlights that a significant number of respondents (88%, $n=96$) agreed that negative attitudes by health professionals towards mental health service users result in a lack of empathy. The latter was confirmed by service users who indicated the following:

When they see us sick people, they say we are crazy because you are affected for the rest of your life. So how can this be that they [staff] don't feel for you because you mentally ill. This does not make me feel very well (*KZN Service User - SS, April 2016*).

When I was first diagnosed, I was taken to Lentegeur Hospital and the doctor there was very harsh and negative towards my condition. He did not have a nice manner with me (*WC Service User - AC, March 2016*).

Lebowitz and Ahn (2014) stated that “empathy is important for the therapeutic alliance between mental health providers and patients and significantly predicts positive clinical outcomes” (p. 17786). They state that often the biological explanations given to understand psychopathology are largely responsible for less empathetic responses towards people with

mental disability. Biological interventions are framed within a medical model of treatment, which focuses on defects and dysfunction. It is therefore critical that psycho-social models frame the discourse to increase the empathy of health professionals when treating mental illness. Empathy is a critical ingredient in patient management and contributes to positive clinical outcomes. Eighty-one percent (80.7%, $n=88$) of the respondents agreed that negative perceptions of mental illness by health professionals lead to pessimism about patient prognosis. According to Thornicroft, Rose and Kassam (2007) discrimination towards people with mental illness appears to be rife amongst professional groups. These authors refer to Hugo's (2001) Australian study:

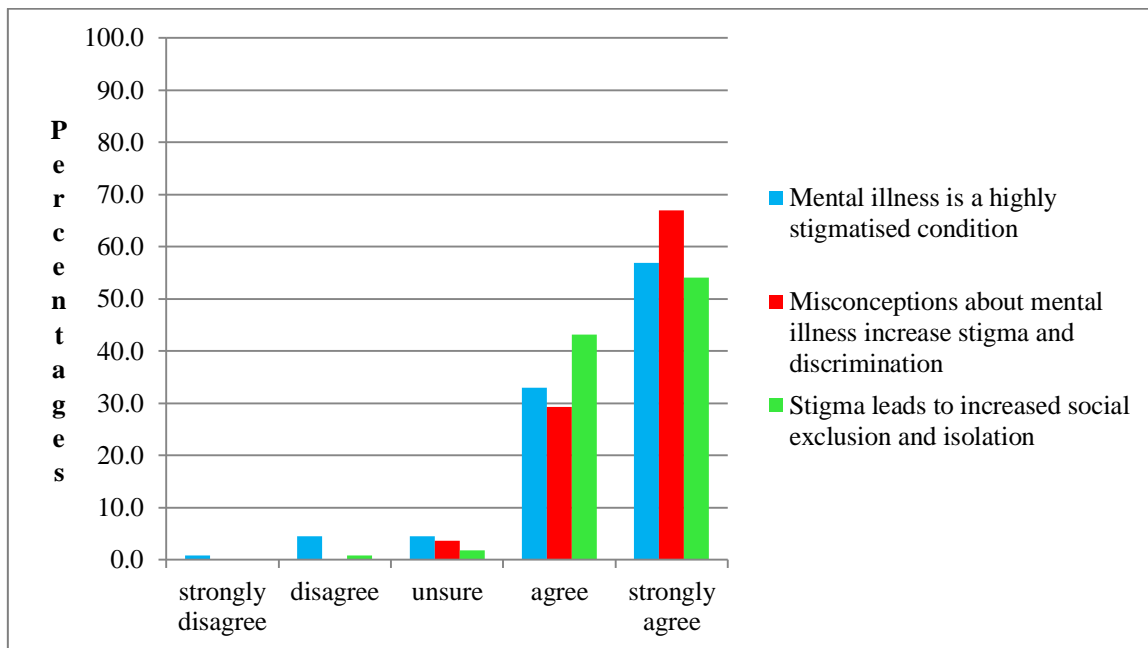
Professional groups were found to be less optimistic about prognosis, and less positive about likely long-term outcomes, when compared with the general public. Medical staff were less optimistic about outcomes than other professional groups, with mental health nurses generally most optimistic. Most professionals based their attitudes on their experiences of working with people with mental health problems (Hugo, 2001, p. 419).

An equal number of mental health professionals (47.7%, $n=52$) agreed that there is a perception amongst health professionals that psychiatric patients take longer to improve, compared to patients with other health conditions. Mental health professionals (37.7%, $n=41$) disagreed, whereas (47.7%, $n=52$) agreed that treating mental illness is more stressful than treating patients with other health conditions.

4.3.2.3 Perceptions of Stigma and Mental Illness

Mental illness remains one of the most stigmatised health conditions, which created barriers to treatment and limits full integration into work, education, communities and families.

Figure 18: Stigmatisation and Mental Illness



The greatest barrier that people with mental illness face is society’s attitude towards them. This includes stigma and discrimination by health professionals. Figure 18 depicts that a significant number (89.9%, $n=98$) of respondents agreed that mental illness remains one of the most highly stigmatised conditions.

Stigma is complex and complicated by self-stigma, public stigma and structural stigma. Service users who participated in the focus interviews experienced multiple levels of public and structural stigma.

The responses about public stigma were as follows:

I will say that we sometimes get judged by the community because of our mental state and mental illness and we get treated differently from other people in the community. It’s like there goes that mad person I mean it can happen to anybody. I have Bi-polar mental illness. It is something that happens and there is nothing you can do about it. Sometimes people walk for years with the illness until one day they breakdown and you snap. So we are all human beings and it doesn’t matter whether you have a mental illness or not being discriminated against because you have a mental illness that’s not on. We need to be treated as human beings (*EC Service-user - CMS, March 2016*).

Our rights are not always the same as others. The problem is that we are treated differently – when you walk around or walking in

the street people harass you. When you sit in certain company they reject you or they ask you to leave – they just put you aside or when there is a conversation going on at work they don't speak to you. They would rather make fun of you – they make a fool out of you. You must also watch where you go and who you social with and not to mix with the wrong crowds (*EC Service-user -W, March 2016*).

If you go to the rural areas they stigmatise psychiatric patients – everyone says that person is a witch (*EC Service-user - PD, March 2016*).

Service users also experienced structural stigma as follows:

You will find that when you go to the hospital or the clinic when you go there you are being separated from the other people. This side is the medical condition and that side is a big board saying psychiatry and everyone knows that's me and everybody knows that you're seeing the psychiatrist and know that you're mad because why they're not educated about this. They know nothing – they can't differentiate between psychiatric or whatever because they don't know this is what I found out. They know nothing and I do think that it is important for people to know about this. (*EC Service-user -PN, March 2016*)

Mental health service users often face multiple forms of discrimination that impact on their recovery. The Royal College of Psychiatrists Report (2001) stated the following:

Some patients face multiple forms of discrimination on account of mental illness, especially when there is comorbidity such as personality disorder, but often also because of race (doctor and patient often come from different ethnic groups), age, gender or sexual orientation; or because of the nature of the illness, as when the patient may be perceived as blameworthy or dangerous; or because of social class. To such a list, we might add features such as homelessness or personal appearance – mode of dress, or hairstyle, or tattoos or body piercing. When there is social distance between doctor and patient, prejudice very easily slips in (p. 17).

Shrivastava, Johnson, and Bureau (2012) stated the following:

Stigma is a risk factor leading to negative mental health outcomes. It is responsible for treatment seeking delays and reduces the likelihood that a mentally ill patient will receive adequate care. It is evident that delay due to stigma can have devastating consequences (p. 70).

Almost all respondents (96.4%, $n=105$) agreed that misconceptions about mental illness increase stigma and discrimination, whereas 97.2% ($n=106$) mental health professionals agreed that stigma always leads to increased isolation and exclusion.

Corrigan and Watson (2002) stated that:

Many people with serious mental illness are challenged doubly. On one hand, they struggle with the symptoms and disabilities that result from the disease. On the other, they are challenged by the stereotypes and prejudice that result from misconceptions about mental illness. As a result of both, people with mental illness are robbed of the opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people (p. 16).

When persons with mental illness are isolated and excluded from the activities of daily living their recovery is arrested and integration into communities is made more difficult.

Services-users experienced exclusion in various ways:

When people won't talk to you – when you pushed aside and they don't want to be friends with you anymore (*WC Service-user – MC, March 2016*).

Due to stigmatisation, they put us in separate group as people. They shy away from one – they don't want to associate with one (*WC Service-user KT, March 2016*).

Even though I don't experience it a lot, sometimes I feel my opinion is not considered and that I would be shut down. Sometimes I just keep my mouth shut. Even though it might be a good idea... (*WC Service-user -AF, March 2016*).

4.3.2.4 Perceptions regarding Dismissive Attitudes and Impact on Mental Health

Priorities

This section presents the perceptions of mental health professionals and services users' views regarding the impact of dismissive attitudes on the prioritisation of mental health.

Figure 19: Dismissive Attitudes and Mental Health Priorities

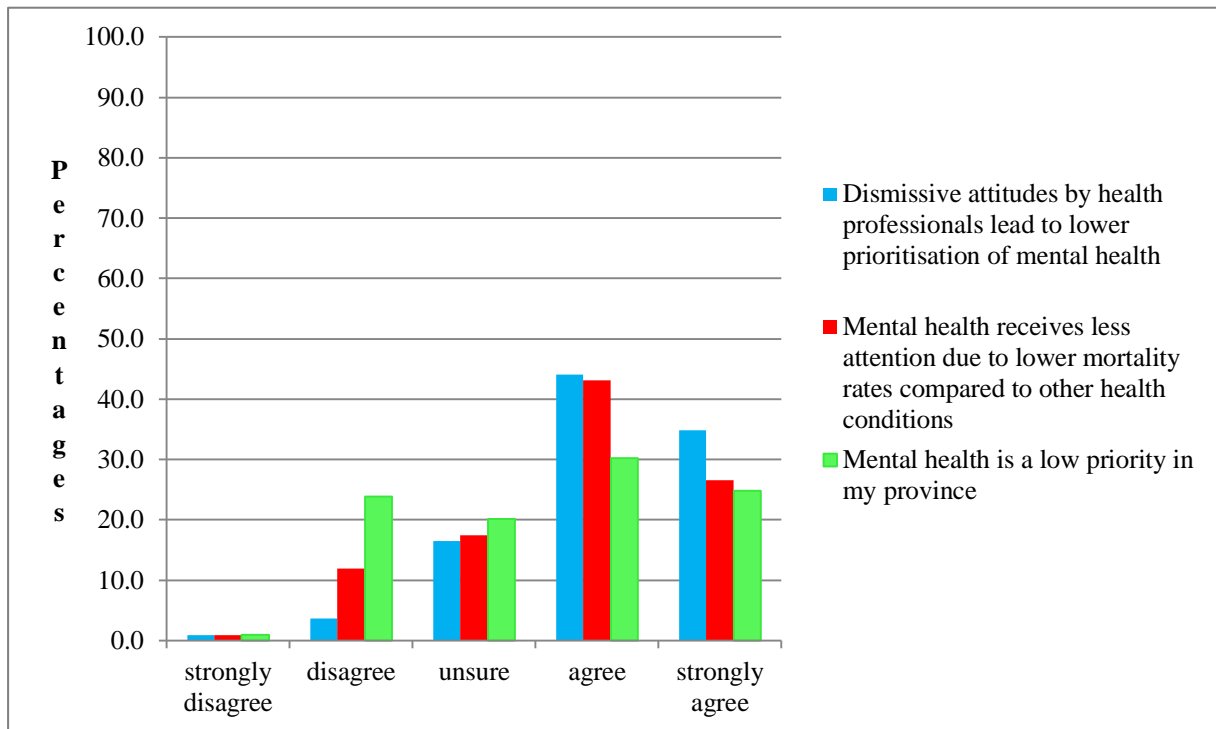


Figure 19 highlights that 78.9% ($n=86$) mental health professionals agreed that dismissive attitudes by health professionals always lead to lower prioritisation of mental health resources. Stigma has a powerful negative impact on the low prioritisation of mental health resource. Gureje and Alem (2000) confirmed the latter by stating the following:

In most parts of the continent, people’s attitudes towards mental illness are still strongly influenced by traditional beliefs in supernatural causes and remedies. This belief system often leads to unhelpful or health-damaging responses to mental illness, to stigmatization of mentally ill persons and those who attempt suicide, and to reluctance or delay in seeking appropriate care for these problems. Such beliefs also affect the provision of mental health care services for the needy; thus, policy-makers are often of the opinion that mental illness is largely incurable or, at any rate, unresponsive to orthodox medical practices (p. 475).

At least 69.7% ($n=79$) of respondents agreed that mental health receives less attention due to lower mortality rates compared to other health conditions. These findings are worrying considering the increase in suicide rates particularly among the South African youth. Schlebusch (2005) stated that “the average 9.5% non-natural deaths due to suicides in young

people in South Africa is almost as high as the overall (including adult) suicide rate of around 11%” (p. 182). There is also a clear link between mental illness and chronic diseases.

Latoo, Mistry, and Dunne (2013) highlighted the complex interaction of a number of factors that have resulted in an increase in mortality rates of persons with mental illness, and stated the following:

Evidence has consistently shown that patients with mental illness have greater physical health morbidity and mortality compared to the general population. Many factors have been implicated and include a generally unhealthy lifestyle, side effects of medication, and inadequate physical healthcare. Higher rates of suicide and accidents are other known risks. Psychiatric patients are more likely to smoke, have less inclination to exercise, and are prone to poor dietary habits and obesity, the latter through general inertia, the result of the adverse effects of neuroleptic medication, or increased alcohol use. Psychotropic medication is associated with impaired glucose tolerance and diabetes, metabolic syndrome, dyslipidaemia, cardiovascular complications, extrapyramidal side effects and sexual dysfunction. A broad range of clinician and organisational factors prevent access to adequate physical healthcare that in turn compounds the above problems (p. a621).

The Canadian Mental Health Association (2008) reported that “diagnostic overshadowing occurs frequently and can result in serious physical symptoms being either ignored or downplayed” (p. 1). National Association of State Mental Health Program Directors (2006) stated, in their technical report, that on average people with mental illness die 25 years earlier than the general population due to the factors described by Latoo et al. (2013).

Despite the latter, 55.1% ($n=60$) mental health professionals agreed that mental health care is a very low priority in their province.

4.3.2.5. Perceptions regarding Access and Demand for Mental Health Service

Mental health professionals and services users’ perceptions regarding the access and demand for mental health services are explored in this section.

Figure 20: Access and Demand for Mental Health Service

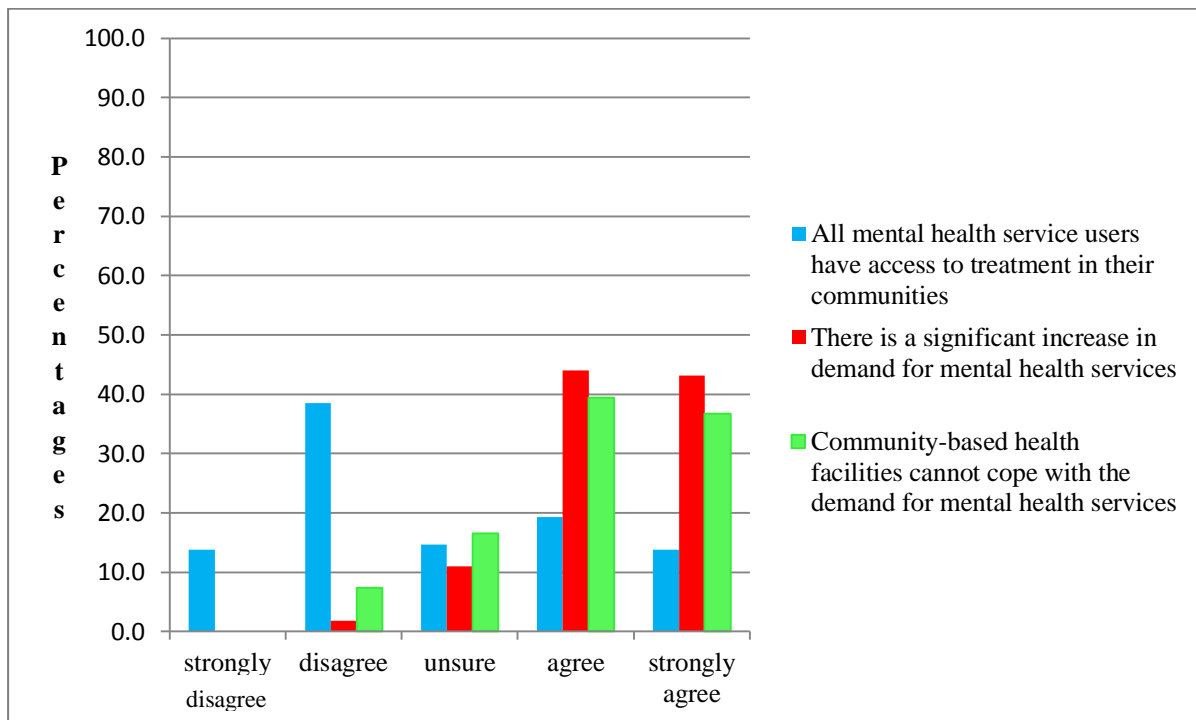


Figure 20 highlights that 52.3% ($n=57$) mental health professionals who participated in the survey disagreed that all mental health service users had access to treatment in their communities in their provinces. These findings highlight the close relationship between those who indicated that mental health care was a very low priority in their province, as illustrated in Figure 19 (p. 105), compared to those who indicated that all mental health service users had access to treatment in their communities in my province.

Figure 20 further illustrates that 87.1% ($n=95$) respondents agreed that there was a significant increase in demand for mental health services in their province. This is supported by the fact that 76.1% ($n=83$) agreed that community-based health facilities could not cope with the increase in demand for mental health services. These findings suggest that despite the increase in demand for mental health services and the fact that community health facilities cannot cope with the increased demand, mental health care still remains a low priority in the country.

4.3.2.6. Perceptions of the Medical Model and Social Model Approaches to Mental Health

Further barriers to improving and expanding mental health services in South Africa were identified within the current the bio-medical framework. Mental health professionals and mental health users’ perceptions about the medical and social models were assessed.

Figure 21: Medical Model and Social Model Approaches to Mental Health

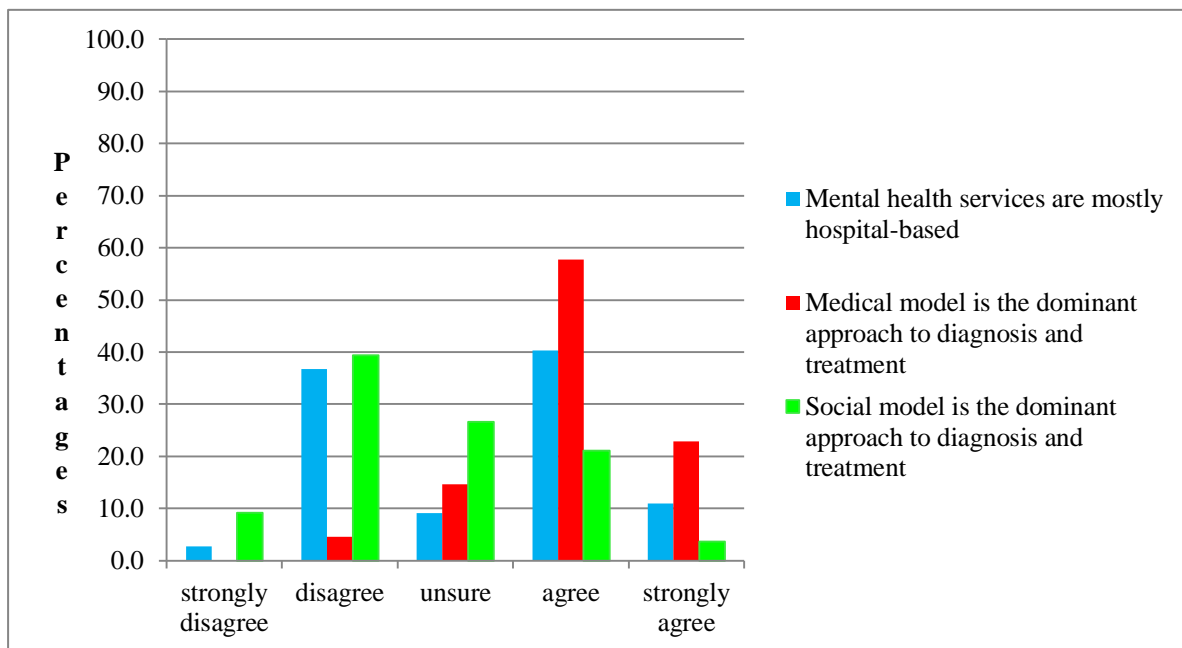


Figure 21 shows that 51.4% ($n=56$) mental health professionals agreed that mental health services were mostly hospital-based, whereas 39.5% ($n=43$) disagreed. However, a significant number (80.7%, $n=88$) of the mental health professionals agreed that the medical model remained the dominant approach to diagnosis and treatment. Only 48.6% ($n=53$) disagreed that the social model was the dominant approach to diagnosis and care.

These findings confirm that the approach to diagnosis and treatment continues to be dominated by the medical model. Engel (1977) stated:

The dominant model of disease today is biomedical, with molecular biology its basic scientific discipline. It assumes diseases

to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioural dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behaviour; it also demands that behavioural aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes (p. 130).

Mkhize and Kometsi (2008) stated that “while South Africa has adopted the PHC system and its underpinning principles, implementation has been generally biomedical in orientation” (p. 107). Service-users confirmed this, noting the following:

I get monthly injections and then I get tablets for the side-effects. So it is mainly prescribed medication (*WC Service user – KT, March 2016*).

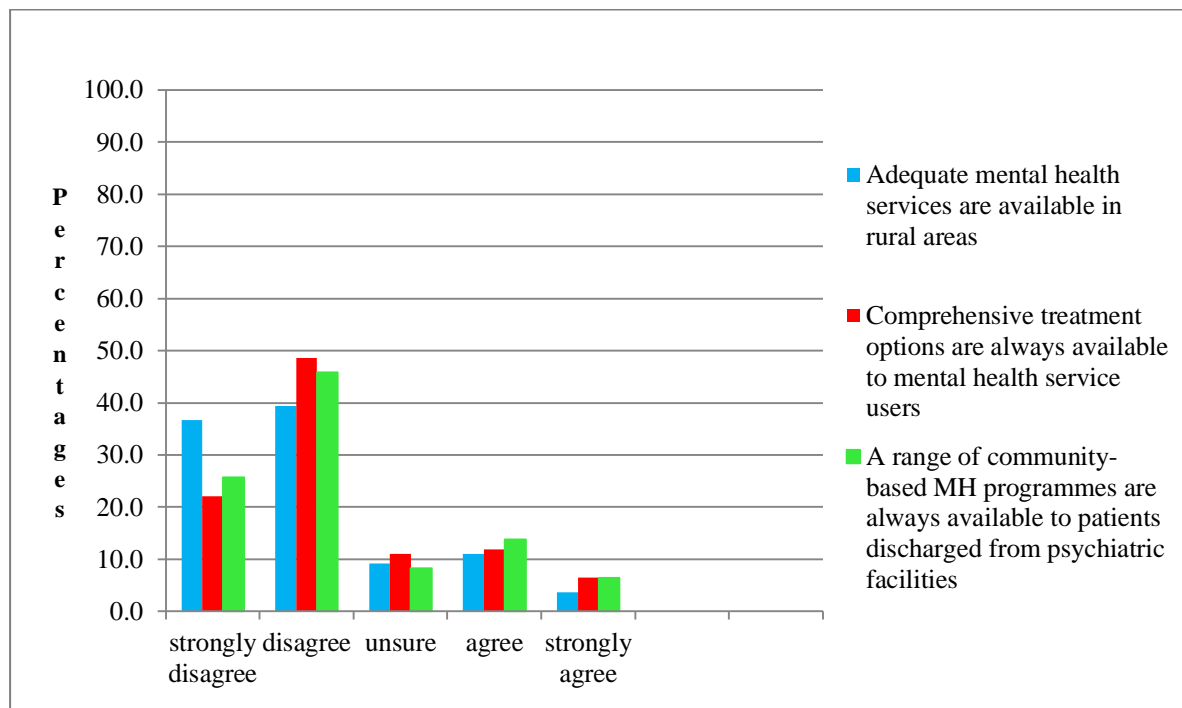
I also get medication for my psychiatric illness and also for my anaemia and I also get hormone replacement medication (*WC Service-User YW, March 2016*).

Thus the dispensing of medication is the primary treatment approach. The medical model’s treatment approach is often perceived as disempowering.

4.3.2.7 Available Treatment Options

This section presents the available treatment options available within communities.

Figure 22: Available Treatment Options



As illustrated in Figure 22 (p. 109), a significant number (76.1%, $n=83$) of mental health professionals disagreed that there are adequate mental health services in rural areas across provinces. Service users from rural areas who participated in the focus groups indicated:

The people from the rural areas, they walk the long distance to go to the clinic and by the time they arrive it is already closed. They have to sleep somewhere nearby in order to come so that they can be seen by to the clinic – you see (*Limpopo Service-user, PD, April 2016*).

Yes, we all seem very healthy but when you in a bad space I can understand and I know you will say if you're in a bad space but there are people who would have to walk miles and miles as you said to get their medication (*Limpopo Service user, AF, April 2016*).

These findings confirm the Rural Mental Health Campaign Report (2015) that stated: “Rural areas account for almost half the country’s population but still remain the most underserved and marginalised”(Rural Mental Health Campaign Report, 2015, p. iv). The report further highlighted that “This current configuration of the mental health care system does not provide for the psychosocial and cultural needs of mental health care users living in rural areas” (ibid). Morgan and Sherry (2015) described the features of mental health services in rural areas as follows:

- Inaccessible services, mostly sited in urban tertiary centres
- Grossly inadequate budget allocations by provinces
- Frequent drug stock-outs, leading to high relapse rates
- Lack of human resources for mental health
- Lack of psychosocial rehabilitation, resulting in poor recovery and “revolving door” care
- Stigma and discrimination (p. 1)

Seventy-one percent ($n=77$) of mental health professionals went further and disagreed that comprehensive mental health treatment options are always available to mental health service users in their provinces. These findings are confirmed by Lund et al. (2012) who stated that the treatment of people with severe mental illness at a primary health care level consists mainly of medication management. They added that “Beyond medication monitoring, there is little community-based psychosocial rehabilitation (PSR) at this level in

South Africa, and several studies have highlighted shortcomings in this regard” (p. 403). These findings are also confirmed by Petersen et al. (2009). Mental health professionals in this study largely disagreed (71.6%, $n=78$) that a range of community-based programmes were available to patients discharged from psychiatric facilities.

Service users indicated the following:

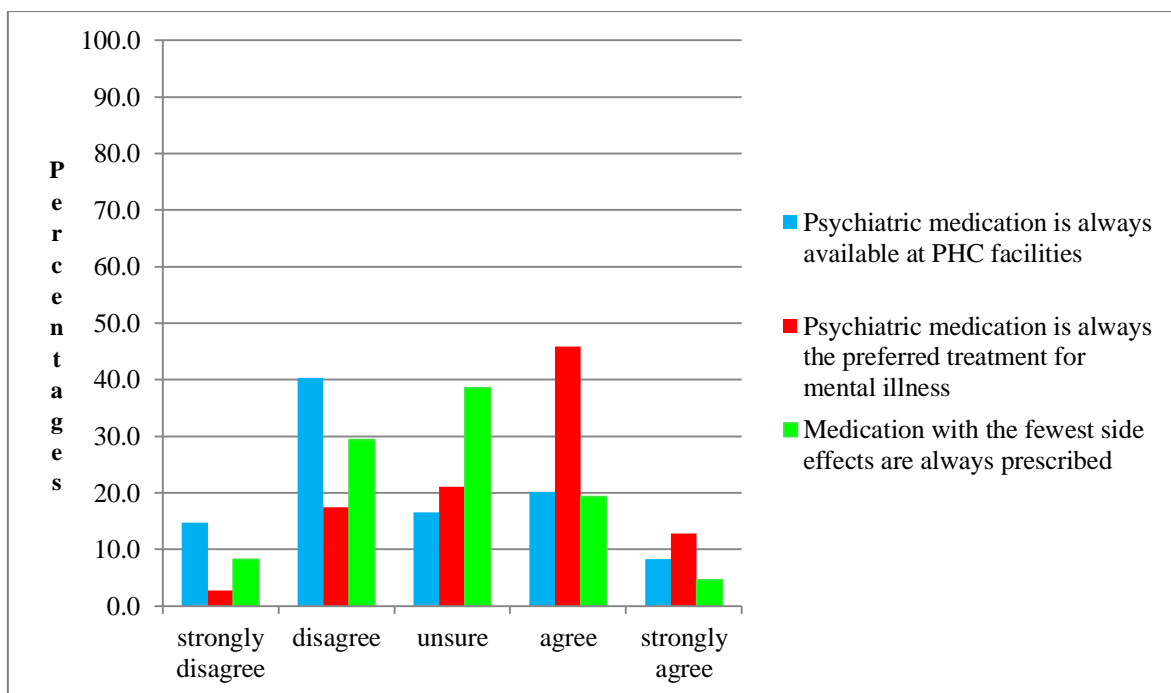
Surely they can have more effective group therapy where people who are ill come as a group and where the psychiatric nurse can implement better models of behaviour modification because one is diagnosed according to the way one is behaving (*WC Service user, KT, March 2016*).

Not everybody gets to see the social worker, the psychiatrist or the students to talk about questions or you talk about mental illness where they can give you some guidance. There are no groups... (*KZN Service user, FH, April 2016*).

4.3.2.8. Current State of Mental Health – Medication

Mental health professionals and service users’ perceptions about medication were examined.

Figure 23: Current State of Mental Health – Medication



As depicted in Figure 23 (p. 111), 55.1% ($n=60$) mental health professionals disagreed that medication was always available at PHC facilities, whilst 58.7% ($n=64$) indicated that psychiatric medication is always the preferred treatment option for mental illness.

According to the Stop Stock Outs Campaign, 10% of reported medication stock outs between January and July 2015 were psychiatric medications. Rural areas are hardest hit by 'stock outs', as problems are exacerbated by logistical and human resource constraints, such as large distances between facilities and understaffing (Rural Mental Health Campaign Report, 2015, p. 21).

In a recent study conducted by the South African Federation for Mental Health in the North West Province and Mpumalanga, 85% of service users reported that the stock-out of medication was common (Sunkel, 2016).

Mental health service-users related their experiences of medication stock outs:

The Diazepam – most times there isn't enough. Then you have to go back. When I went [to the clinic] they only gave me two weeks supply so they said I must phone and find out whether any had arrived to get a refill of Diazepam (*WC Service use, YW, March 2016*).

It does not happen often. Look they only give us tablets that they have and then you have to come back again. It messes your whole system up. You must start all over again. I waited about a month for my tablets. I get sick if I don't get the tablets (*NC Service user, GH, April 2016*).

Sometimes when I go to the clinic for medication then they are out of stock. Or they say come next week or they give me a number to say I must call to if you don't want to come. Sometimes when we need the medication they say that they don't have it but you can go to the pharmacy to buy the medication (*KZN Service User, ZZ, April 2016*).

The WHO AIMS Report on the Mental Health System in South Africa (2007, p. 28) confirms that psychotropic medication was mostly available at psychiatric facilities but to a lesser extent at Primary Health Care. Lund et al. (2012) stated the following:

The availability of medication is one of the key components in delivering effective, quality rural mental health care services. For many people having access and availability to psychiatric medication is essential to their own recovery and management process. The lack of access to medication at rural clinics is more than a logistical or policy issue; it deeply impedes on people's right to health and dignity (p. 403).

Access to medication is critical for better treatment outcomes and thus improvements in sufficient medication stocks at PHCs needs to be addressed.

An almost equal proportion of mental health professionals were unsure (38.5%, $n=41$) and disagreed (37.7%, $n=41$) that medication with the fewest side-effects were being prescribed.

4.3.2.9. Perceptions regarding the Current State of Mental Health – Infra-Structure and Bed Availability

Mental health professionals and service users identified the conditions of mental health facilities and bed availability.

Figure 24: Current State of Mental Health – Infra-Structure and Bed Availability

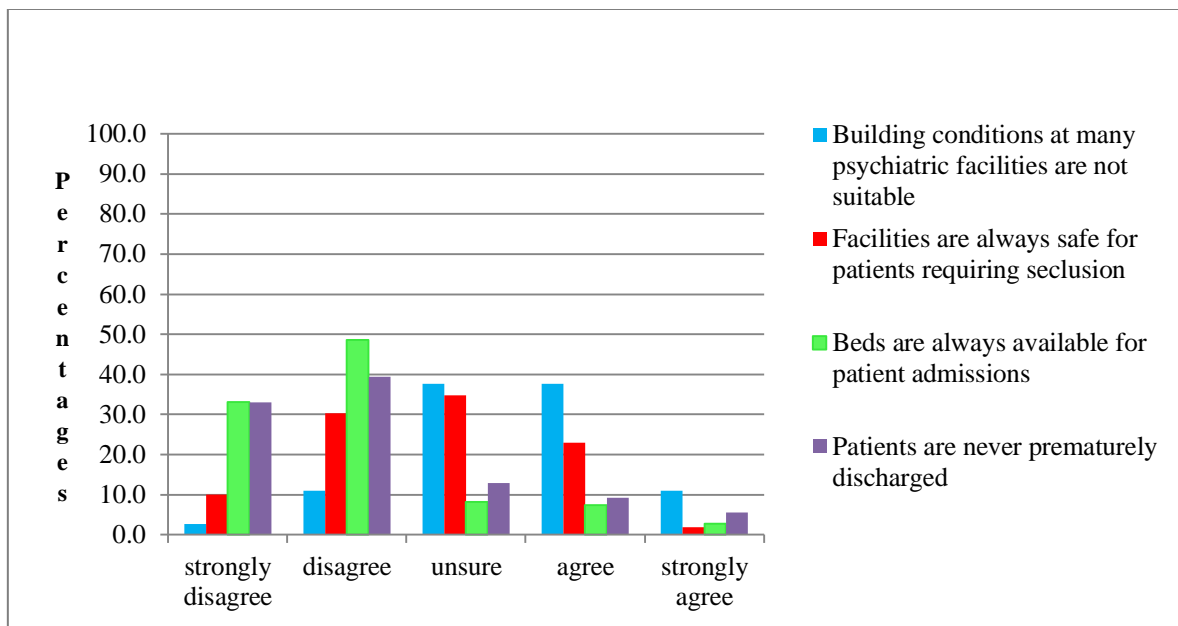


Figure 24 illustrates that 48.6% ($n=53$) mental health professionals agreed that the building conditions at many psychiatric facilities were not suitable for satisfactory patient care, whilst (37.6%, $n=41$) were unsure. Burns (2011, p. 104) stated that psychiatric hospitals remained outdated, falling into disrepair, and were often unfit for human use whereas Janse van Rensburg (2012) stated that:

The extensive infrastructural limitations at district and regional levels are currently significant obstacles to the effective and humane assessment and management of patients requiring psychiatric admission or outpatient services. For example, in terms of 72-hour assessment at the point of entry to healthcare services, current legislation was implemented without any budgetary provision on national or provincial level, to allow for, for instance, the transfer of administrative support to local and regional general hospitals (previously performed by the magistrates' offices of the Department of Justice). Furthermore, no provision was made for the adjustment of the physical facilities of these hospitals which have to accommodate the new services (including those for involuntary users). As a consequence, 72-hour assessments are currently predominantly performed in unsafe, inappropriate structures with inadequate trained staff, or a lack thereof, with respect to numbers and expertise (p. 135).

He added that currently long-term facilities in several regions are inadequate and far from where the service users live.

Mental health service users commented on the conditions of the primary health care facilities, noting the following

The toilet facilities at West End Clinic are pathetic. It is not even clean or looked after – nothing. So if you want to urinate or whatever you have to be very careful – that is supposed to be health care facility. What is even more irritating is that primary care patients are usually more than what we are and we sit separately but they are uneducated about mental health so they are quick to judge? Mental illness does not ask how rich you are or how poor you are or where you come from. If something that happens and nobody can change it (*EC Service-user, CMS, March 2016*).

There are two hospitals. Some go to Dr C.N. Phatudi and some go to Letaba Hospital. The Dr C.N. Phatudi toilets are not functioning and the environment is not so clean. The toilets, even after they are cleaned, they are still dirty. And you go there, you come back more sick because of the environment (*Limpopo Service-user FL, April 2016*).

Some added that conditions within psychiatric hospitals during involuntary admissions were not satisfactory either:

Conditions [in the closed wards] were tough. We had to share with many – we had to bath as a group in the company of men. There is no privacy (*KZN Service user, RJ, April 2016*).

For me, I spent a lot of time [in a closed ward] and what I experienced was when I wanted water there was no tap for me when I wanted water I would shout and nobody would come. That was my experience... (*KZN Service user, NN, April 2016*).

Seclusion, yes... You have got to use the bedpan; you must sleep with the mattress, which is on the floor without a sheet and without a pillow. I suppose they must put you there because they don't know whether you'll be violent or what is happening to you but that should be slightly improved. Where the bathrooms were they just open anyhow (*KZN, Service user, FH, April 2016*).

Really we get that type of story about that place they lock the people up. I was also there my arm was broken and you walk pass and you can see the people. You have no privacy they're like monkeys locked up in a jail there. I went and spoke to the person – somebody's son was there while I was there I spoke to this lady and I spoke to her son for part of this and he had to urinate on the floor in the corner. He had no bucket or nothing... (*EC, Service user, RS, March 2016*).

The experiences reported by mental health services users were confirmed in the findings of the Committee of Enquiry that investigated allegations of human rights abuses of psychiatric patients at the hospital in KwaZulu-Natal. Mkhize (2007) found overwhelming evidence of patient neglect, inadequate recreational facilities and patients spending most of their time in wards, having no exercise, patients sleeping on the floor, female patients having no access to underwear, serious shortage of staff, and other violations.

Thirty-five percent of respondents were unsure whether facilities were always safe for patients requiring seclusion, whilst 40.4% ($n=44$) disagreed that the seclusion wards were safe, as shown in Figure 24 (p. 113). Eighty-nine mental health professionals (81.6%) disagreed that beds were always available for patients requiring admission; however 72.4% ($n=79$) disagreed that patients were never prematurely discharged. The majority of mental health service users disagreed that beds were always available and highlighted that they had experienced premature discharge:

It's not really any beds but no bed availability (*WC Service-user, LN, March 2016*).

I stayed one week in hospital. And when I was discharged, I still felt very weak (*Limpopo Service user, JM, April 2016*).

Some people, when they go to hospital, they get fine. But after a week, they go back home they don't get the right treatment (*Limpopo Service user, SM, April 2016*).

Yes, it could be so because there are no more beds. That is why when they have to admit other people – they have to make space (*Limpopo Service –user, JN, April 2016*).

Lund and Petersen (2011) in a systematic review of mental health services research from January 2000 to October 2010 found that there was early discharging of patients owing to bed shortages, resulting in the “revolving door” phenomenon that was exacerbated by the lack of adequate provision of community mental health care. These authors referred to Ramlall, Chipps, and Mars (2010) study in KwaZulu-Natal where they found that “63.9% of designated general hospitals in the province reported inadequate resources, including insufficient designated beds, specialist staff and seclusion rooms to deal with the demand and challenges of caring for disruptive patients – this is despite the findings that 75.6% of admissions were involuntary or assisted indicating that the service caters mostly for MHCUs with severe mental illness” (p. 667–670). Lund and Petersen (2011) further concluded the following:

On the negative side, whilst there has been a reduction in psychiatric hospital bed numbers, there has not been sufficient investment in the development of community-based psychosocial rehabilitative services to support de-institutionalisation. The result has been “dehospitalisation” and the development of the classic revolving-door phenomenon (p. 753).

Severe shortages of beds have led to crisis discharge policy, which has led to increased readmission of patients. The findings of this study reveal that the non-availability of beds led to an increase in premature discharges. Niehaas et al. (2008) noted that the “so-called crisis discharge” was associated with a significantly increased risk of readmission and shorter time until readmission.” (p. 4).

4.3.2.10. Socio-economic Conditions and Poverty – Impact on Mental Health

Mental health professionals and service users’ perceptions of the impact of poor-socio economic conditions and poverty on mental illness and the consequent increase in demand for mental health services were also identified.

Figure 25: Poor Socio-Economic Conditions – Poverty and Impact on Mental Health

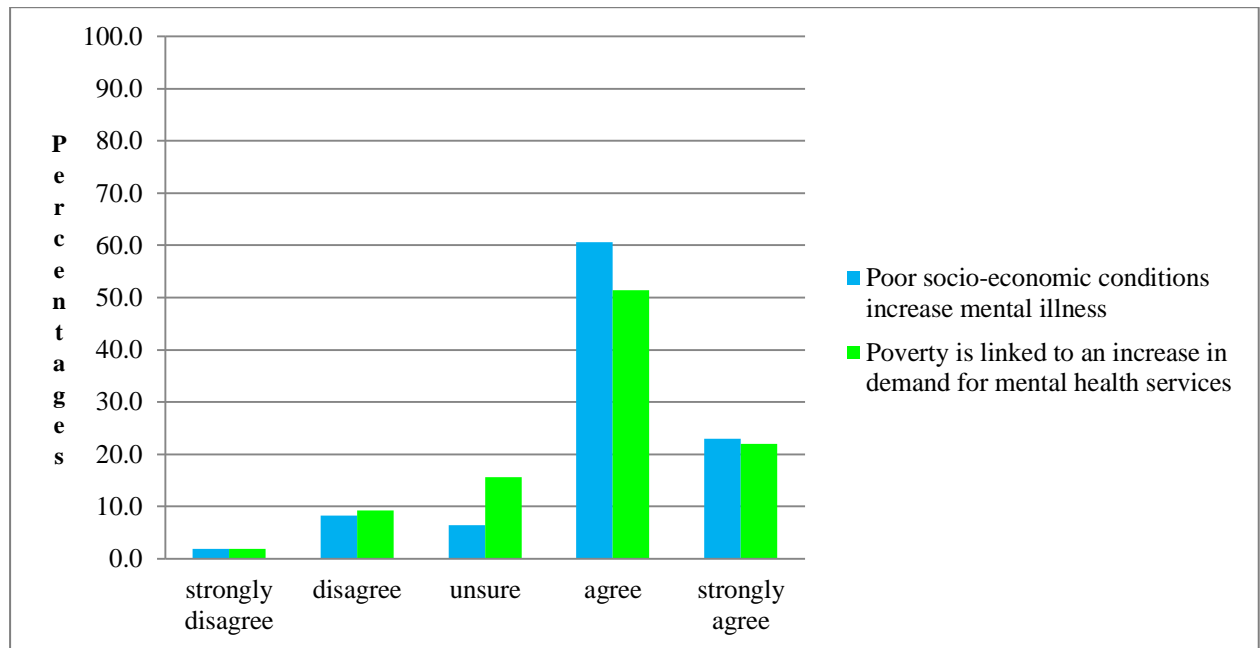


Figure 25 highlights that a significant number (83.5%, $n=91$) of mental health professionals agreed that poor socio-economic conditions increased mental illness in their provinces, whereas 73.4% ($n=80$) agreed that there was a direct link between poverty and the increase in demand for mental health services as reflected in Figure 25.

These findings concur with Lund et al. (2011) that “mental ill health and poverty interact in a negative cycle in low-income and middle-income countries” (p. 7). Lund (2012) noted the following:

In 2010, the first systematic review of common mental disorders and poverty in LMICs found strong and consistent associations between common mental disorders and low education, food insecurity, inadequate housing (including structural aspects of housing and overcrowding), low social class, low socioeconomic status and financial stress; but less consistent associations with reduced income and consumption (p. 15).

The link between poverty and mental illness has been corroborated in other studies. Funk, Drew, and Knapp (2012) noted that “the poor are disproportionately affected by mental disorders” (p. 166). People with the lowest socio-economic status have eight times greater relative risk of having schizophrenia than those belonging to the highest socio-economic strata. They added that people with mental illness are four times more likely to be unemployed or partly employed. They further noted that the rate of common mental disorders is twice more frequent amongst the poor, adding that poverty ultimately exposes people with mental illness to great risk factors.

The reality is that many individuals diagnosed with mental illness are unable to find suitable employment and thus remain dependent on social security benefits. Mental health service users highlighted the difficulty in accessing jobs and the constraints of a meagre grant:

It is a right to be employed and to learn day by day. I can work – I have 5 years’ experience. Hire me but I’ve been let down and I think that is wrong. I have been treated differently, because of my mental illness – I am only human. I have taught myself to work the computer – I have skills and I have taught myself to do things. Of course, I make mistakes and if I’m not a 100% sure I’ll ask someone. I just want to have the opportunity to work and don’t look down on me and say that because I am slow and have Attention Deficit Disorder I can’t work with children (*WC Service-user, AF, March 2016*).

Before I got a disability grant, I was working at a factory for 4 years before I became sick. When I came out of hospital people treated me coldly. I was on sick leave for 6 months and they could not even pay me a salary. When I went back to work they said sorry we can’t keep you – go... (*EC Service User, CMS, April 2016*).

Disability grants are not sufficient... We have to depend on our families and they can’t afford it and we are getting older... (*KZN Service-user, RJ, April 2016*).

According to Statistics South Africa’s Poverty Trends in South Africa – An examination of Absolute Poverty between 2006 and 2011 (2014), 45.5% of South Africans lived below the poverty line. Thus assumptions may be made that a significant cohort with mental illness

lives in challenging financial situations since research has shown that there is a relationship between poverty and mental illness.

4.3.2.11. Violence and Mental Illness

Violence in communities and its impact on mental health will be discussed in this section.

Figure 26: Violence and Mental Health

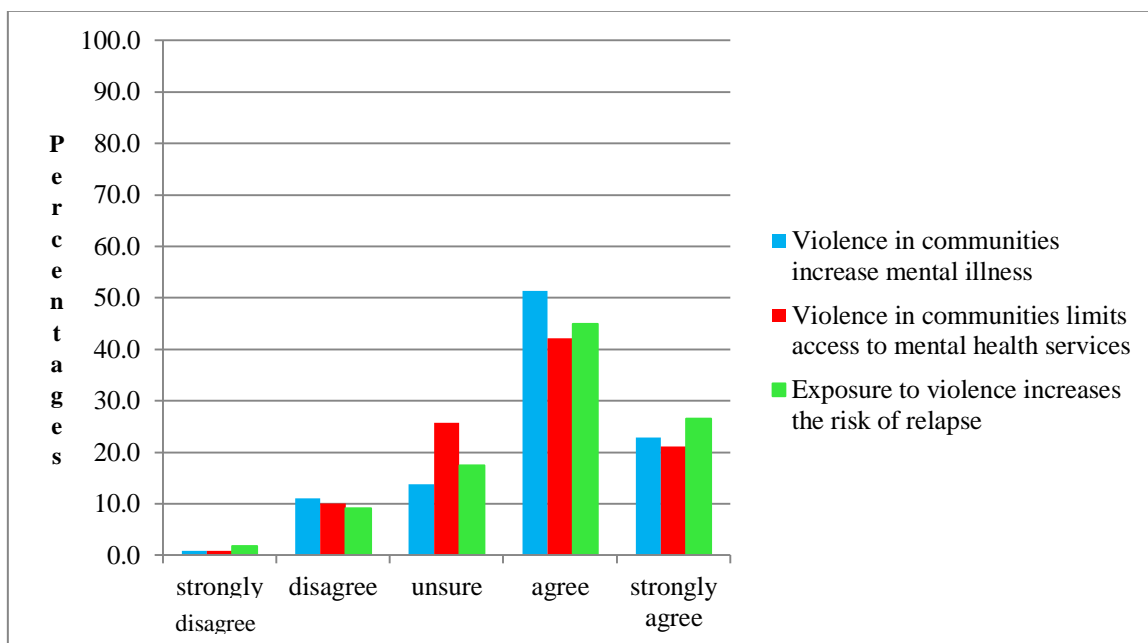


Figure 26 highlights the impact of violence in communities on mental health. Mental health professionals (74.3%, $n=81$) agreed that violence increases mental illness and has a compound negative impact on access to mental health services. Mental health professionals (63.3%, $n=69$) agreed that violence in communities limit access, whereas 71.6% ($n=78$) of respondents indicated that exposure to violence for people living with mental illness predisposes them to an increased risk of relapse.

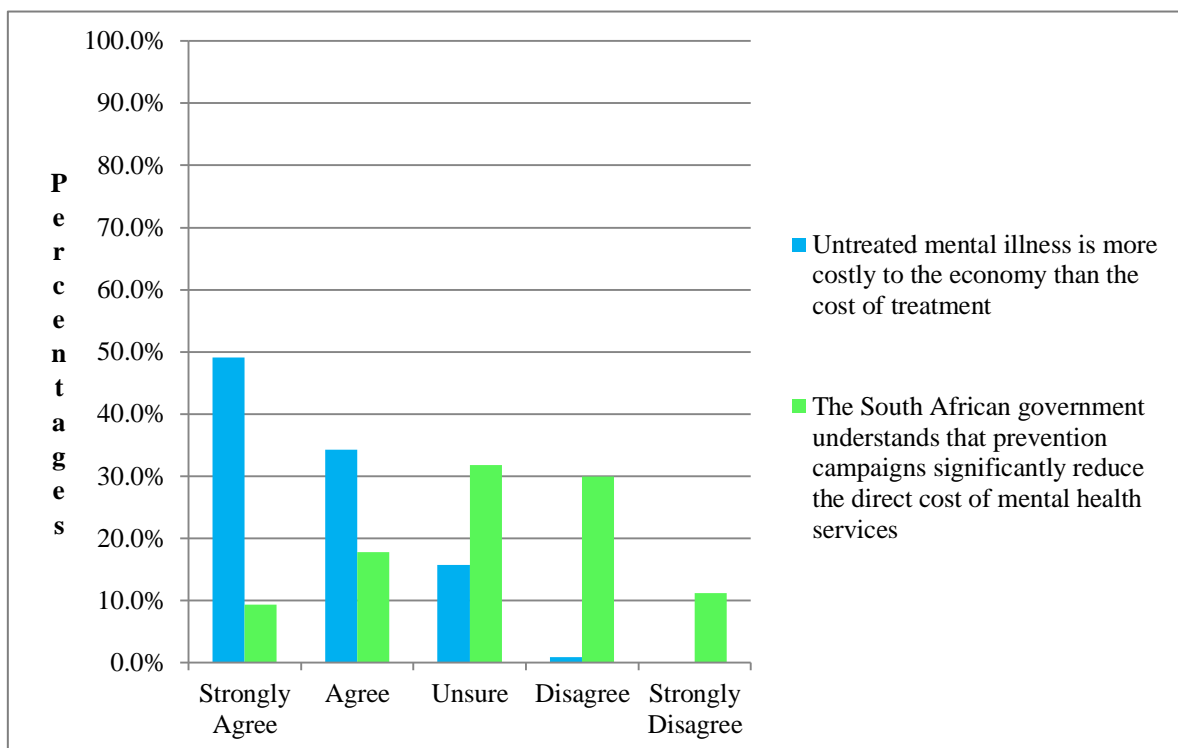
4.3.3. Financial and Human Resource Allocations for Effective Community-based Mental Health Programmes

This section deals with mental health professionals' perceptions about financial and human resources allocations for mental health in South Africa and what provisions are required to

facilitate the delivery of effective community-based mental health programmes. It will focus on the following findings related to the current state of mental health NGO funding and resources; human resource challenges in mental health services, as well as incentives for mental health professionals:

4.3.3.1. *Current State of Mental Health NGO Funding and Resources*

Figure 27: Cost of Mental Health Services



Lund et al. (2012) reported that “the total annual cost in lost earnings for South Africans with mental disorders was in the region of R30 billion (\$3.6 billion). This is in stark contrast to government’s projected total annual expenditure on mental health services of around R500 million (\$59.3 million)” (p. 1). Their findings clearly indicated that it cost South Africa much more not to treat mental illness than it would to treat mental health conditions. As illustrated in Figure 27, the majority of mental health professionals (83.3%, $n=91$) agreed and

support the findings of the PRIME study (2012) that untreated mental illness is more costly to the economy than the cost of treatment.

Figure 27 (p. 120) shows that 41.1% ($n=45$) of mental health professionals disagreed that the South Africa government understands that prevention campaigns significantly reduce the direct cost of mental health, whereas 31.8% ($n=35$) were unsure.

Figure 28: NPO Funding and Resources in Provinces

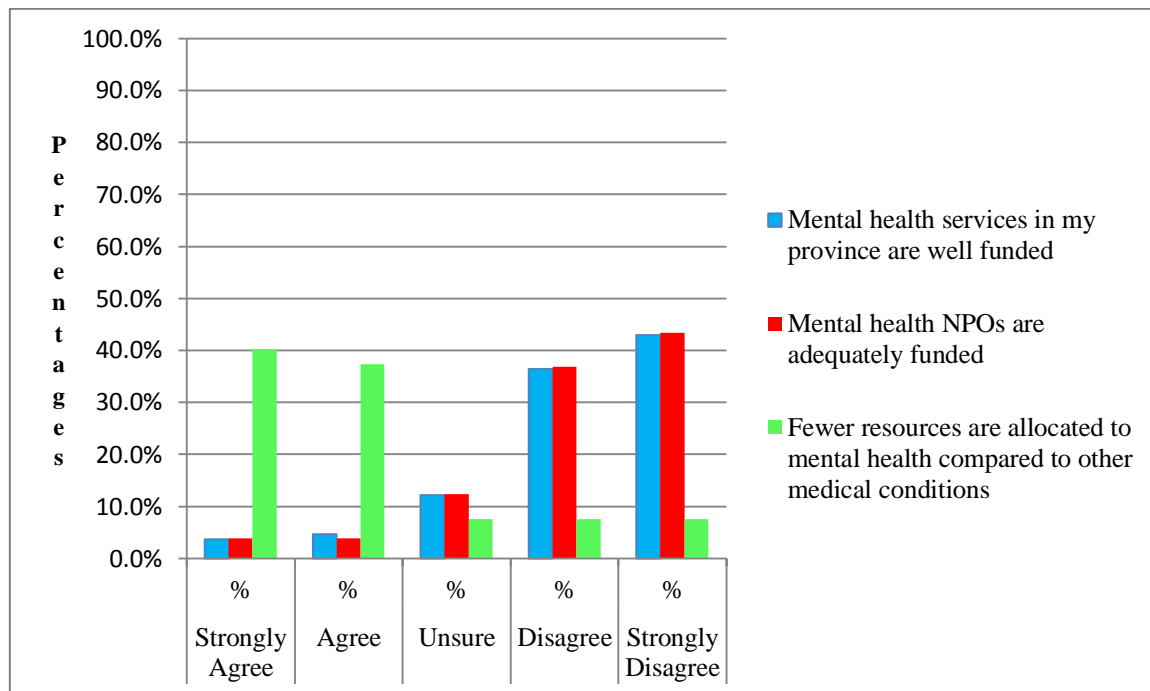


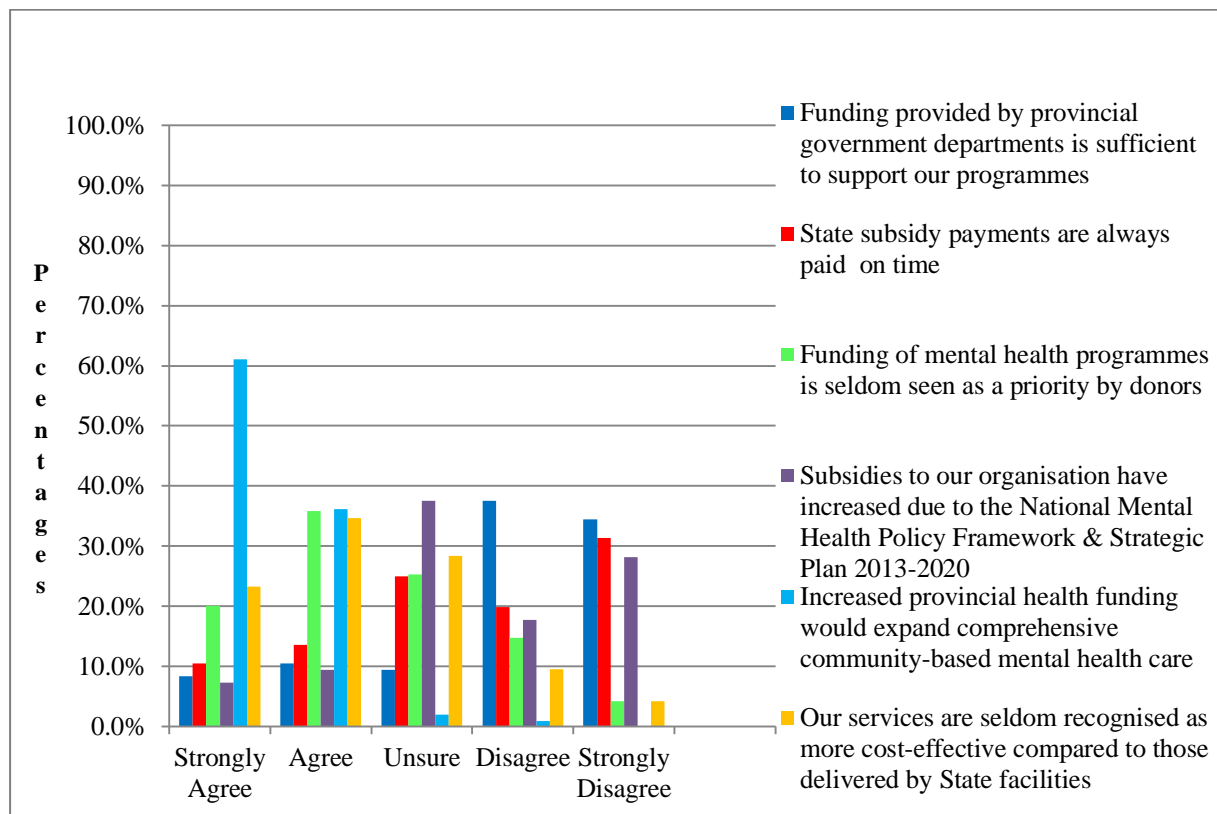
Figure 28 illustrates that the majority of mental health professionals (79.4%, $n=87$) disagreed that mental health in their province was well funded. Mental health professionals (80.2%, $n=89$) disagreed that mental health NPOs are adequately funded. A mental health service user gave her impression by noting the following:

I think most of the state of mental health right now is not receiving government support money wise because we have been cut down by almost half like we used to have. Government is not funding at all... (*KZN Service-user, FH, April 2016*).

A significant number of respondents (77.6%, $n=85$) agreed that fewer resources are allocated to mental health, compared to other medical conditions. Petersen and Lund (2011)

confirmed in their study the lack of mental health resources and under-provisioning of designated beds and specialist staff. Mental health has continued to be one of the most neglected of all the health services despite the prevalence and affordability of treatment options. The lack of provisioning of mental health resources largely accounts for the 75% of people in South Africa and lower middle-income countries having no access to mental health services. This situation is compounded in rural areas where medication stock-outs and a serious lack of access to mental health care have been reported (Rural Mental Health Campaign Report, 2015).

Figure 29: Funding of Mental Health NPOs



A significant majority (71.9%, $n=78$) of social workers disagreed that funding provided by provincial government departments is sufficient to support their programmes, as illustrated in Figure 29.

The South African Federation for Mental Health Analysis Report on Annual Statistics for Financial Year 2014–2015 (2015) highlighted that on average, consolidated, mental health NPOs receive 59.4% of their funding from both the Department of Social Development and the Department of Health. Table 5 illustrates that subsidies decreased drastically over the three financial years despite annual inflation of approximately 6% year on year.

Table 5: Comparative Analysis: Variances in Sources of Income

COMPARATIVE ANALYSIS: VARIANCES IN SOURCES OF INCOME			
SOURCES OF INCOME	2013–2014	2014–2015	2015–2016
Government subsidies	R68 177 918-25	R 64 979 315-74	R59 271 938-00
International funding	R16 131 170-02	R 1 072 769-00	R488 420-00
NLDTF (now known as the National Lottery Commission)	R14 639 378-74	R 3 500 952-00	R102 123-00
Donor funding	R7 761 771-00	R 4 869 705-07	R5 781 041-00
Other	R4 586 455-02	R 15 250 179-00	R5 711 122-00
Contracts	R4 568 562-00	R 6 516 775-50	R3 232 454-00
Corporate funding	R3 203 468-00	R 8 607 796-00	R1 337 082-00
Dividends from investments	R1 345 355-55	R 1 394 243-82	R293 043-00
EAP	R824 460-68	R 445 470-76	R557 123-00
Events	R806 022-36	R 1 004 848-00	R3 634 726-00
Capital projects	R736 011-00	R 576 470-00	R238 089-00
Campaigns	R597 266-60	R 482 471-10	R159 195-00
Training	R246 566-00	R 560 373-00	R10 110 944-00
TOTALS	R123 624 405-22	R109 261 368-99	R90 917 300-00

The funding allocation represented in Table 5 is, however, deceptive, since the funding varied greatly from one State department to another, and from one province to another. Some provinces received no increase in their funding in the financial years identified in Table 5, whilst others were minimal. Subsidy allocations to non-profit mental health organisations had decreased annually instead of increasing by the inflation rate. The reduced income is also an indication that no funding had been made available for the expansion of community-based mental health services. There is an enormous burden on these mental health NPOs to find the

income from alternative income initiatives, such as providing training, running campaigns, events, Employee Assistance Programmes, business, investments, and sourcing income from corporates, trusts and foundations and international funders.

Figure 29 (p. 122) further highlights that half (51.1%, $n=56$) the social workers disagreed that State subsidy payments were always on time. These findings suggest that a number of provinces were not paying subsidies on time that had huge implication for cash flow management. State departments in certain provinces such as the Western Cape had good capacity and systems in place to ensure that they complied with the Service Level Agreements. Fifty-six percent of social workers ($n=61$) agreed that funding of mental health programmes was seldom seen as a priority by donors.

Figure 29 (p. 122) also illustrates that the majority of social workers (57.9%, $n=63$) agreed that their organisations' services were seldom recognised as more cost-effective compared to those delivered by State facilities. Desmond and Gow (2001) in their study on the Cost-Effectiveness of Six Models of Care for Orphan and Vulnerable Children in South Africa found that community-based services offered by NGOs were more cost-effective than those offered by the formal sector. This was confirmed in an informal comparative study in 2009 by the Provincial Mental Health Forum that found that mental health service costs per person provided by NGOs compared to those provided by the DOH in the Western Cape were by far less costly. (See Appendix J, pp. 310–311).

Sinanovic and Kumaranayake (2006) in their study on financing and cost-effectiveness analysis of public-private partnerships on the provision of TB treatment in South Africa stated the following:

Expansion of private-public partnerships could potentially lead to reduced government sector financing requirements for new patients: government financing would require \$609–690 per new patient treated, in contrast to public-private non-government sites that would only need to \$130–139 per patient (almost a five-fold reduction in costs)"(p. 11).

These findings suggest that hospital-centric approaches to mental health care are far more expensive than community-based mental health services.

Raviola, Becker, and Farmer (2011) and Burns (2010) argued that despite neuropsychiatric disorders comprising a significant proportion of the disease burden, on average only 4% of the health budget is spent on mental health. Burns (2009) stated that of the 18 African countries where data was available, 15 of these countries spent less than 1% of their health budget on mental health. Freeman (2013) made the point that the cost of treating someone with a mental illness was considerably less than the cost of mental illness going untreated.

Only 45.8% ($n=50$) of the social workers disagreed that subsidies to their organisations had increased due to the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013).

The findings as reflected in Figure 29 (p. 122) illustrate that almost all (97.2%, $n=106$) mental health professionals agreed that an increase in provincial health funding would expand comprehensive community-based mental health care. A focus group respondent said:

Minister Aaron Motsoaledi, he is a good Minister, but he can't do everything. He's got his hands in too many pies – he needs people under him who are given the right finances (*EC Service-user RS, March 2016*).

These findings suggest that provincial funding, to expand mental health services at PHC level, remains inadequate. Burns (2011) stated that there was no specific budget within health at provincial and national levels for mental health. He added further that there were gross inequities in funding across provinces for mental health care, whilst on average only 4% of the health budget in South Africa was spent on mental health. His findings were supported by mental health NPOs who receive a subsidy for specific mental health service ranging from between 25–45% percent, with an average 0–6% increase per annum in these subsidies with absolutely no funds set aside for expansion. This therefore raises questions as to whether the

National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) will remain a pipe-dream. Mental health NPOs are often left with the burden of funding the balance of the cost of these services. This is despite the fact that 17 mental health NPOs provided the backbone of services to 79 800 mental health service users in South Africa in the 2014–2015 financial year (South African Federation for Mental Health Analysis Report on Annual Statistics for Financial Year 2014–2015, 2015, p. 26).

The WHO (2004) stated the following:

Moreover, low treatment costs (because of lack of treatment) may actually increase the indirect costs by increasing the duration of untreated disorders and their associated disability. Overall, the economic costs of mental ill-health are enormous and not readily measurable. In addition to health and social service costs, lost employment, reduced productivity, the impact on families and caregivers, the levels of crime and public safety and the negative impact of premature mortality, there are other hard-to-measure costs, such as the negative impact of stigma and discrimination or lost opportunity costs to individuals and families that have not been taken into account (p. 15).

Even though the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) stated that “the indirect cost of treating mental disorders outweighs direct treatment costs in developed countries and may be higher in developing countries, budget allocation to reduce this burden remains dismally low” (p. 14). They added that “in the first nationally representative survey of mental disorders in South Africa, lost earnings among adults with severe mental illness during the previous 12 months amounted to R28.8 billion and this far outweighs the direct cost of care in mental health” (National Mental Health Policy Framework and Strategic Plan 2013–2020, 2013, p. 14).

4.3.3.2. Human Resources Challenges in Mental Health and Responses to these Challenges

There are various human resource challenges in the field of mental health service that include the following:

- Working conditions of mental health professionals
- Retention of mental health social workers and their working conditions
- Working conditions at mental health NPOs
- Violence and mental health social work services

4.3.3.2.1. Working Conditions of Mental Health Professionals

Mental health professionals and service users shared their perceptions about the working conditions in relation to job-related stress, job workload, shortage of staff, and lack of support of mental health professionals.

Figure 30: Working Conditions of Mental Health Professionals

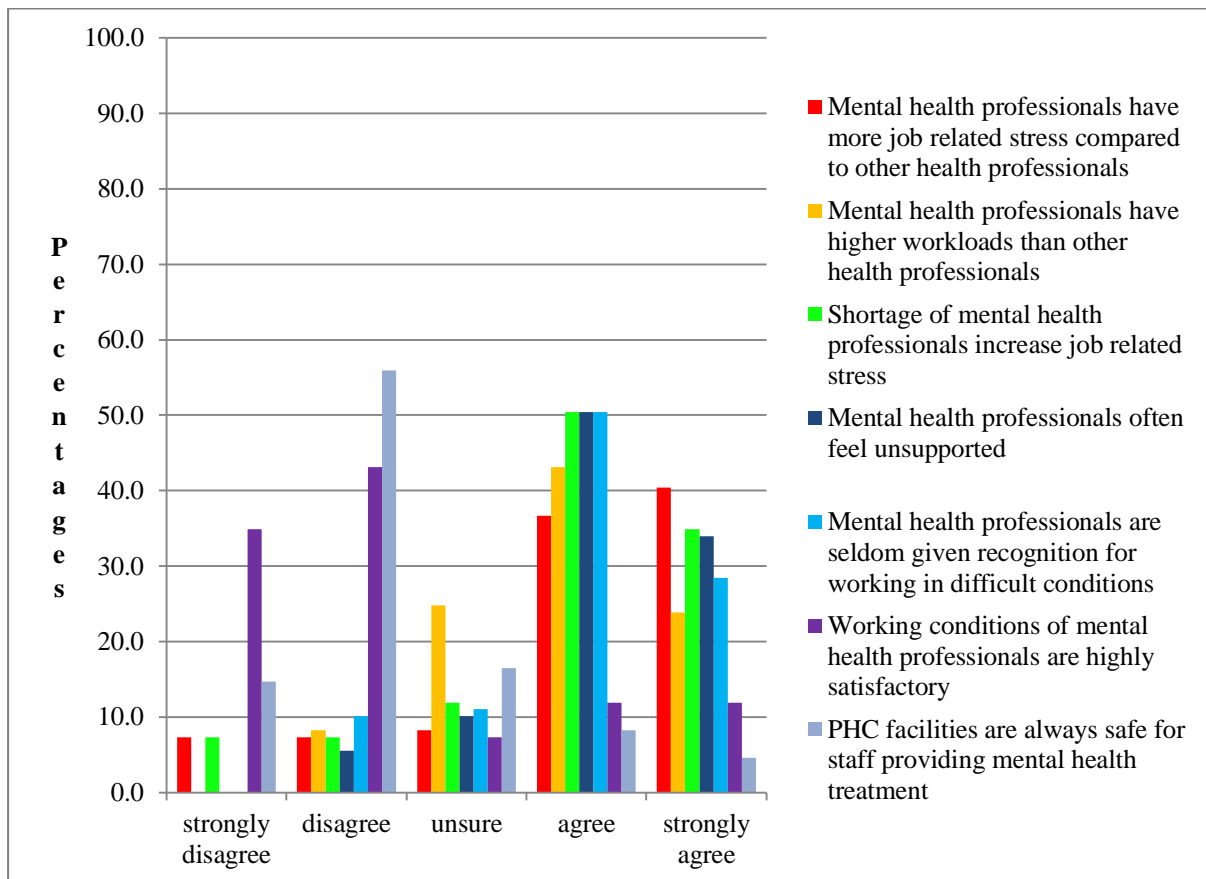


Figure 30 highlights that a significant number (77.1%, $n=84$) of mental health professionals agreed that mental health professionals have significantly higher job-related stress compared

to other health professionals. The issue of stress among mental health professionals was not explored in the focus groups.

There are obviously various contributing factors responsible for high job-related stress. At least 67% ($n=74$) respondents agreed that mental health professionals had significantly higher workloads than other health professionals.

Figure 30 (p. 127) highlights a significant number of participants (85.4%, $n=93$) agreed that a shortage of mental health professionals increased stress in their jobs.

According to Lloyd, Sanders, and Lehmann (2010) noted that:

Transformation of the health system has been hampered by inadequate numbers and inequitable distribution of health workers between private and public sectors and rural and urban areas, lack of appropriate skills throughout the system and poor planning and monitoring. Key weaknesses are the failure to produce adequate numbers of health professionals and the extreme maldistribution of personnel (p. 172).

Staff shortages thus increase stress levels of health professionals, but also impact on service users. Mental health service users reported the following:

You see you are the one experiencing the illness. There in Khayelitsha there is no psychiatrist so you are being seen by the nurses... (*WC Service-user, AC, March 2016*).

They always say there is a shortage of staff and always say there is only one doctor (*EC Service –user, PN, March 2016*).

At the clinic I never see any doctor – even now I don't see any doctor. I don't even know what my psychiatrist looks like. They just ask if I'm taking my medication (*EC Service-user, PD, March 2016*).

And the problem is that if the psychiatrist is there, they normally only take a number of people. And you find that they normally don't get to see all the people and then they [patients] are sent back home (*KZN Service –user EL, April 2016*).

Service users also highlighted management challenges:

The problem is the top management in these places. Quality top management is required that will give you the right finances and the right resources, right support and basically management. Top management needs to put checks and balances in place. So it's accountability by top management (*EC Service-user RS, March 2016*).

If they give people in management positions – they must be screened and properly screened. You can't put any Tom, Dick and Harry into a management position in the DOH, you understand, but someone who has knowledge. We need someone who can grasp what is going on – what needs improvement and what doesn't (*EC Service-user CMS, March 2016*).

Thus the shortage of mental health professionals and the need for carefully selected management personnel were highlighted as major challenges by the service users.

As illustrated in Figure 30 (p. 127), a large majority (84.4%, $n=92$) agreed that mental health professionals often felt unsupported, whereas a significant number (78.9%, $n=86$) agreed that mental health professionals were seldom given recognition for working in difficult conditions.

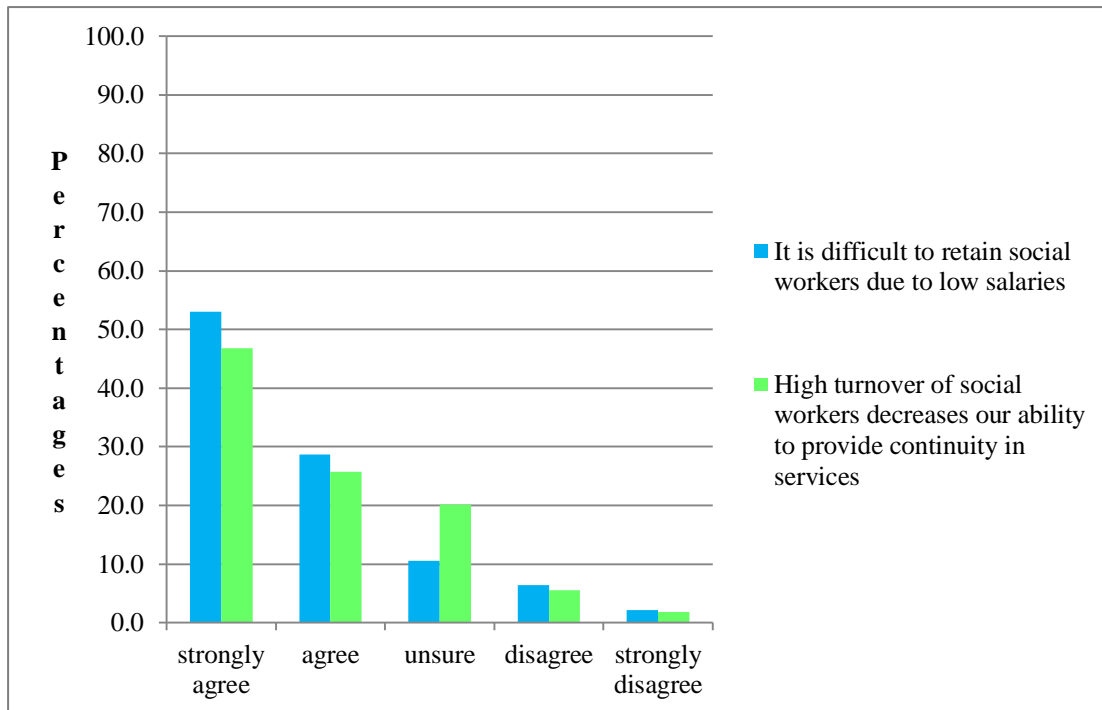
The majority (78%, $n=85$) of mental health professionals disagreed that the working conditions were highly satisfactory, whereas 70.7% of respondents ($n=77$) disagreed that primary health facilities were always safe for staff providing mental health treatment. Evans et al. (2005), Willems (2014), and Morse et al. (2012) suggested that undesirable conditions increased burn-out among mental health professionals that, in turn, impacted negatively on service users. Coetzee and de Villiers (2010) attributed job-related stress to various factors such as role ambiguity, poor work relationships, lack of resources for the job, career constraints, workload and inability to cope, work-home interface challenges, as well as the physical conditions.

Ting, Jacobson, and Sanders (2011) also highlighted that “secondary traumatic stress (STS) also referred to as vicarious trauma, compassion stress, or compassion fatigue is prevalent among mental health professionals who work with traumatized clients” (p. 327).

Morse et al. (2012) noted that high burn-out, increased absenteeism, high turnover, fatigue, exhaustion and suboptimal functioning at work, are all predictors of stress amongst mental health professionals. They also suggested that burnt-out workers might be less able to be empathic, collaborative and attentive.

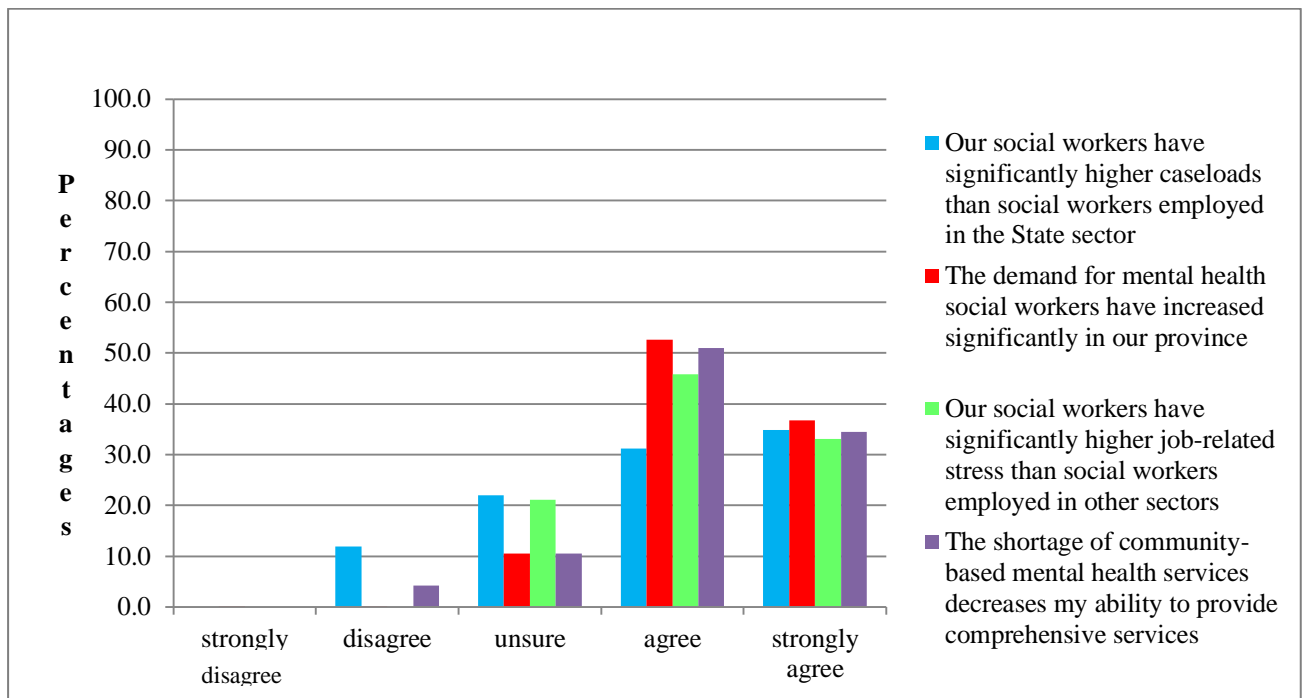
4.3.3.2.2. Retention of Social Workers and their Working Conditions

Figure 31: Retention of Mental Health Social Workers



A large majority (81.7%, $n=89$) agreed that it was difficult to retain their social workers due to low salaries. Lombard (2008) cited Du Toit (2006) who stated that “This increasing discrepancy, as well as the fact that NGOs cannot bring their remuneration packages in line with inflation, is paralysing many organisations” (p. 7). In the 2014–2015 financial year some of the mental health NPOs in certain provinces either had no subsidy increases or minimal increases. This created further salary gaps between mental health NPOs compared to the State sector social workers. However, the Department of Social Development in the Western Cape provided up to 40% increases in social development in the 2014–2015 financial year. The majority of social workers (72.5%, $n=79$) agreed that the high turnover of social workers resulted in discontinuity of services. Social workers provided most of the community-based mental health services and this category of mental health professionals needed to be incentivised through appropriate salaries.

Figure 32: Working Conditions at Mental Health NPOs



As illustrated in Figure 32, 66.1% ($n=72$) of social workers agreed that social workers at their mental health NPOs had significantly higher caseloads than social workers employed in the State sector.

The majority of social workers at the mental health NPOs (89.4%, $n=97$) agreed that the demand for mental health social work services had increased significantly in their province. These findings are in agreement with the findings highlighted in Figure 20 (p. 107) in which mental health professionals agreed that there was an increase in demand for services.

Social workers (78.9%, $n=86$) at the mental health NPOs, as highlighted in Figure 20 (p. 107), agreed that their social workers had significantly higher stress than social workers employed in other sectors. The studies on mental health burnout and stress identified high levels of exhaustion and stress amongst social workers compared to other mental health professionals (Evans, et al., (2005); Morse, et al., 2012; Willems, 2014). Evans et al. (2005) found that the stress levels of mental health social workers working in community-based settings were almost double the highest reported. Morse et al. (2012) noted that

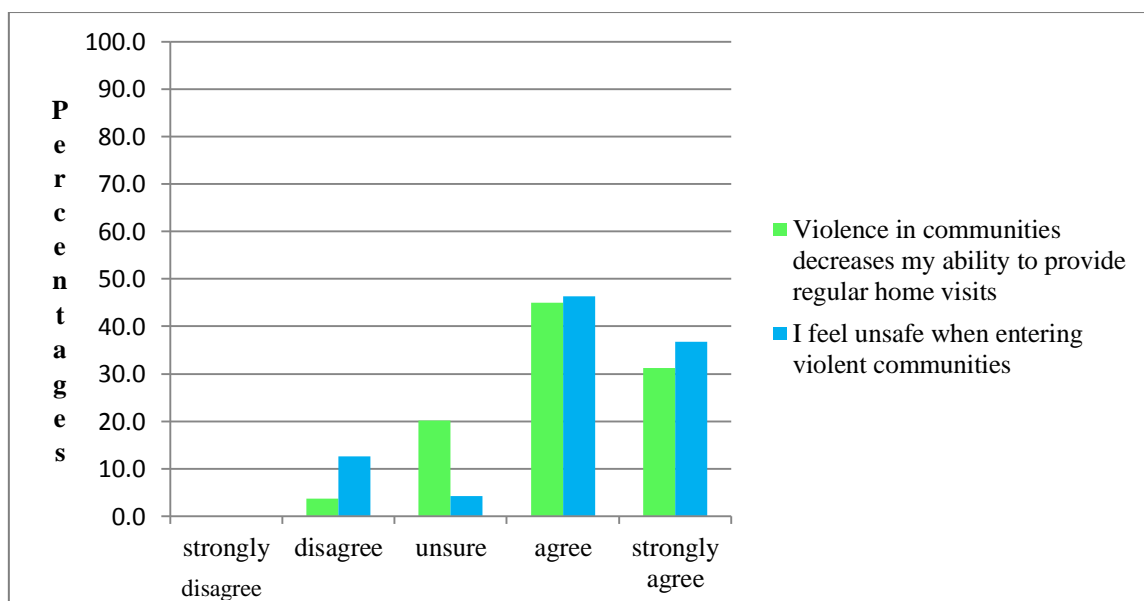
“Differences in burnout between various mental health occupational types have yielded some evidence for higher burnout among community social workers compared to nurses and psychiatrists in one study in two European cities” (p. 3). This concurred with results illustrated in Figure 30 (p. 127).

The majority of social workers (85.4%, $n=93$) agreed that the shortage of community-based mental health services decreased their ability to provide comprehensive services. These results concurred with Burns (2011) who highlighted the serious shortage of community mental health services. The inference that can be drawn from these findings is that, despite The South African Federation for Mental Health Analysis Report on Annual Statistics for Financial Year 2014–2015 (2015) that highlighted the comprehensive and extensive intervention packages of care, mental health resources remain limited.

4.3.3.2.3. Violence and Mental Health Social Work Services

Figure 33 below measures the degree to which social workers at the 17 NPOs are affected by violence in their provinces.

Figure 33: Violence and Mental Health Social Work Services



A significant majority of social workers (76.2%, $n=83$) agreed that violence in communities reduced their ability to provide regular home visits and this confirmed earlier findings. The reduction in services as a result of the violence has implications for service users' recovery outcomes.

Eighty-three percent of social workers ($n=90$) also agreed that they always felt unsafe when entering violent communities. The Western Cape Province, particularly the Cape Flats area, has a serious gang violence problem that is largely unpredictable and generally creates great instability in these communities. Social workers entering these communities are at great risk and so are the beneficiaries of the service.

4.3.3.2.4. Responses to Resource Challenges

Responses to some of the aforementioned challenges include incentives for mental health professionals as well as improved working conditions.

Figure 34: Incentives for Mental Health Professionals

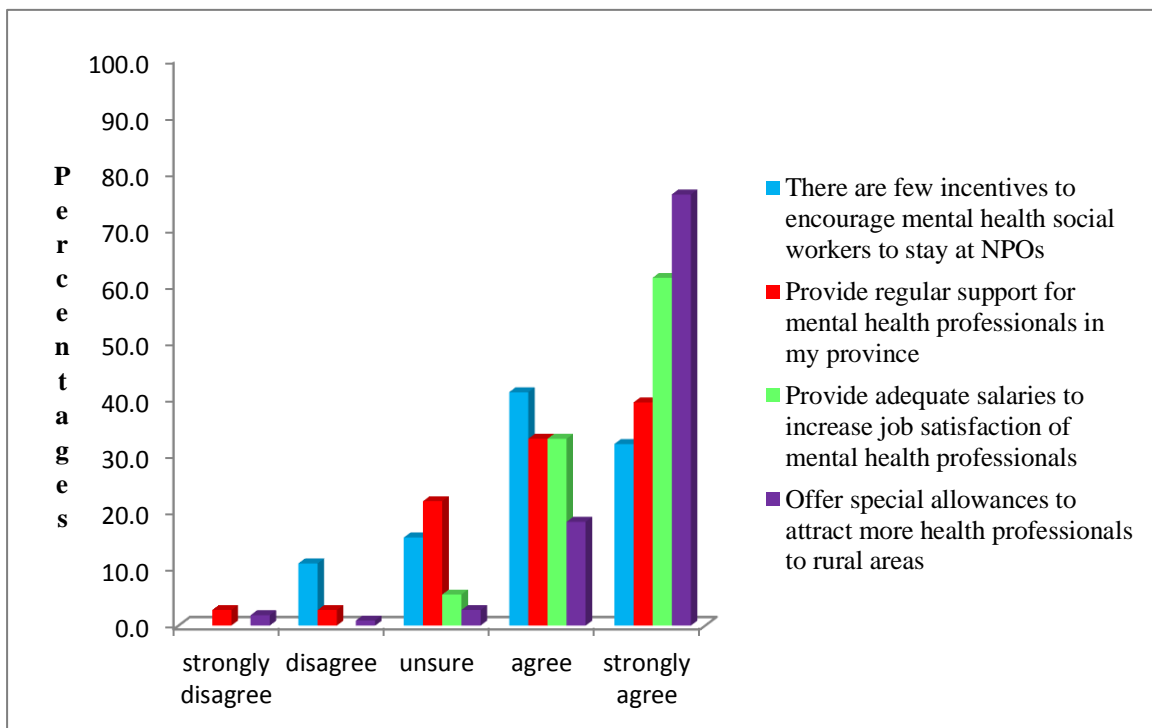


Figure 34 (p. 133) illustrates that over 73.4% ($n=80$) social workers agreed that there were few incentives to encourage mental health social workers to remain at NPOs and this confirmed the findings of Du Toit (2006) and Lombard (2008).

The successful implementation and reintegration of community-based mental health in resource-poor communities, requires targeted strengthening approaches in human resource capacity to deliver effective community-based mental health services.

A large percentage (72.4%, $n=79$) of respondents agreed that mental health professionals in their province should be provided with regular support. Many of the health professionals, including non-specialist health workers, had to manage the quadruple burden of disease in the form of communicable diseases, such as HIV/AIDS and TB, maternal and child mortality, and non-communicable diseases that include mental health, adding to huge workloads hindered by shortages of health professionals across the country.

Willems (2014) highlighted in her study that stress experienced by social workers was the highest amongst mental health professionals.

The majority of the respondents (94.5%, $n=103$) agreed that adequate salaries need to be provided to increase job satisfaction of mental health professionals, whilst exactly the same percentage (94.4%, $n=103$) agreed that special allowances should be offered to attract more health professionals to rural areas. Lloyd et al. (2010) concurred by stating that “The lack of incentives to stay in the public health system, and the ease with which health workers can migrate, has resulted in many health professionals emigrating to Northern countries or moving to the more lucrative and well-funded private sector” (p. 172).

The South African government introduced the occupation-specific dispensation (OSD) on 2007, which is a financial incentive strategy to attract, motivate, and retain health professionals in the public sector. However, the implementation of the OSD was fraught with implementation challenges. According to Ditlopo et al. (2013), lack of consultation regarding

policy implementation, rushed implementation, time and resourcing, poor co-ordination and communication were among the major obstacles. Incentives to retain mental health professionals should include financial and non-financial incentives.

Ndetei, Khasakhala, and Omolo (2008) highlighted the importance not only of financial but also non-financial incentives for health workers such as the following:

- improved working conditions;
- training and supervision; and
- good living conditions, communications, health care and educational opportunities for themselves and their families (p. 3).

Despite social work being identified as a scarce skill in South Africa in 2007, very little has been done to incentivise this profession. A study by Calitz, Roux, and Strydom (2014) highlighted factors such as poor working conditions, high caseloads, low salaries, increased demand for services, lack of resources and support, long working hours, as well as decreased job dissatisfaction that contributed to the shortage in social work.

4.3.3.2.5. Improved Working Conditions

This section discusses the perceptions about how working conditions could be improved.

Figure 35: Improving Working Conditions

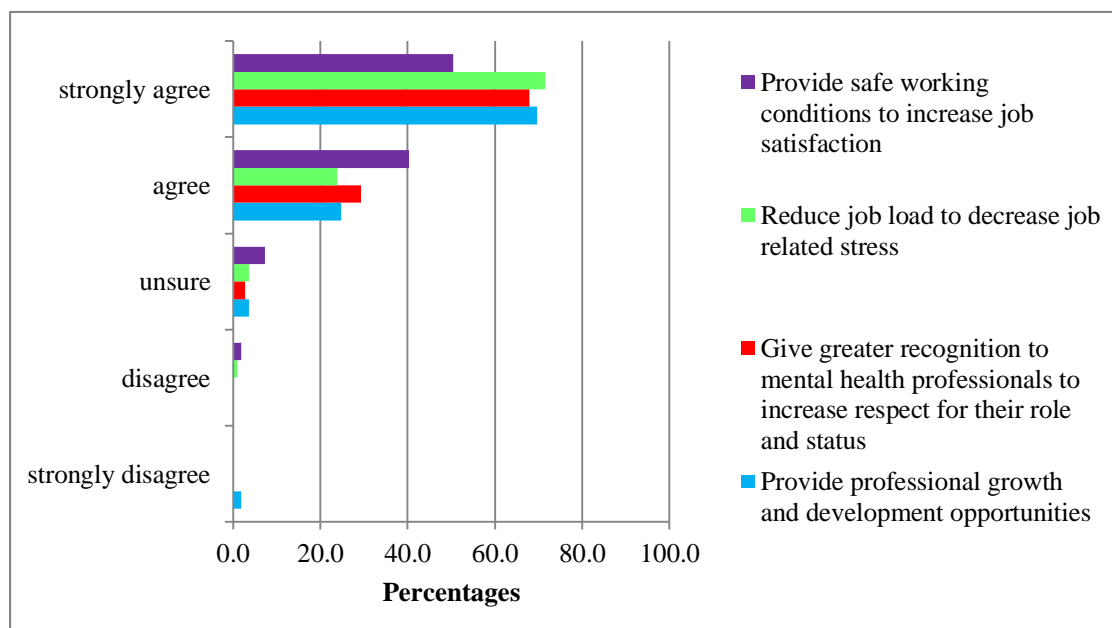


Figure 35 (p. 135) highlights that a significant majority of mental health professionals (94.5%, $n=103$) agreed that they should be provided with professional growth and development opportunities. A large number of respondents (97.3%, $n=106$) agreed that to strengthen the human resource capacity to deliver effective community-based mental health services in resource-poor communities, greater recognition needed to be given to mental health professionals to increase their role and status in these communities. These findings appear to indicate that mental health professionals often feel under-valued, with little recognition given for their work in lower socio-economic challenging communities. The latter is supported by the findings highlighted in Figure 30 (p. 127) in which a significant majority of respondents (78.9%, $n=86$) agreed that mental health professionals were seldom given recognition for working in difficult communities.

Figure 35 (p. 135) identifies that 95.5% ($n=104$) of the respondents noted that reduced job workloads would decrease job-related stress. Job workloads are often intrinsically linked with demand and shortage of a range of mental health professionals and non-specialist health workers. A large number (90.9%, $n=99$) of respondents agreed that safe working conditions would increase job satisfaction.

4.3.3.2.6. Human Resource Capacity in Provinces

This section discusses findings related to the human resource capacity in the provinces to deal with mental health, expand the mental health staff and include non-specialists, collaborate with traditional healers, as well as peer interventions and non-profit organisation (NPO) partnerships.

Figure 36: Human Resource Capacity in Provinces

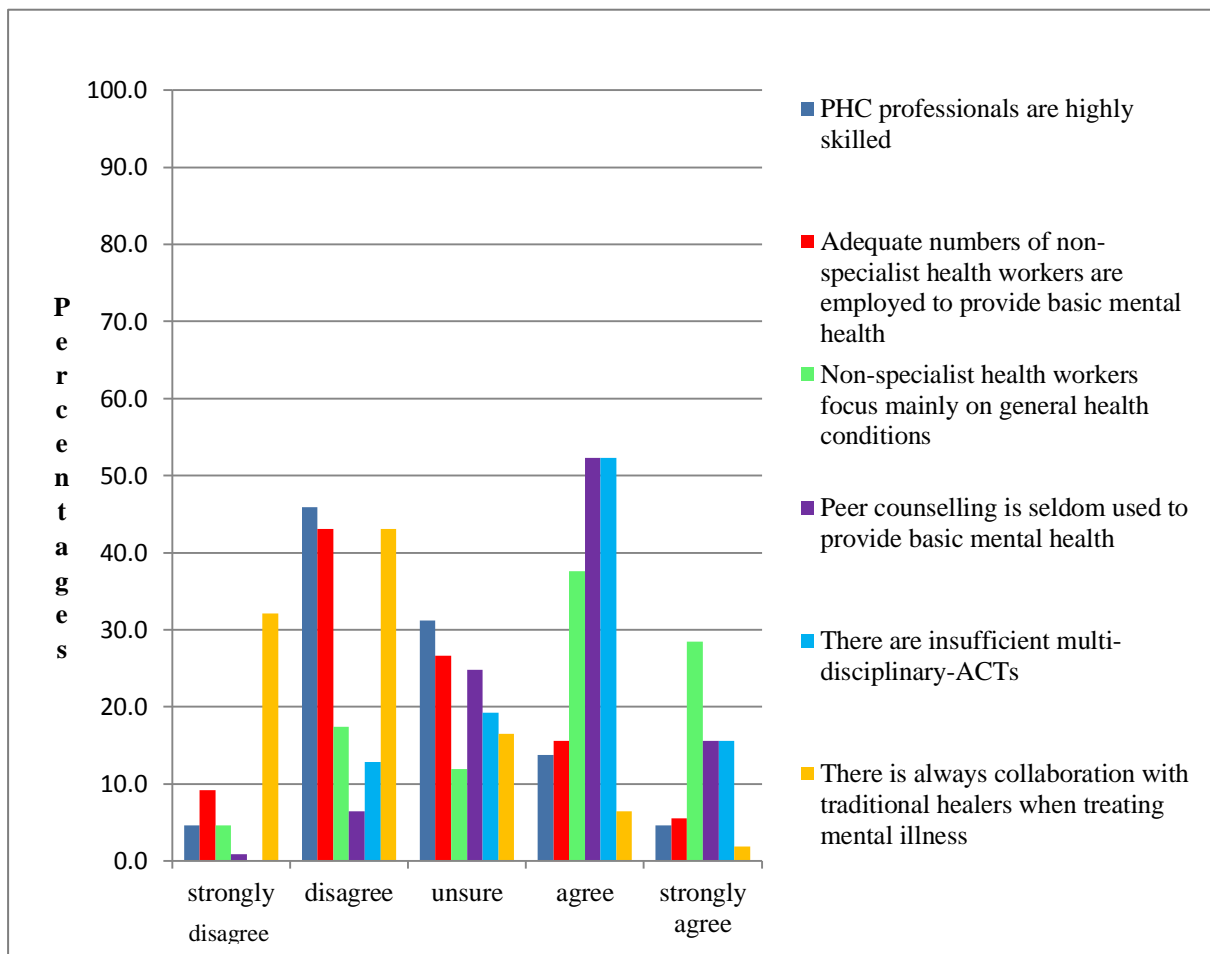


Figure 36 reflects that over half (50.5%, $n=55$) of the mental health professionals disagreed that primary health care professionals were highly skilled in treating mental disorders, whereas (31.2%, $n=34$) were unsure. The respondents (52.3%, $n=57$) disagreed that there was an adequate number of non-specialists employed to provide basic mental health. Of significance, 66% ($n=72$) agreed that the non-specialist health workers focused mainly on general health conditions. According to Mkhise and Kometsi (2008), non-specialist health workers (PHC workers) were often overloaded and did not have sufficient time to manage people with mental disorders. The reengineering and integration of mental health into primary health care and the National Health Insurance requires non-specialist health workers to provide mental health care as well. However, these primary health care workers are

overburdened and tend to focus on conditions such as HIV/AIDs, TB, and other non-communicable diseases, often overlooking the underlying mental health symptoms linked to these and other illnesses.

A significant number of mental health professionals (67.9%, $n=74$) agreed that peer counselling was seldom used to provide basic mental health care. Mental health service users indicated that they could play a significant role in providing peer psycho-education:

I believe you can educate another person that is how it works (*WC Service-user, LN, March 2016*).

So you have people who have been there and know what it [mental illness] is about and they can pass on information and that is how you go on. (*WC Service-user, LVN, March 2016*).

The majority of the respondents (67.9%, $n=74$) agreed that there were insufficient multi-disciplinary mental health specialist teams – Assertive Community Teams (ACT) – in their provinces. The vast majority of mental health professionals (75%, $n=82$) disagreed that there was always collaboration with traditional healers when treating patients with mental illnesses across the nine provinces.

According to Ensink and Robertson (1999) the majority of respondents from traditional African backgrounds consulted the traditional healer first when experiencing symptoms of mental illness.

4.3.3.2.7. Expand Mental Health Personnel and Include Non-specialists

Mental health professionals and service users perceived the need to expand mental health personnel and include non-specialists as follows:

Figure 37: Expanding Mental Health Personnel

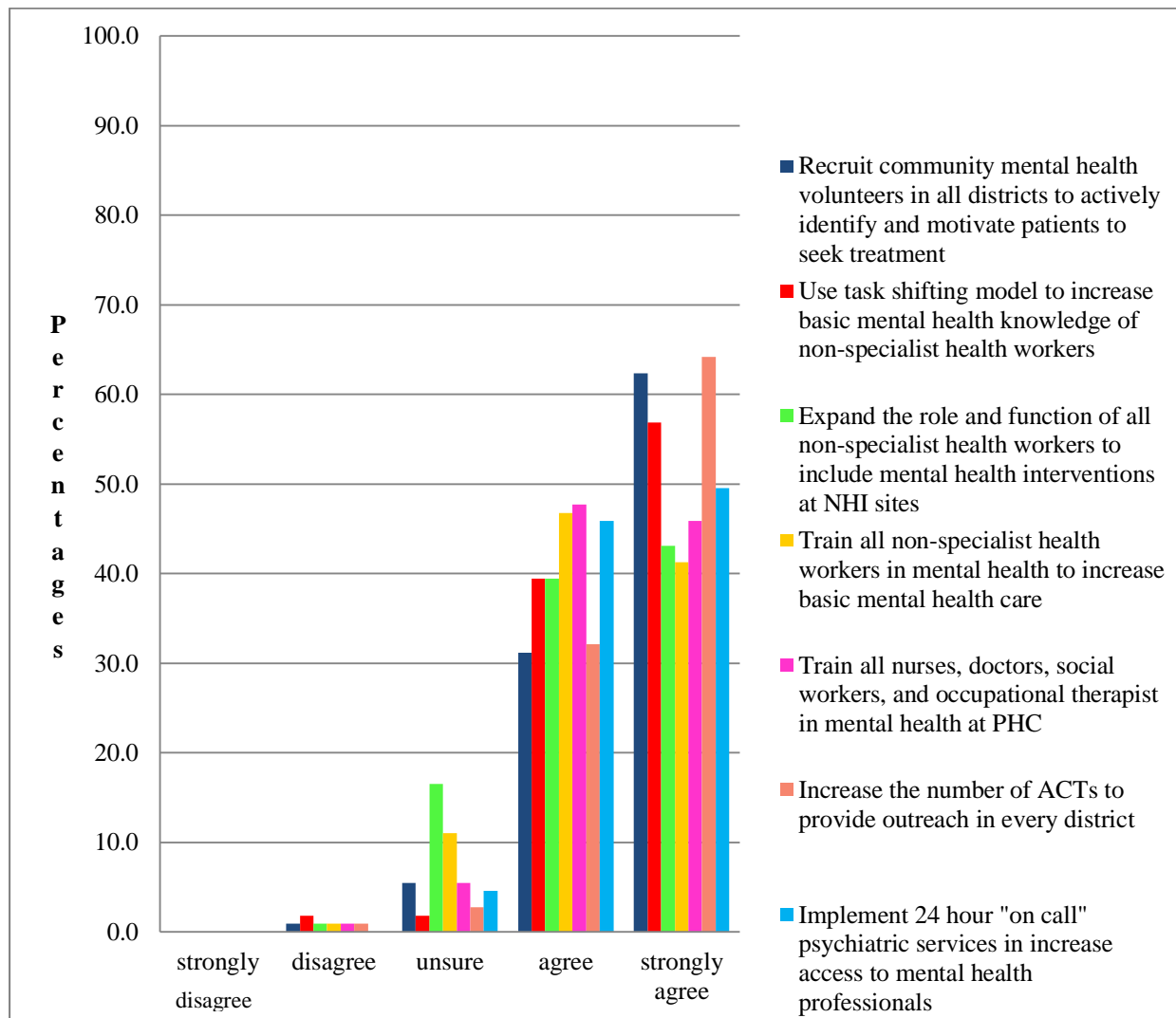


Figure 37 highlights that a large number (93.6%, $n=102$) of respondents agreed that mental health volunteers should be recruited in all districts to actively identify and motivate patients to seek treatment. A focus group participant added the following:

Beauty mentioned this morning about volunteers coming in for those who are really, really sick and need to be cared for and assisted with bathing (*Limpopo Service-user BM, April 2016*).

Byaruhanga et al. (2008) stated:

Community volunteers have the following responsibilities: identification and referral of patients for treatment; home visits (follow up of patients, assessment of home situation and treatment compliance); provision of basic information to the community concerning the care of mental health patients in the community; encouragement of community social support especially to patients

and families; help in the resettlement of patients and their engagement in productive activities; and liaison work between the community and health unit. These volunteers are motivated young people who have basic literacy skills (p. 124).

The role of the volunteers and village health committees will assist with early detection and intervention and strengthen mental health services in particularly under-resourced rural communities.

Figure 37 (p. 139) also illustrates that 96.3% ($n=105$) mental health professionals agreed that task-shifting models should be used to increase basic mental health knowledge of non-specialist health workers. There were 82.5% of respondents ($n=90$) who agreed that the role and function of non-specialist health workers at NHI sites should be expanded to include mental health. From these findings it can be inferred that the current focus is primarily on general health to the exclusion of mental health. The majority of the mental health professionals (88.1%, $n=96$) agreed that all non-specialist workers should be trained in mental health to increase the provision of basic community mental health care. The WHO mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings (2010) is an excellent guide for training of non-specialist staff at PHC level. However, some adaptation is required for the South African context.

A significantly high percentage of respondents (93.6%, $n=102$) agreed that all nurses, doctors, social workers and occupational therapists needed to be trained in mental health at PHC structures/facilities. Lloyd et al. (2010) stated that “while the curricula of health professionals have undergone some changes, the training has continued to be curative in focus and the clinical training platform has not been significantly expanded to include peripheral sites” (p. 177). The success of delivering effective mental health care at community level is dependent on training of these health professionals. This would ensure correct diagnosis and early treatment.

According to the findings as depicted in Figure 36 (p. 137) respondents agreed that there were insufficient Assertive Community Teams (ACTs) operating at district level in their province. A significant majority of mental health professionals (96.3%, $n=105$) agreed that the number of ACTs needed to be increased in every district. However, a good mix of trained health professionals and non-specialists could be included in these teams particularly in rural communities.

A significant proportion of respondents (95.4%, $n=104$) agreed that a 24-hour “on call” psychiatric service would increase access to mental health professionals.

4.3.3.2.8. Collaboration with Traditional Healers

This section presents and discusses perceptions about increasing support through the use of traditional healers and partnering with NPOs.

The majority of respondents (91.1%, $n=100$) agreed that collaboration with traditional healers to strengthen mental health resources would be required; the majority of the respondents (73.3%, $n=80$) also agreed that training programmes would be required to increase mental health literacy of traditional healers.

The Sorsdahl et al. (2010) study indicated that traditional healers have multiple explanations for psychosis and non-psychotic conditions and their interventions could vary. They added that traditional healers do not only use herbs and substances solely from “traditional” sources, but have also incorporated modern ingredients into their medication that are potentially toxic. They highlight that collaboration with traditional healers is essential to maximise treatment opportunities for people living with mental illness. Thus “Interventions designed to increase the mental health literacy of traditional healers and to encourage referral practices for the mentally ill would be beneficial” (Sorsdahl, et al., 2010, p. 289).

4.3.3.2.9. Peer Interventions and NPO Partnerships

Perceptions about increasing support through the use of peers and partnering with NPOs are presented and discussed in this section.

The majority of mental health professionals (98.1%, $n=107$) agreed that the human resource capacity in poorly resourced communities could be strengthened by providing increased outreach and support through peer interventions. A significant number of mental health professionals (88.9%, $n=97$) indicated that human resource capacity could be further strengthened by increasing mental health partnerships with the mental health NPOs who employ approximately 110 social workers and other mental health staff across South Africa.

4.3.4. Bio-medical Approach and Integrated Community-based Model

This section deals with the perceptions of mental health professionals and service users regarding the current bio-medical approach to mental health services and how they propose to improve, modify, strengthen and include a social model of comprehensive mental health care at a primary health care level for resource-poor communities in South Africa.

4.3.4.1. Location and Approach for Comprehensive Mental Health at PHC Level

Perceptions about whether or not mental health care should be targeted at the PHC level and whether or not a social model with a patient-centred focus would improve mental health treatment outcomes are presented and discussed in this section.

Figure 38: Location and Approach for Comprehensive Mental Health at PHC Level

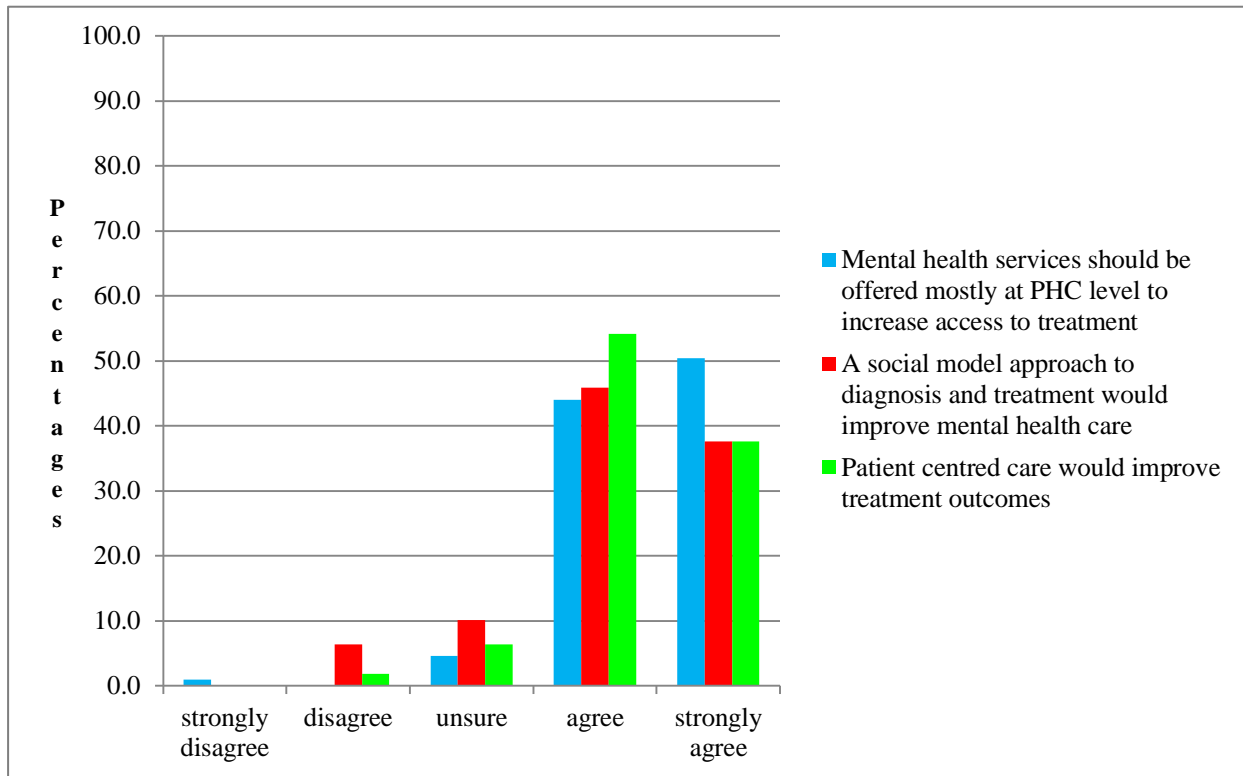


Figure 38 highlights that the majority (94.5%, $n=103$) of mental health professionals agreed that mental health services should be offered mostly at a PHC level to increase access to treatment. This concurs with the second objective of the WHO Global Mental Health Action Plan 2013–2020 (2012) that aims to “To provide comprehensive, integrated and responsive mental health and social care services in community-based settings” (p. 6). These findings concur with policies that advocate for the need to upscale mental health services at a PHC level. The WHO report on Integrating Mental Health into Primary Care – A global perspective (2008) stated that integrating mental health into PHC is the most viable way to increase access to mental health. A key objective of the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) supports this and emphasises the scaling up of decentralised integrated mental health service within communities in South Africa.

Figure 38 (p. 143) further emphasises that, within this context of decentralised integrated mental health services, the majority (83.5%, $n=91$) of respondents agreed that a social model approach to diagnosis and treatment would improve mental health care. In contrast to the findings reflected in Figure 21 (p. 108) respondents indicated that the medical model is the dominant approach yet suggest the social model as the preferred for better treatment outcomes.

The majority (91.7%, $n=100$) of mental health professionals agreed that the provision of patient-centred care would significantly improve treatment options.

4.3.4.2. *Improvement of Community-Based Mental Health Services at PHC Level*

Perceptions about how community-based mental health services could be improved are presented and discussed in this section.

Figure 39: Improvement of Community-Based Mental Health Services at PHC Level

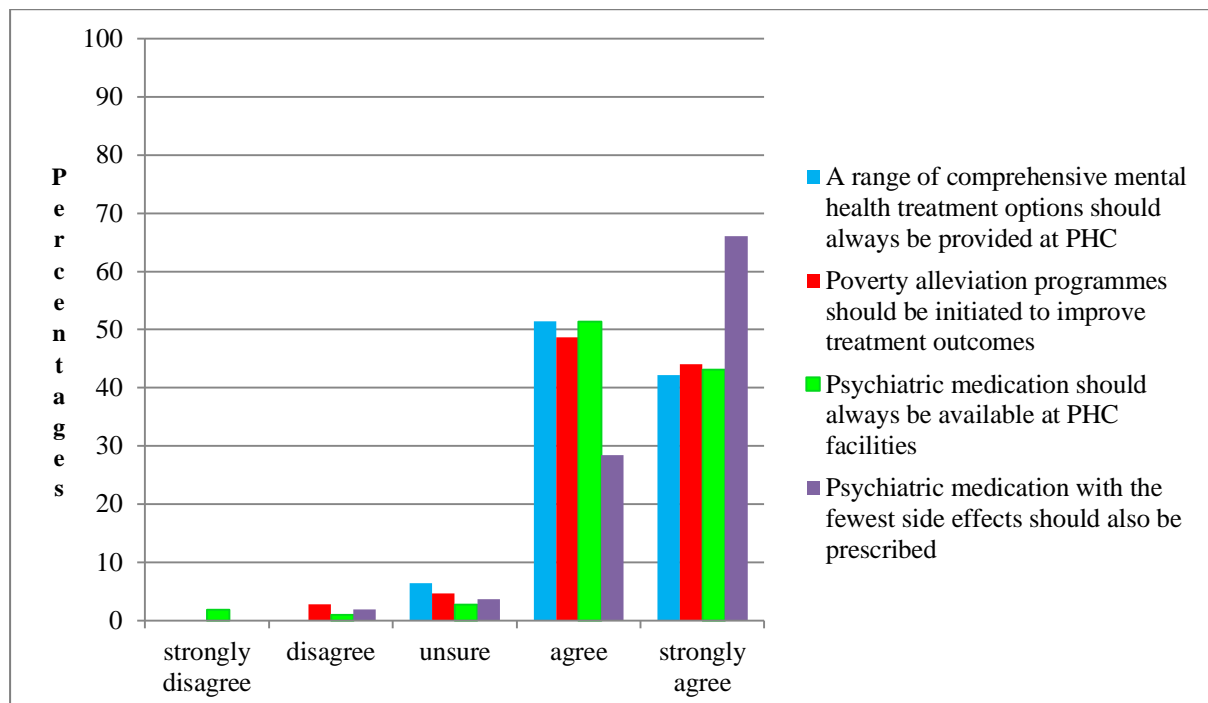


Figure 39 (p. 144) highlights that the majority (93.5%, $n=102$) of mental health professionals agreed that a range of comprehensive mental health treatment options should always be provided at a PHC level. Currently the primary focus of treatment at PHC clinics is on medication management, as indicated in Figure 23 (p. 111), to the exclusion of other intervention options that have better treatment outcomes to facilitate recovery. Mental Health service users recognised the need to extend interventions beyond medication:

You see just taking your medication isn't always balancing out (*EC Service-user CMS, March 2016*).

Surely they can have more effective group therapy where people who are ill come as a group and where the psychiatric nurse can implement better models of behaviour modification... (*WC Service-user KT, March 2016*).

Not everybody gets to see the social worker, the psychiatrist or the students to talk your questions or you talk about mental illness where they can give you some guidance. There are no groups... (*KZN Service-User FH, April 2016*).

Figure 40 (p. 147) illustrates that a large majority (92.6%, $n=101$) of mental health professionals agreed that poverty alleviation programmes should be initiated to significantly improve treatment outcomes. Mental Health NPOs have played a significant role in implementing poverty alleviation programmes through protective workshops, Learnerships with various Sector Education and Training Authorities, integration companies, supported employment programmes, open labour market placements, and special job creation programmes such as the Beadability Project and brick-making projects. However, these programmes are provided mainly by the mental health NPO sector with few referrals received from PHC facilities, leading to fragmented intervention. Crick et al. (2011) noted that mental health and poverty interact in a negative cycle and added that people with mental illness are at risk of drifting into or remaining in poverty. Crick et al. (2011) added that “To break this cycle, interventions are needed that address both social causes of mental illness and the disabilities and economic deprivation that are a consequence of mental illness” (p. 7). Based

on a summary of studies that reviewed the impact of poverty alleviation interventions on mental health, they added that “improvements in economic status go hand in hand with improvements in clinical symptoms, creating a virtuous cycle of increasing returns” (p. 7).

Figure 40 (p. 147) illustrates that the majority (94.5%, $n=103$) of the respondents agreed that medication should always be available at PHC facilities. A significant number (94.5%, $n=103$) of mental health professional agreed that psychiatric medication with the fewest side-effects should be prescribed. Participants in the focus groups noted the following:

I think it is quite imperative that we are entitled to get pills and we are inclined to get some side-effects (*KZN Service-user ML, April 2016*).

There is medication, which I have taken which has also given me some side-effects (*KZN, Service-user SM, April 2016*).

When I went to the doctor I had side-effects. First I went to him, it was 2 years ago, with the same side-effects and he refused and did nothing but now he said he is going to give me something but I had to persuade him to agree to give me something. It is really tough (*KZN Service-user FH, April 2016*).

The Standard Treatment Guidelines and Essential Medicines List for South Africa (2012) stipulate the specific medication that can be prescribed in the public health care sector, including precautions and guidelines for administration of psychiatric medication. The list of available drugs is limited, however, due to costs and affordability. These may not necessarily always be suitable for certain patients, whereas an extensive, often more effective drugs list is available in private mental health care. Side-effects to medication are one of the leading barriers to medication adherence, whilst poor medication adherence results in poor outcomes and affects mental health recovery. It is therefore critical that patients are afforded the opportunity to access psychiatric medication with the least side-effects.

4.3.4.3. Improvement of Community-Based Mental Health Facilities at PHC Level

Perceptions about how community-based mental health facilities could be improved are presented and discussed in this section.

Figure 40: Improvement of Community-Based Mental Health Facilities at PHC Level

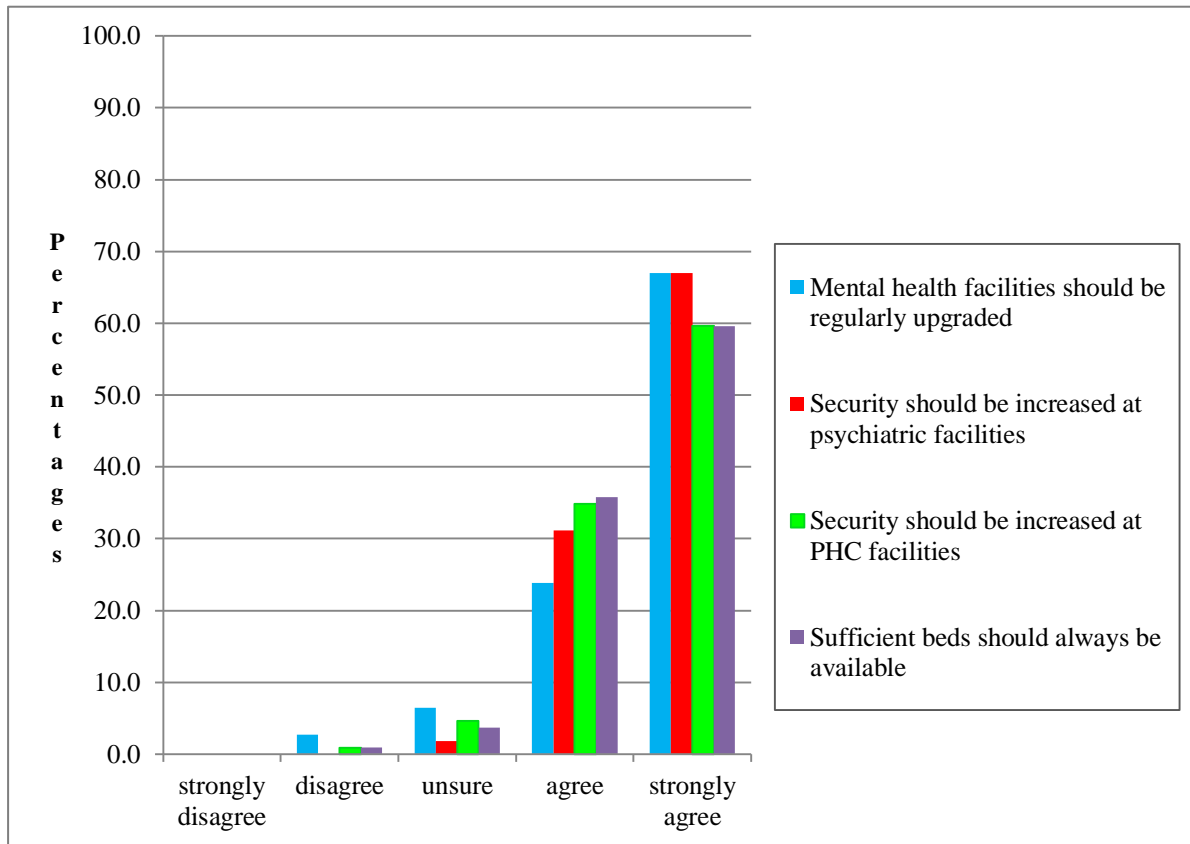


Figure 40 illustrates that the majority (90.9%, $n=99$) of mental health professionals agreed that mental health facilities should be regularly upgraded. Focus group participants confirmed these findings:

The hospitals and the clinics really need upgrading because we go there every day. It's something [clinics and hospitals] we use every day because we have to fetch our medicine. These are things that need to be looked at. All the tiles need to be replaced or the doors because people aren't dogs (*EC Service-user CMS, March 2016*).

We need more venues to see psychiatric patients to see the doctor and the pharmacy because there is one room in the clinic and a lot of us have to wait for the nurse to see this one before another one can come (*KZN, Service-user TD, March 2016*).

Janse van Rensburg stated (2012) the following:

As a matter of urgency, it is essential that the state takes up its responsibility, according to Chapter 2 of the MHCA No. 17 of 2002 (among others), to provide adequate structures, systems and funds for the specified services and facilities on national, provincial

and facility level, with specific emphasis on district hospital infrastructure capacity. Since the lack of provision of the aforementioned routinely results in poor service conditions, mental health practitioners' clinical judgment, decisions and practice may, in the meantime, be compromised as a result of existing sub-standard infrastructure and poor staffing conditions (p. 135).

Almost all (98.2%, $n=107$) respondents, as portrayed in Figure 40 (p. 147), agreed that security should be increased at mental health facilities. A similar response was received from mental health professionals (94.5%, $n=103$) who agreed that security should be increased at PHC facilities. These findings suggest that there is insufficient and inadequate security at mental health facilities, as well as at PHC facilities. The safety of mental health professionals employed at mental health facilities and at PHC clinics requires external as well as internal security. Janse van Rensburg (2012) noted that "Although about 204 district hospitals country-wide are currently providing these required (involuntary) services, no facilities were created in which safe and adequate care can be ensured. While this would require a separate area in these district hospitals with dedicated psychiatric beds, no such facilities exist in most hospitals" (p. 135).

The vast majority of mental health professionals (95.4%, $n=104$) agreed that sufficient beds should always be available. As previously indicated in Figure 24 (p. 113), 81.6% ($n=89$) of the mental health professionals indicated that beds were not always available for patients. These findings indicated that the shortage in bed availability impacts on early intervention responses and premature discharges.

4.3.4.4. Strengthening Human Resource Capacity

Perceptions about the strengthening of mental health human resources are presented and discussed in this section.

Figure 41: Strengthening Mental Health Human Resources

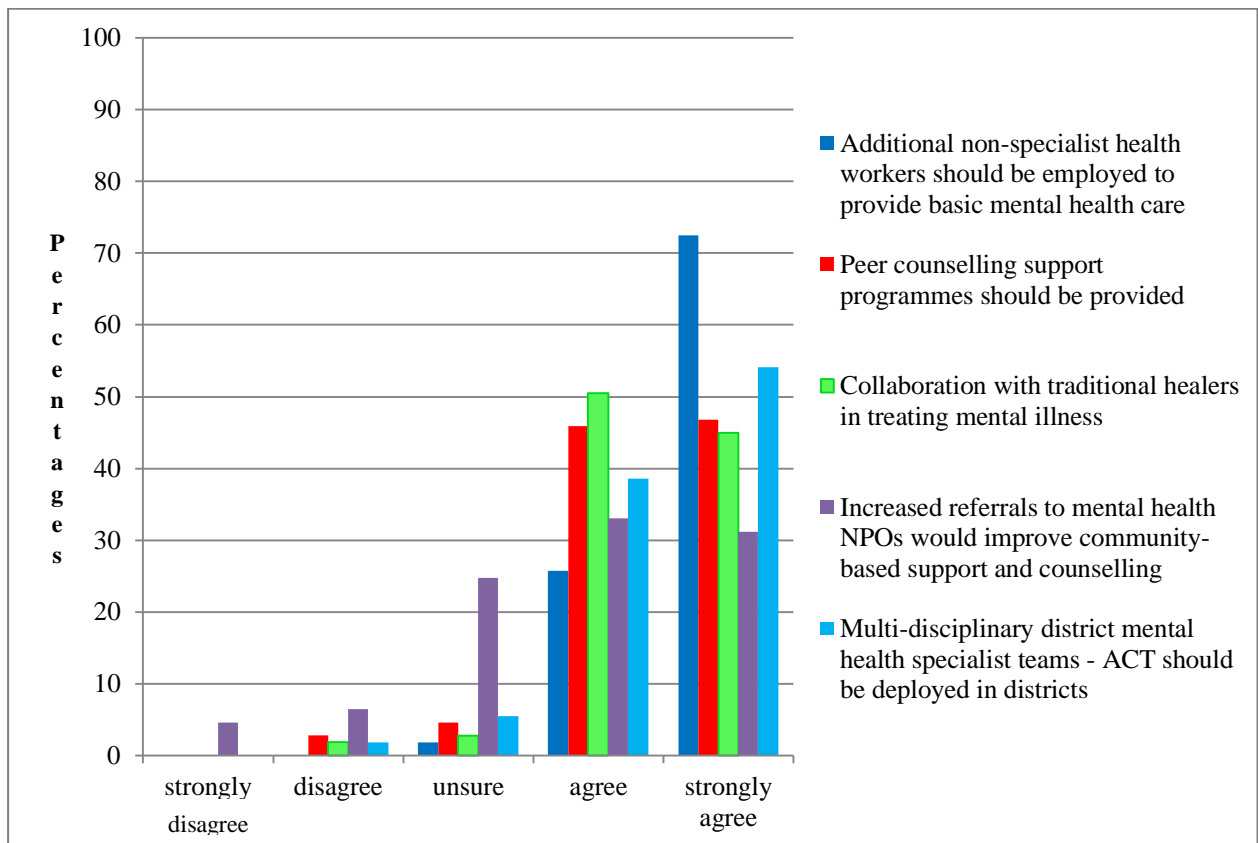


Figure 41 illustrates that a large majority (98.2%, $n=107$) of mental health respondents agreed that additional non-specialist health workers should be employed to provide basic mental health in communities. “At present there are estimated to be 65 000 CHWs operating in the country, the great majority of whom undertake a limited set of activities, mainly in HIV and TB programmes” (Lloyd, et al., 2010, p. 174). There is a dire shortage of mental health professionals in South Africa, particularly in rural communities. This was corroborated by participants in the focus group in the previous section when discussing the working conditions of health professionals.

It is therefore imperative that additional non-specialist health workers are employed to ensure that the appropriate human resource allocations are provided to successfully reengineer and integrate mental health services at a PHC level. Lloyd et al. (2010) stated the following:

Despite the government's expressed commitment to PHC, the NDoH has continued to support and sustain a clinical model of health service delivery, primarily utilising doctors and nurses. The clinic-based services are limited in their ability to reach community level and, being focused on curative aspects, are often inadequate with regard to prevention, health promotion and rehabilitation services (p. 177).

A large number (92.7%, $n=101$) of respondents agreed that the additional cadre of human resources should be peer counsellors who could assist to improve community-based mental care. The majority of respondents noted that peer counselling support programmes should be provided as part of community-based mental health services at a PHC level. Peer counselling is based on a recovery-orientated model of intervention and is a powerful self-help approach that can reduce the cost of mental health admissions by keeping clients well within their communities and outside of hospital.

The Charter of Peer Support stated that peer support programmes should be available to all who need it. However, this model is seldom used in South Africa and has been promoted mainly through a limited number of mental health NPOs. Peer support and counselling is a formal process, requiring mental health service users to have advanced significantly in their own recovery journey and to be formally trained and supervised within this model of intervention. Participants in the focus groups also recommended support groups:

Then we should have a group coming around every month or every second week to talk to us, to hear our opinions and to speak about the conditions or ask us questions and we can give answers. Even our hospitals should have groups (*KZN Service-user, FH, April 2016*).

It is run by a social worker (*KZN Service-user, MM, April 2016*).

Figure 41 (p. 149) also highlights that the majority (95.5%, $n=104$) of mental health professionals agreed that collaboration with traditional healers in treating mental illness is necessary. This collaboration could also facilitate mental health education and training of traditional healers, to ensure that remedies prescribed are not harmful but work in synergy to support recovery and wellness.

Seventy (64.2%) mental health professionals agreed that increased referrals to mental health NPOs would improve community-based support and counselling to service users. This would maximise mental health resources and programmes offered by the mental health NPOs and ensure greater co-ordination of comprehensive mental health care.

A significant majority (92.6%, $n=101$) of respondents agreed that multi-disciplinary district mental health specialist teams, also known as Assertive Community Teams (ACT), should be deployed to cover all districts in their provinces.

Botha, Koen, Oosthuizen, Joska and Hering (2008) noted that often “revolving-door” patients place enormous pressure on acute inpatient services, whilst families are faced with the burden of trying to stabilise and or contain patients in their homes. Often these patients are confronted by the difficult social circumstances that prevent access to public health services and therefore limit access to medication. These teams provide access to treatment in the community and within the homes of service users, thus increasing better patient outcomes. Despite the success of reduced readmissions due to Assertive Community Teams (ACT) interventions, few districts in South Africa have had the benefit of these teams, resulting in a fairly significant percent of those living with a diagnosis but without treatment.

4.3.4.5. Additional Strengthening Measures at PHC Level

This section presents and discusses the perceptions of mental health professionals and service users’ perceptions about additional strengthening measures.

Figure 42: Additional Strengthening Measures at PHC Level

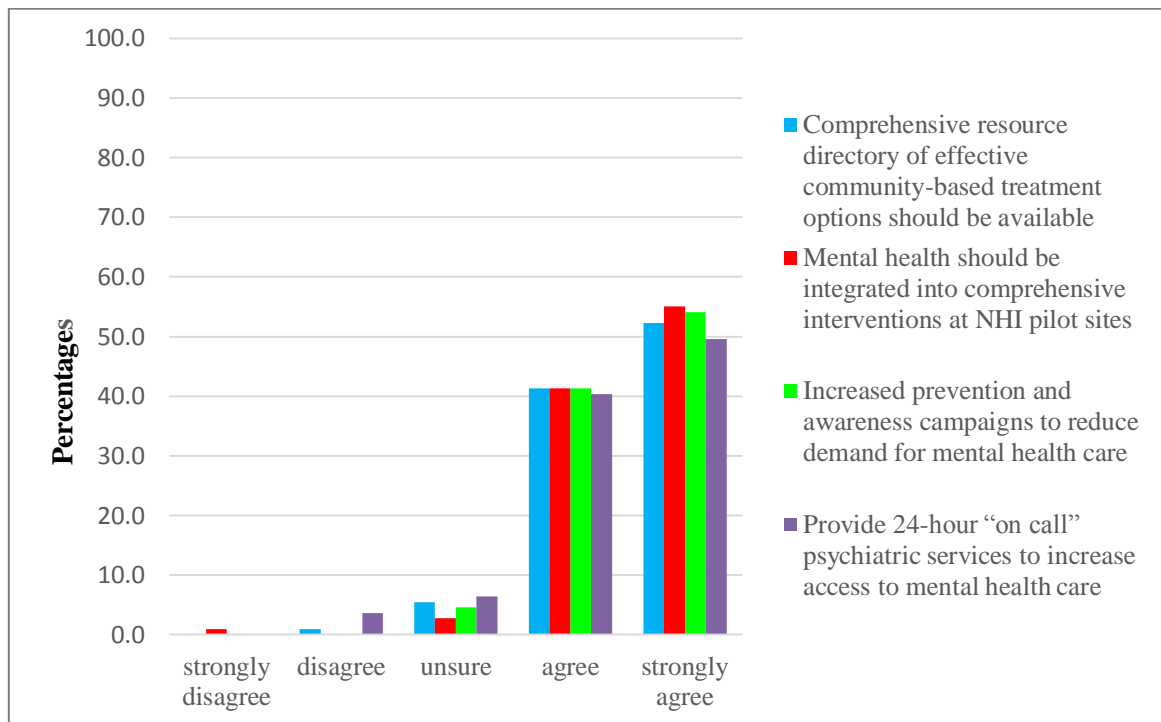


Figure 42 depicts a need, based on these findings, that a significant majority (93.6%, $n=102$) agreed that a comprehensive resource directory of effective community-based mental health treatment options should be readily available in their province. The inference that can be drawn from these findings is that, alongside the directory of mental health treatment options and interventions referral pathways, there is a need to establish and strengthen the link between NPOs and PHC clinics or facilities.

The vast majority of mental health professionals (96.3%, $n=105$) indicated that mental health interventions should be fully integrated into NHI pilot sites. A significant number (95.4%, $n=104$) of respondents agreed that increased prevention and awareness campaigns would significantly reduce the demand for mental health care. Participants in the focus groups highlighted the need for public education about mental illness:

I think the community at large – they really don’t know and need to be educated and like he says mental illness is psycho-social (*EC Service-user PN, March 2016*).

I will say yes but then we need to have open public meetings to inform people about mental health. It is not going to happen overnight. If we all stand up by talking and stand up and talk about what mental illness is - a lot of things will change (*EC Service-user PN, March 2016*).

There is a lot of things – other people say it is witchcraft, other people say you have demons. You see people lack of knowledge. The government needs to educate more in the townships you see (*WC Service-user AC, March 2016*).

They added that mental health awareness needed to be included in the school curriculum:

They know nothing and I think that it is important for people to know about this [mental illness]. If it was me they would be educated, if people were educated at the same age you understand it can be introduced in every curriculum at schools so that when kids as they are growing up they will be aware that there is such a sickness and that anybody can get it (*EC Service-user PN, March 2016*).

Professionals as well as parents needed to be educated about mental illness:

Nurses need to be better educated about mental health at these places [PHC clinics] (*EC Service-user CMS, March 2016*).

And another thing, our parents and family need to be educated about this illness because my parents did not see my sickness – they just treated me as a normal person. They did not understand so there were always fights and fights (*WC Service-user AC, March 2016*).

First to educate your family – they have a role to play (*WC Service-user LN, March 2016*).

Education of parents – it is almost like being trapped in ignorance – one is so heavily doped on medication that one walks around like a zombie, you know (*WC Service-user KT, March 2016*).

Using media to raise awareness and education about mental health was suggested:

People should be informed using radio and TV about mental illness (*WC Service-user YW, March 2016*).

They should use YouTube to inform people of schizophrenia. I have used YouTube and found that there are doctors talking about schizophrenia. There is no lack of information anymore. The only thing you need to do is go to the library and get a library card and just surf the internet. Yes, there is a lot of information available. I would not be sitting here if there weren't any information. (*WC Service-user MC, March 2016*).

There needs to be posters put up that come from the DOH informing people about mental health (*EC Service-user CMS, March 2016*).

Mental health service users needed to be directly involved in psycho-education:

I believe you can educate another person – that is how it works (*WC Service-user LN, March 2016*).

So you have people who have been there and know what it is about and they can pass on information and that is how you go on (*WC Service-user LVN, March 2016*).

According to the WHO (2004):

There is a wide range of evidence-based preventive programmes and policies available for implementation. These have been found to reduce risk factors, strengthen protective factors and decrease psychiatric symptoms and disability and the onset of some mental disorders. They also improve positive mental health, contribute to better physical health and generate social and economic benefits. These multi-outcome interventions illustrate that prevention can be cost-effective. Research is beginning to show significant long-term outcomes (p. 13).

The majority of mental health professionals (89.9%, $n=98$) agreed that providing 24-hour “on call” psychiatric services in the nine provinces would increase mental health care. This service could tap into a referral pathway for both comprehensive community-based interventions at PHC clinics or facilities and the holistic services provided by NPOs to strengthen interventions. Besides the direct services that could be provided by the 24-hour “on call” psychiatric services to services users, this resource could also be maximised by these psychiatrists providing advice to PHC facilities and non-specialist health workers, considering that the latter occupational classes would have no or limited specialist mental health knowledge. These findings concur with Figure 37 (p. 139).

4.3.5. Impact of Inadequate Mental Health Services on the Human Rights of Service Users

This study also explored mental health professionals and service users' perceptions about vulnerability and discrimination including an exploration of how the human rights of service users are being impacted upon.

4.3.5.1. Perceptions of the Association between Vulnerability and Discrimination

Mental health professionals and service users' perceptions about the connection between vulnerability and discrimination are presented and discussed in this section.

Figure 43: Perceptions of the Connection between Vulnerability and Discrimination

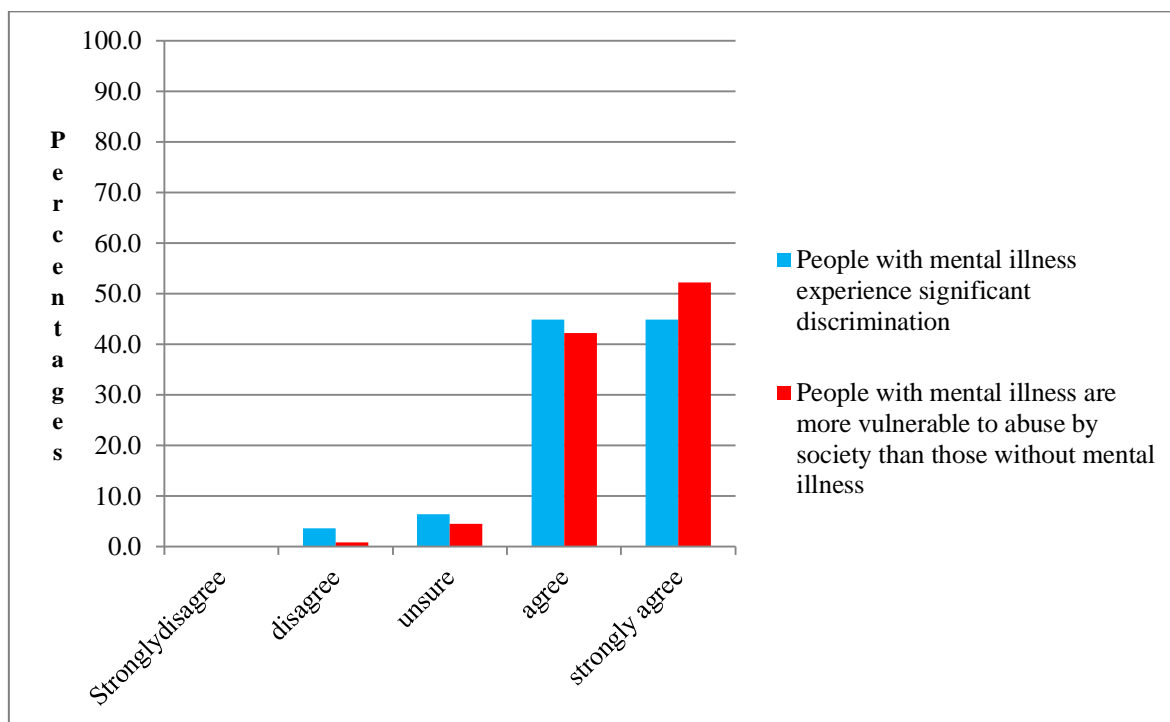


Figure 43 illustrates that all mental health professionals (90%, $n=98$) across the nine provinces agreed that people with mental illness experience significant discrimination in our country. The latter was confirmed by mental health service-users who experienced excessive discrimination and related their experiences as follows:

So we sit with these issues, we sit with this stigma that the community is giving us and judging us and saying there goes that man. A lot needs to be done to change the attitude. As long as there is stigma we as mental patients get judged by our community, by our families and people around you then nothing will change (*EC Service-User, CMS, April 2016*).

Everyone judges me. They called me names. They shout at me (*Limpopo Service-user, KS, April 2016*).

They use your condition against you. You are not treated as a normal person (*NC, Service-user, LZ, April 2016*).

Jill, a mental health care user in North West province, clearly expressed the impact of stigma: “I feel ashamed of my diagnosis and the severity of it ... People see mentally ill people as being mad and should be locked away in an institution” (Rural Mental Health Campaign Report, 2015, p. 12).

The majority (94.5%, $n=103$) of mental health professionals agreed that people with mental illness are more vulnerable to abuse by society than those without mental illness.

These findings were supported by the participants in the focus groups:

We are very famous for witch hunts and treating people with mental disabilities in the wrong way. Every now and again there is something in the newspaper, about some hospital that has somebody chained up. It is only when it comes to the papers that something gets done about it. There was one case where this minister – where this young girls had epilepsy, they prayed for her for three days, and eventually she died and they found her with bruises and everything. This minister was then charged with culpable homicide; it was actually murder, and he got community service. He and his folk chained her and prayed her to death. They caused her death and then a while ago and a more recent one there was another incident where they found people chained up in a church and they were not prosecuted even though it was a big thing in the papers (*EC Service-user, RS, March 2016*).

They [family] felt they had to protect my children against me, what they did, they took my children. The family, they took all my children away from me. They took my children to my brother’s house and my children live now with my brother and his wife. Unfortunately, the girl was sexually abused and the child was telling me that these things were happening by the uncle’s house and I confronted them all and I said that I know about these things. I told them that I am going to the police station and I went to the police station and they laughed and said there was no such thing. They said it was a family problem meanwhile my child was being sexually abused. The police should have got involved in this.... (*EC Service-user, PD, March 2016*)

Despite the progressive Constitution of the Republic of South Africa, No. 108 of 1996 and Bill of Rights, the RSA Mental Health Care Act, No. 17 of 2002, and the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013), “People suffering from mental illness are among the most disadvantaged groups in society. They suffer severe personal distress and they are stigmatised, discriminated against, marginalised and often left vulnerable” (Swanepoel, 2011, p. 127).

According to Burns (2009):

Furthermore, the experience of persons with mental disability is one characterized by multiple interlinked levels of inequality and discrimination within society. Efforts directed toward achieving formal equality should not stand alone without similar efforts to achieve substantive equality for persons with mental disabilities. Structural factors such as poverty, inequality, homelessness and discrimination contribute to risk for mental disability and impact negatively on the course and outcome of such disabilities (p. 19).

People with mental illness often suffer from multi-discrimination, compounded by stigma and prejudice towards them. Drew et al. (2011) noted that the violation and stigmatisation of individuals diagnosed with mental illness include: discrimination surrounding employment; marriage, parenting, and family planning; access to health services; sexual violence; access to housing; entitlement to vote; and access to basic education and other services. People with mental disability are not only exposed to socio-economic structural discrimination, but also physical, sexual and psychological abuse. The lower the levels of optimal functioning and the more severe the mental illness, the higher the levels of vulnerability and the lack of ability to report the violations perpetrated against them. This is commonly seen amongst women with psycho-social disability who rarely have access to justice when reporting sexual abuse. In the Sexual Abuse Victim Empowerment Programme of Cape Mental Health it has been found that the victim’s account of the violation is often questioned and the sexual abuse minimised.

4.3.5.2. Human Rights Violations

Mental health professionals and service users' perceptions about human rights violations are presented in Figure 44 and discussed.

Figure 44: Human Rights Violations

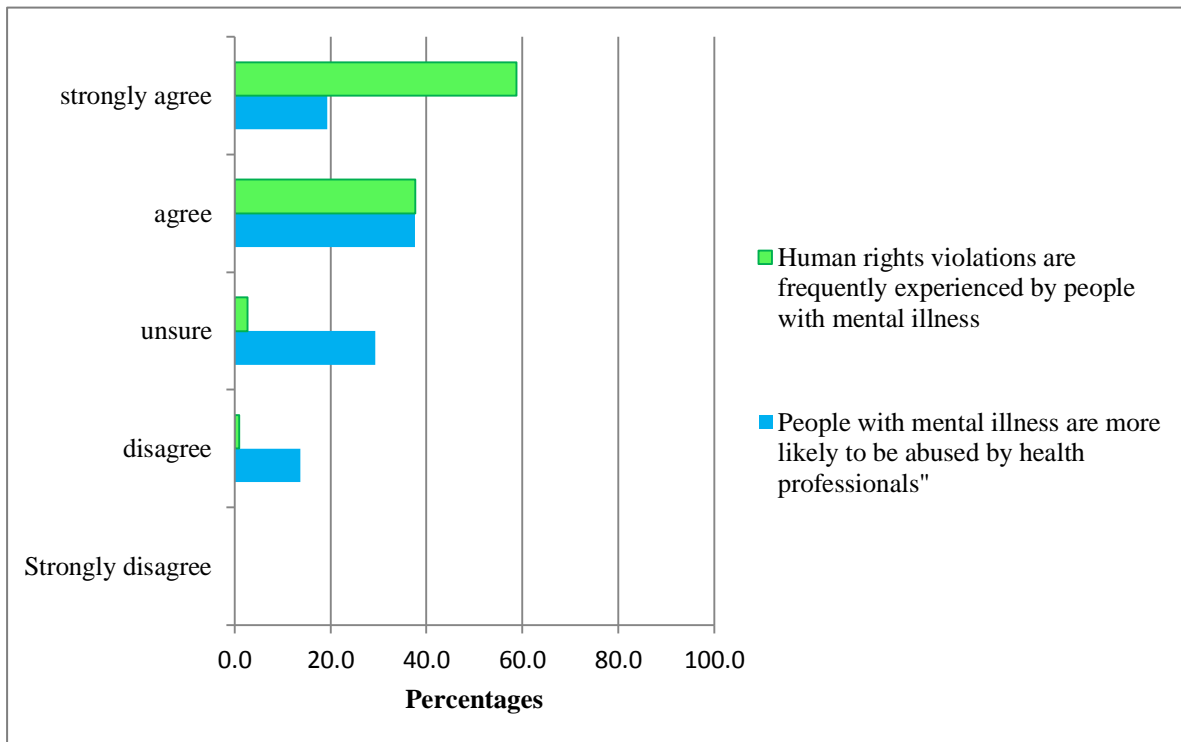


Figure 44 highlights that the majority of mental health professionals (96.3%, $n=105$) agreed that human rights violations are frequently experienced by people with mental illness. Mental health professionals (59.6%, $n=62$) agreed people with mental illness are more likely to be abused by health professionals

In Drew et al.'s (2011) study, 51 people with mental and or psycho-social disabilities coming from eighteen lower middle-income countries (LMICs) were interviewed. Participants in that study indicated several ways in which their human rights were being negatively impacted upon:

- Exclusion, marginalisation, and discrimination in the community
- Denial or restriction of employment rights and opportunities
- Physical abuse/violence
- Inability to access effective mental health services
- Sexual abuse/violence
- Arbitrary detention
- Denial of opportunities for marriage/right to found a family
- Lack of means to enable people to live independently in the community
- Denial of access to general health/medical services
- Financial exploitation (p. 3)

The participants in the Drew et al. (2011) study added that the environment in which these human rights violations were being perpetrated was more likely to occur in the following localities in descending frequency:

- General community settings in everyday life
- Home and family settings
- The workplace or potential workplace
- Psychiatric institutions and mental health services
- Hospitals and health-care services
- Prisons, police, and the legal system
- Government and official services
- Schools and the education sector

Mental health service users' experiences during involuntary admissions were reported as follows:

There is an open ward and a closed ward. At first I was in a closed ward and I did not have that much opportunity to go out, but when I was in the open ward it was better. If you do anything wrong they put you in your pyjamas whole day long, the whole day long. They put you in different groups – group A, group B, group C. If you're in group A, you can go out as much as you like; if you're in group B you can go to church on a Sunday. When you're in group C, you can't do anything – you can't even go to church on a Sunday. You must stay in the ward and be locked up for the whole day. You know this was not right, I was only there because I was a State patient – that is why I did not go home and they kept me there for 9 years. I was 19 years old and only came out in 2013. They told me nothing when they took me. They just told me that I am mad and that they will take me to another place in East London but I told them my mother is in Grahamstown... (*EC Service-user, JS, March 2016*)

One is often very passive within and one isn't strong enough to fight for one's rights when one isn't well. In legitimate cases and in other cases one is well to speak up for oneself but is one heard or is one quiet and just do what one is told that you're getting an injection whether you like it or not, you know (*WC Service-user, KT, March 2016*).

There is something called the strong room. In this strong room the patients who are psychotic are locked up there in straitjackets. Sometimes you are sedated because you are so ill. You don't get any water to drink. Nobody cares about you – for two weeks you are in straitjackets. Even though they [nursing staff] are right opposite your ward nobody pays attention. Nobody cares and something has to be done. They treat you like an animal. You can't even go to the bathroom. Something has to be done to change that because they think you're an animal. Nobody cares about you even if they know your relatives are coming. They treat you like an animal (*EC Service-user, PN, March 2016*).

According to the study by Drew et al. (2011), the fourth and fifth most likely places for abuse to occur was in psychiatric institutions, mental health services, hospitals and other health-care services. This was confirmed in the Commission of Enquiry into the Human rights abuses at psychiatric hospitals in KwaZulu-Natal Province (Mkhize, 2007).

4.3.5.3. Human Rights: Infrastructure and Access to Medication

Survey respondents and focus group participants' perceptions of the consequences of poor building conditions and the lack of access to medication are presented in Figure 45 (p. 161) and discussed.

Figure 45: Human Rights: Infrastructure and Access to Medication

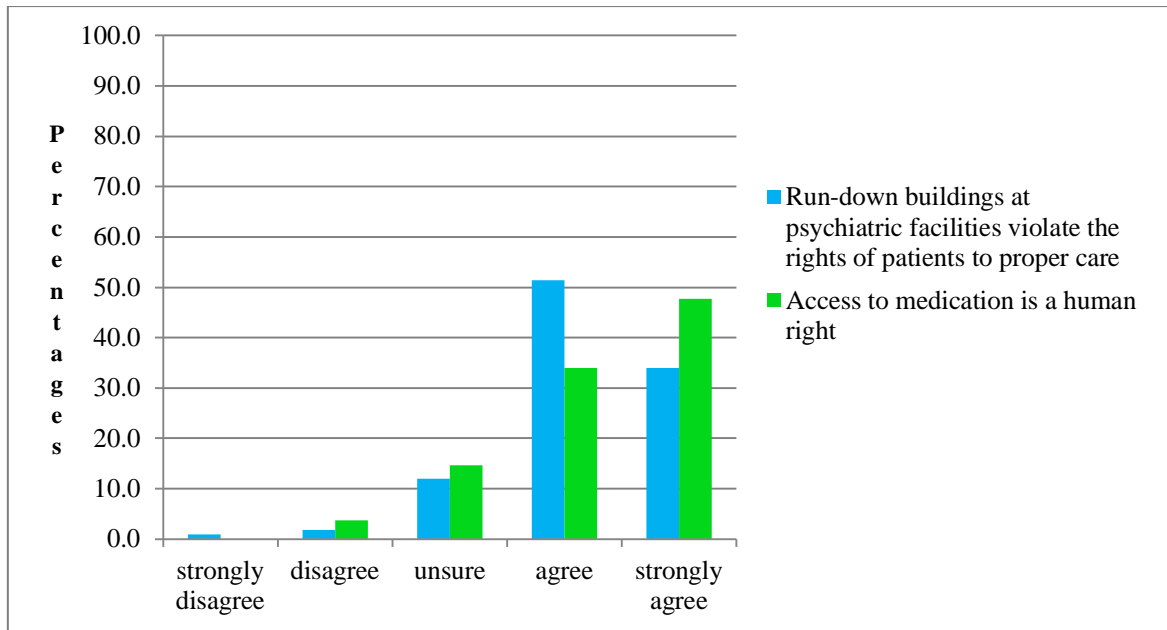


Figure 45 indicates that the majority of mental health professionals (85.3%, $n=93$) agreed that run-down buildings at psychiatric facilities violate the rights of patients to proper care. Drew et al. (2011) indicated that:

Previous reports have documented the poor physical conditions in many facilities accessed by people with mental and psychosocial disabilities. Although this usually refers to substandard living conditions in residential mental health facilities and psychiatric hospitals, it is important to recognise that poor conditions and infrastructure are also prevalent in prisons, nursing homes, halfway houses, and facilities for traditional spiritual healers (p. 4).

They added that “Deficiencies in the built environment of mental health facilities can impede effective treatment and recovery, which can result in worsened mental and physical health of service users” (Drew, et al., 2011, p. 4).

Mental health professionals cited several experiences of neglected buildings and conditions at primary health care clinics and within psychiatric wards as discussed in Section 4.3.2.9., Figure 24 (p. 113).

There is no doubt that access to prescribed medication for a mental condition is a basic right enshrined in the United Nations Convention on the Rights of Persons with Disability (2006) and the Constitution of the Republic of South Africa, No.108 of 1996.

Despite mental health professionals' agreeing that access to medication is a human right (81.6%, $n=89$), more than half (55.1%, $n=60$) disagreed that psychiatric medication was always available. Focus group participants reinforced these findings by indicating the following:

We have a right to medication (*KZN Service-user MH, April 2016*).

You have the right to receive medication and you have a right to see a doctor whenever you need to see the doctor (*KZN Service-user, FH, April 2016*).

The right to the correct medication and appropriate medication is essential (*Limpopo, Service-user KS, April 2016*).

However, the realities are often different in practice, as indicated by mental health professionals and focus group participants in (Section 4.3.2.9., p. 111–114). Mental health service users noted the following:

Sometimes the medication is not ok. Not all of the tablets are there (*Limpopo Service-user JM, April 2016*).

Sorry to break your word, sometimes they don't have all our tablets. And they are people who cannot do much. Luckily, I still had a box at home. It does not happen often. Look they only give us tablets that they have and then you have to come back again. It messes your whole system up (*NC Service-user, GH, April 2016*).

According to the Rural Mental Health Campaign Report (2015), The Stop "Stock Outs" Campaign found that psychiatric medications accounted for 10% of reported medication stock outs between January and July 2015 in rural areas. Morgan and Sherry (2015) reported a mental health service user as saying that "Sometimes the medication is not available and I am referred to the hospital that is far and even there the medication is not available. Two months I did not receive Haloperidol as it was not available" (p. 22).

4.3.5.4. South African Police Role in Mental Health Rights

Mental health professionals and service users' perceptions of the role of the SAPS with regards to protection and upholding of service user human rights are presented in Figure 46 and discussed.

Figure 46: South African Police Services Role in Mental Health Human Rights

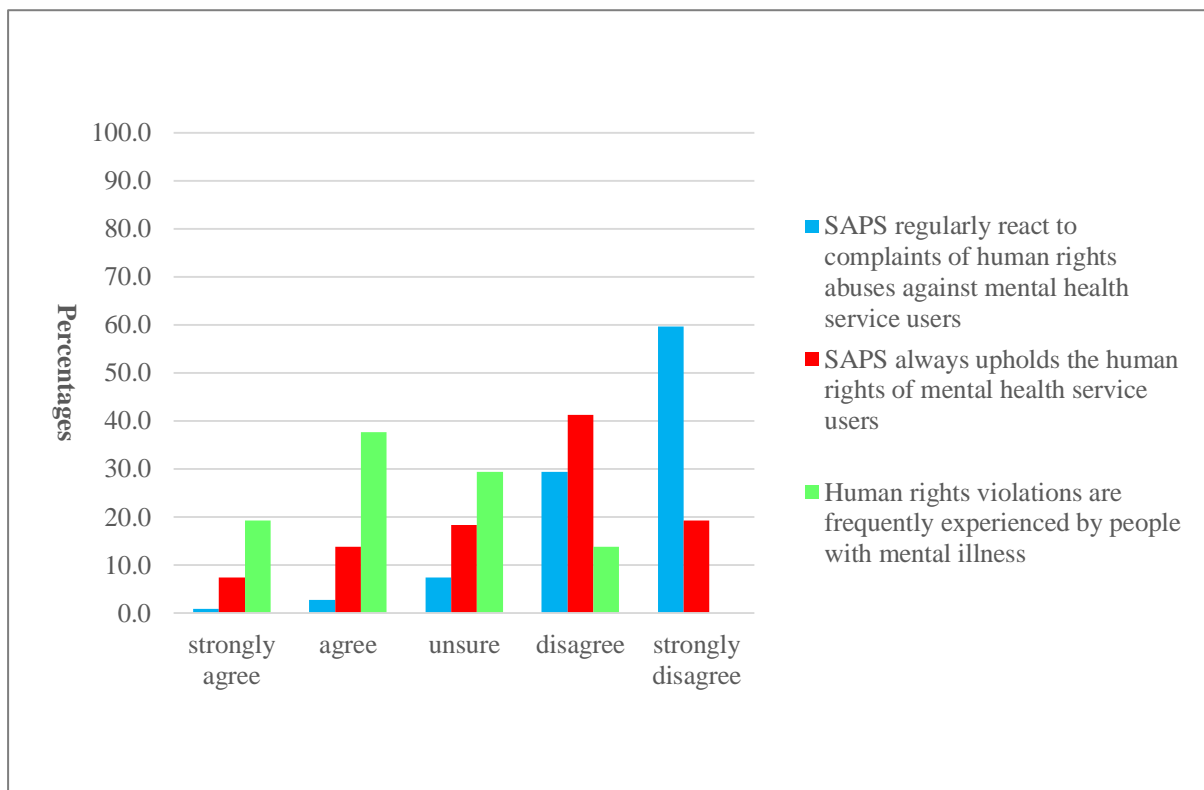


Figure 46 identifies that the majority of mental health professionals (89.%, $n=97$) disagreed that the South African Police Services (SAPS) regularly reacts to complaints of human rights abuses against mental health services users. Furthermore, the majority (60.6%, $n=66$) of respondents disagreed that the SAPS always upholds the human rights of mental health service users in their provinces. The experience of mental health service users was reported as follows:

When someone in my community comes to me and says I am crazy – I’m a mad person, I can’t just go to the police station because the police will laugh at me and I don’t have money to come into town to inform my social worker that someone called me crazy – I’m a mad person. When you go to the police station they really laugh at you because they also think that you’re insane by coming to the police station (*KZN Service-user, TD, April 2016*).

Even at the police station, if you go and complain, when they find out that you have a mental illness they treat you like nothing (*EC Service-user, CMS, March 2016*).

They [police] stop talking to you and they start talking to your family (*EC Service-user, RS, March 2016*).

The WHO (2010) noted that people with mental illness are highly vulnerable and are at greater risk of abuse and discrimination. They added that people with mental disability are also often deprived of their political, civil and legal rights. The role of the SAPS is therefore critical to protect and react to complaints submitted by service users.

My experience is, I was diagnosed in 1994 with Bipolar – then there was no-one to protect me. I don’t have a family so I can’t go to my family and say you know when I’m in need of something or when things are getting too much for me. You see the thing is there is no law protecting us at all – that is why even at the clinic or at the hospital if you come with a letter from a psychologist or a psychiatrist the sister at the clinic will immediately judge you (*EC Service-user CMS, March 2016*).

Despite the majority of mental health professionals (59.6%, $n=62$) agreeing that human rights violations were frequently perpetrated against people with mental illness, as reported in Figure 44 (p. 158), the majority of the respondents disagreed that the SAPS regularly reacts to these complaints and therefore violates the human rights of mental health users.

4.3.5.5. Mental Health Service User Advocacy Rights

Perceptions about the mental health service users’ advocacy rights are presented in Figure 47 (p. 165) and discussed.

Figure 47: Mental Health Service User Advocacy Rights

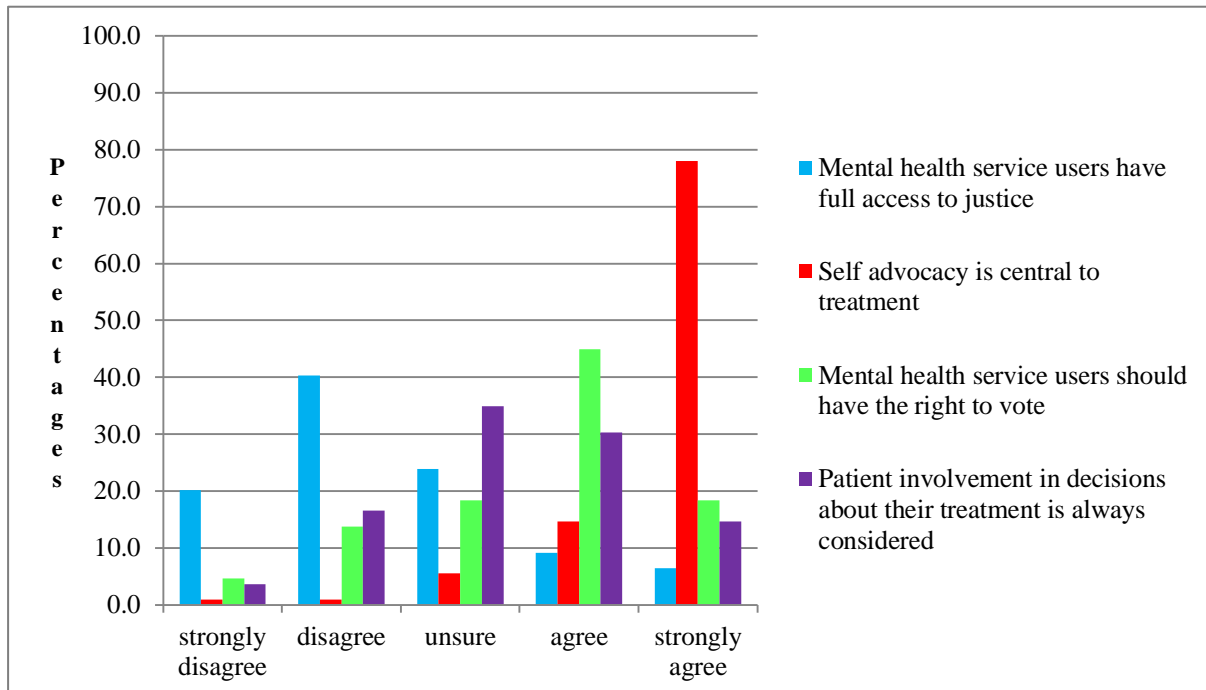


Figure 47 highlights that the majority of the mental health professionals (60.6%, $n=66$) disagreed that mental health service users had full access to justice.

The majority of mental professionals (92.7%, $n=101$) agreed that self-advocacy was central to treatment. Drew et al. (2011) suggested that it is essential that the service user remains at the centre of decision-making on issues that affect their lives and with the necessary support and explanations on relevant issues. This is fundamental to patient-centred interventions. Some participants in the focus groups highlighted that they were not given information about their diagnosis or information about their mental health.

Focus group participants stated the following:

The whole year in 2014, I did not know what was happening to me. I didn't know what illness I was sick of and what diagnosis I had. The whole of 2014, I didn't know what was going on in my life. The only thing I know I was just sleeping. In 2015, I was healing so I started to do research on the computer. So when I discussed with people about mental illness they told me about schizophrenia. So when I went to the clinic I started asking what illness am I suffering from but all along I had my clinic file and no one told me

I was suffering from schizophrenia even at the hospital where I go (WC, Service-user, AC, March 2016).

You have the right to ask your doctor to explain to you about your mental illness if you're not sure of your mental illness. That is what I did. I was first diagnosed with Bi-polar and then in 2014 they said no I'm not Bi-polar but Schizo-affective disorder so I said to the doctor that I don't know what it is (WC Service-user, YW, March 2016).

You have the right to know your diagnosis and the report (KZN, Service-user MH, April 2016).

Figure 48 (p. 170) indicates that 63.3% ($n=69$) of mental health professionals in the province agreed that mental health service users should have the right to vote. It is important to note, according to Combrink (2014), that people with mental illness or psycho-social disabilities are the only category of persons with disability who have voting restrictions placed on them according to the electoral RSA Electoral Act 73 of 1998. This Act clearly sets out that persons who have been declared by the High Court to be “of unsound mind or mentally disordered”, or are detained under the RSA Mental Health Care No 17 of 2002 Act, may not register and therefore may not vote. Combrink (2014) argued that “the present exclusion of persons with psychosocial disabilities constitutes an impermissible limitation of this right, which may not survive constitutional scrutiny” (p. 98). She added that this was in direct contravention of the United Nations Convention on the Rights of Persons with Disability. The researcher would argue that mental health users who are functioning optimally at the time of elections should be allowed to vote.

4.3.5.6. Human Rights Structures

Perceptions about the human rights structures established to protect mental health service users are discussed in this section.

The majority (94.4%, $n=103$) of respondents agreed that mental health human rights structures should be established to monitor human rights abuses in provinces. Despite the fact that Mental Health Review Boards were established in terms of the Mental Health Care Act

No. 17 of 2002, only 62% ($n=68$) of mental health professionals agreed that their province had fully functioning Mental Health Reviews, whilst only 44.4% ($n=48$) of respondents agreed that Mental Health Review Boards intervened in human rights abuses in their province.

The focus group participants in the Eastern Cape Province had their own perspectives on the Mental Health Review Boards:

They [Mental Health Review Board] are of no help for any of us. If ever there was one case where they helped us as mental health care patients then I would still be able to say they helped but there is nothing, nothing. They are there but they do nothing for us as mental patients. So we are sitting with a mental health system that is not protecting us and a Review Board that does nothing for us. The fact that my family had me certified and wanted me to be sent away – they are supposed to protect you but where in your life have you heard from a Mental Health Review Board that says sorry but we can't help you (*EC Service-user CMS, March 2016*).

When the Mental Health Review Board visits ED [Elizabeth Donken Hospital] everything is being made to look good, but when they're gone everything goes back to normal (*EC Service-user PD, March 2016*).

The Mental Health Review Board came and spoke to us 1½ years ago and they were very old-school. They did not seem to have a very good understanding about human rights. The UNCRPD – they did not seem to know much about that (*EC, Service-user RS, March 2016*).

The Western Cape Province is one of the few provinces where an active and exceptionally well-functioning Mental Health Review Board operates.

These findings raise concerns considering, firstly, that respondents indicated poor reactions and responses from the SAPS to reports of human rights violations and, secondly, that they reported the inactivity of certain Mental Health Review Boards in certain provinces. Bateman (2012) stated that “worryingly many provinces are still to meet the mandate and criteria for implementation as prescribed in the Act” (p. 68). He added that “In a subsequent letter to the South African Journal of Psychiatry in June last year, Dr Bernard Janse van Rensburg of Gauteng’s Helen Joseph Hospital said that the quality of the referral procedures

and administrative record-keeping of his province's Mental Health Review Board 'needs dramatic improvement' ” (p. 69) and furthermore indicated that “without these, the human rights of mental healthcare users will continue to be compromised” (Bateman, 2012, p. 69).

4.3.6. Critical Partnerships for a Multi-sectoral Approach to Integrated Mental Health Services

This section deals with the perceptions of mental health professionals and service users about critical partnerships. This includes their perceptions of the role of mental health NPOs, service users, carers, traditional healers and community leaders/structures that are required to implement an effective multi-sectoral approach to integrate and sustain community-based mental health programmes in South Africa.

Strategic partnerships, multi-sectoral collaborations and planning of mental health services are required to reduce the current structural fragmentation in mental health services.

4.3.6.1. Multi-sectoral Forums

Perceptions about these mental forums are discussed in this section.

The majority (93.8%, $n=103$) of mental health professionals agreed that mental health service users should fully participate in multi-sectoral mental health forums. This supports the previous findings, as identified in Figure 47 (p.165) that the role and participation of mental health service users as self-advocates are central. It is critical for them to have a direct say in treatment options and to be empowered to make recommendations about interventions that have a direct impact on their recovery.

The majority of mental health professionals (93.6%, $n=102$) agreed that fully functioning multi-sectoral district-based mental health forums should be established to co-ordinate mental health services. These findings highlight the need for multi-sectoral collaboration, which should include traditional healers, faith healers, spiritual leaders, service users, non-specialist mental health workers including NPOs. Mental health services, even though devolved to PHC

facilities, remain fragmented with the various interventions operating in silos. Mental health services could be far more dynamic and better co-ordinated with referral pathway mappings to enrich community-based interventions. These collaborations could enhance the basket of services provided.

4.3.6.2. Mental Health NPOs – Critical Partners

Mental health NGOs play a significant role in implementing community-based mental health services in South Africa. Perceptions about NPOs critical partnerships were only directly gained from the social workers at the 17 mental health NPOs that are affiliated to the South African Federation for Mental Health. These NPOs are the only mental health NPOs in South Africa who provide services pertaining to:

- Intellectual disability
- Psychiatric disability or psycho-social disability
- Mental Health Prevention and Awareness
- Advocacy and Lobbying

Social worker perceptions are presented in Figure 51 (p. 234) and discussed.

Figure 48: Mental Health NPOs – Critical Partners

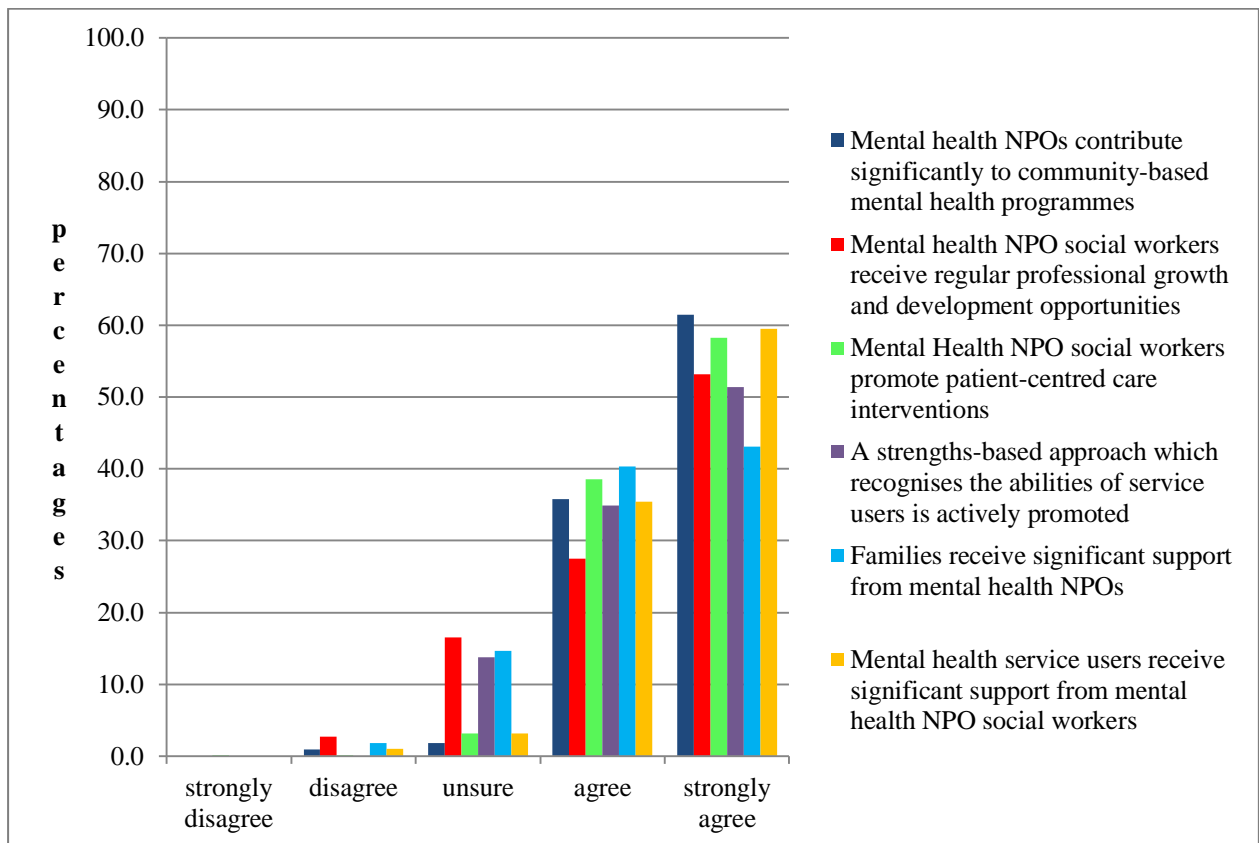


Figure 48 highlights that the majority of social workers (97.3%, $n=106$) agreed that mental health NPOs contribute significantly to community-based mental health programmes. Figure 48 identifies that the majority of social workers (96.8%, $n=106$) agreed that social workers actively promote patient-centred care interventions, whilst 86.3% ($n=94$) agreed that a strengths-based approach, which recognises the abilities of service users, is actively promoted. Mental health social work practice focuses less on the diagnosis, problems and limitations associated with the condition and more on functional abilities and supportive interventions – a practice which identifies and strengthens abilities and capabilities. In so doing, this links the abilities of users with opportunities for recovery and reintegration. Hensley (2012) stated that “Adherence to patient-centred care has also been associated with higher satisfaction and in some cases better outcomes in terms of patients’ experience of physical symptoms and adherence to care regimens” (p. 135). Patient-centred or user-centred

care places the mental health service user at the centre of the intervention and fosters empowerment, respect, joint decision-making and dignity for the user, despite their diagnosis, educational level and social circumstances.

The majority of social workers (88.5%, $n=91$) agreed that families of mental health service users received significant support from mental health NPOs, whilst a significant majority (94.9%, $n=103$) agreed that mental health service users received significant support from their social workers.

The South African Federation for Mental Health Analysis Report on Annual Statistics for Financial Year 2014–2015 (2015) identified the mental health community-based programmes implemented by the 17 mental health NPOs across South Africa (See Table 6, p. 172). Mental health NPOs rendered services to 82 736 persons during 2015–2016 financial year, across rural, peri-urban and urban areas in South Africa.

Table 6: Community-Based Mental Health Programmes by Mental Health NPOs

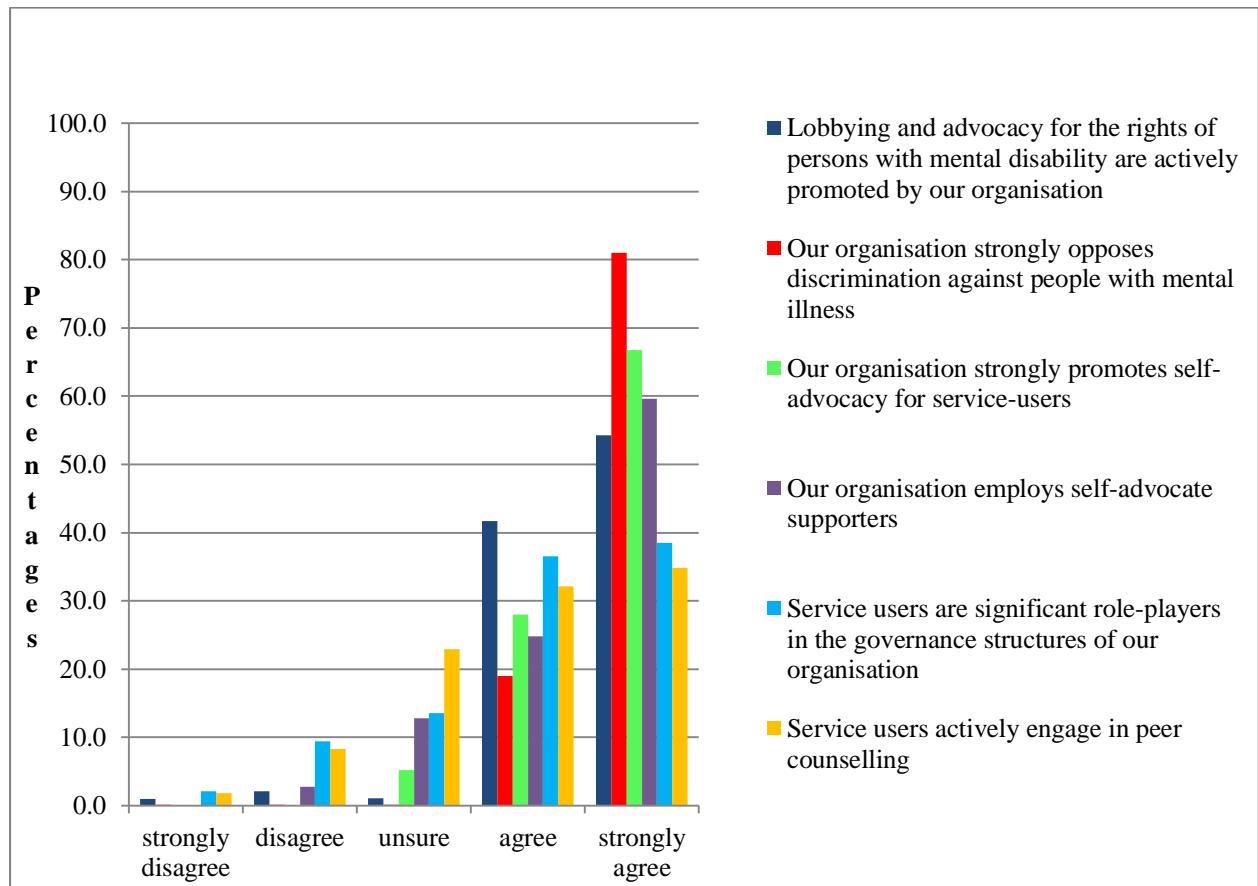
COMMUNITY-BASED MENTAL HEALTH PROGRAMMES BY MENTAL HEALTH NPOS	NUMBER OF THESE PROJECTS IN SOUTH AFRICA
Counselling services	1 131 programmes reaching 17 525 direct service users
Early Childhood Development	51 programmes
Family support	398 programmes reaching 3 473 beneficiaries
Support groups	88 groups
Service user empowerment	101 programmes
Group homes	14
Residential centres with protective workshops	8
Residential centres	7
Homes for persons with severe and profound intellectual disability	3
Special Educational and Care Day Centres	38 benefiting 998 users
Employee Assistance Programmes	5 benefiting 1051 beneficiaries
Protective workshops, skill development workshops and an integration company	42 benefiting 2 571 beneficiaries Programmes include: Learnerships, Open Labour Market (OLM) employment, Supported Employment, Integration Company, etc.,
Psychosocial rehabilitation programmes	22 that also include: Supported Employment, Transitional Employment Placements, Independent Business Units/Job Creation Programmes, etc.
Public education and awareness programmes	<ul style="list-style-type: none"> • 46 radio talks were done during the period under review, with an estimated total reach of 5 360 325 • 6 TV presentation were done, with an estimated total reach of 2 804 000 • 49 newsletter / magazine / newspaper articles were published during the period under review, with an estimated total reach of 3 051 467 • 68 “other” media activities were run during the period under review, with an estimated total reach of 2257 <p>TOTAL number of activities = 169 TOTAL estimated reach of activities = 11 218 049</p>
Other – advocacy programmes, statutory services	14 684 beneficiaries

(South African Federation for Mental Health, Annual Statistics, 2015)

4.3.6.3. Critical Partnership – Mental Health NPO and Mental Health User

The perceptions of NPO social workers about the empowerment of their service users is depicted in Figure 49 and discussed.

Figure 49: Critical Partnership – Mental Health NPO and Mental Health User



The vast majority of social workers (96%, $n=105$), as illustrated in Figure 49, agreed that lobbying and advocacy for the rights of persons with mental disability were actively promoted by their mental health NPO, while all social workers (100%, $n=109$) agreed that their organisation strongly opposed discrimination against people with mental disability. Anti-stigma campaigns and specific lobbying and advocacy are promoted during the various annual campaign months, namely, Intellectual Disability Awareness Month (March), Psychiatric Disability Awareness Month (July) and Mental Health Awareness Month (October). Themes are chosen annually to lobby for the upscaling of mental health services

such as access to medication, access to employment, anti-stigma, dignity in mental health, bed shortages, right to education, and so on. Some of the lobbying and advocacy campaigns have translated into High Court and Constitutional Court judgements such as The Right to Education for Learners with Severe and Profound Intellectual Disability and the unconstitutionality of Section 77(6)(a) of the Criminal Procedure Act, 51 of 1977 regarding the imprisonment of children and adults with serious mental illness and intellectual disability, and so on.

Figure 49 (p. 173) depicts that a significant majority of social workers (94.8%, $n=103$) agreed that their mental health NPO promotes self-advocacy for service users with mental disabilities, whilst 84.4% ($n=92$) of the social workers agreed that their organisation employed self-advocate supporters. Self-advocacy is essential for the empowerment of people with mental illness and allows them to be directly involved in matters affecting their lives. The role of the self-advocate supporter is complex and needs to be clearly understood by the supporter. Their role is to assist the user to understand the issues or context, but they do not have the liberty to speak on their behalf. The self-advocacy movement allows people with mental disabilities to take back control and allows them to have a voice in policy-making, legislation, interventions and social justice issues that are not addressed and result in creating barriers to their integration in society.

The mental health movement and the NPOs are strong supporters of self-advocacy and have acknowledged their role in the governance structures of the NPO Boards. The latter is illustrated in Figure 49 (p. 173) in which a significant majority of social workers (75%, $n=82$) agreed that services users were significant role-players in the governance structures of their organisation and therefore critical partners in mental health service delivery.

Even though 94% ($n=102$) of mental health professionals, as depicted in point 4.3.3.2.7., (pp. 138–141), agreed that human resource capacity should be strengthened through

increased peer interventions, only 67% ($n=73$) of social workers agreed that service users were actively engaged in peer counselling. These findings seem to suggest that despite the commitment from the mental health NPOs to self-advocacy; at least 22.9% ($n=25$) were unsure as to whether service users were actively engaged in peer counselling. This indicated that not all mental health NPOs have maximised this opportunity to expand human resource capacity.

4.3.6.4. Partnership between NPO and State Departments

Social worker perceptions about the partnership between the State departments and NPOs are presented in Figure 50 and discussed.

Figure 50: Partnership between NPO and State Departments

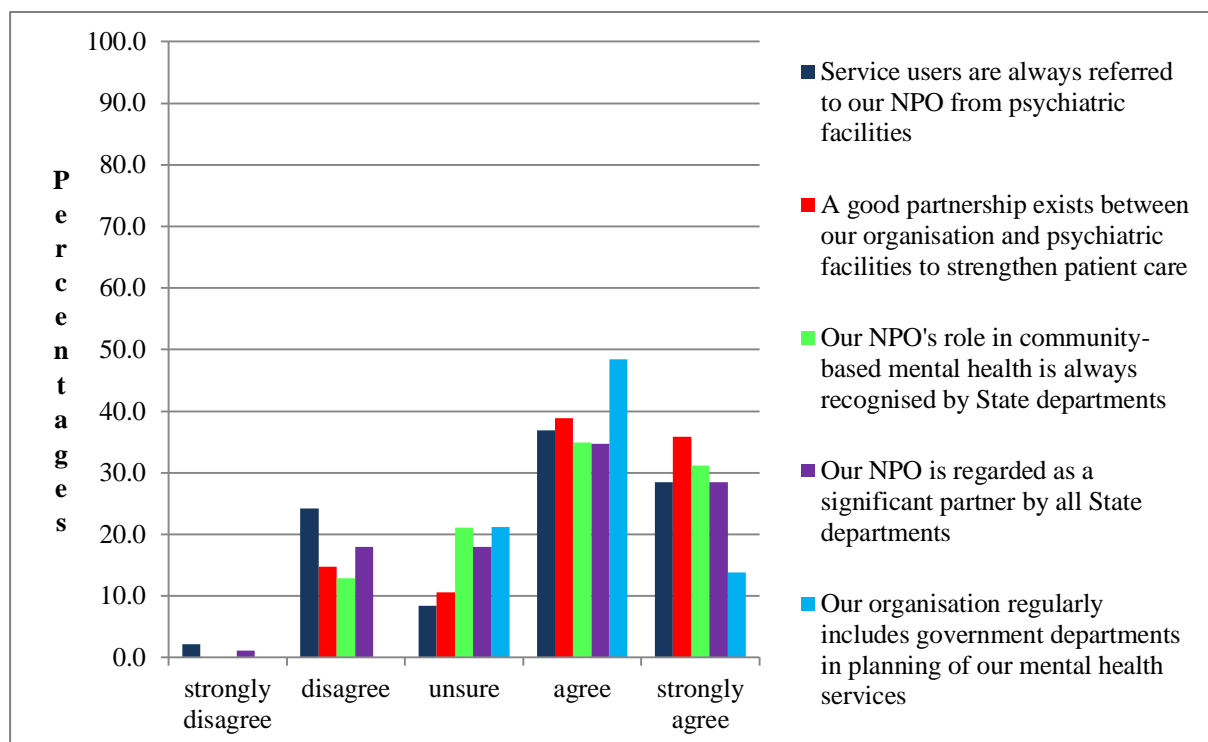


Figure 50 illustrates that 65.2% ($n=71$) of social workers agreed that service users were always referred to their NPO from psychiatric facilities, whilst 26.3% ($n=29$) disagreed. These findings appear to suggest that service users were not always referred to mental health

NPOs to access the range of service options. Social workers 74.8% ($n=82$) agreed that a good partnership existed between mental health NPOs and psychiatric facilities to strengthen patient care. Mental Health NPOs play a significant role and provide the majority of community-based services across various sectors in South Africa. The partnership between psychiatric facilities and mental health NPOs is critical to ensure smooth transitioning from hospital-based care to community-based care.

Only 61% ($n=66$) of social workers agreed that their NPO's role in community-based mental health was always recognised by the State department in their province. These findings suggest that there were some concerns in some provinces where the important role played by mental health NGOs was not always recognised and acknowledged. These findings seem to be supported by the fact that 63.1% ($n=69$) of social workers agreed that their NGO was regarded as a significant partner by all State departments.

Even though the partnership and recognition was reported in the majority of the responses, one would have expected a higher response rate.

Of the social workers 62.2% ($n=68$) agreed that their organisation regularly included government departments in the planning of mental health services. Only 49% ($n=53$) of social workers agreed that provincial government departments seldom consulted with their organisation when planning mental health services in their province. There was general consensus that effective comprehensive community-based mental health interventions and public-private non-government partnerships are essential to maximise human resource capacity and expand the package of mental health services offered through improved collaboration and referral pathways.

4.4. Relationship between Variables – Bivariate Findings

Bivariate analysis using Pearson's Chi-square to test for independence between two categorical nominal variables or two variables was used in the data analysis within the

various subsections to test the empirical relationship between two variables. The Chi-square test for independence is a non-parametric statistical test that is usually used to explore the relationship between two or more categorical variables using cross tabulation (Engel & Schutt, 2009). The null hypothesis indicates that the two variables are independent. This would be apparent if the observed counts in the simple to the expected counts. Table 7 below presents the Descriptive Information of the Central Study Categorical Variables that will include both positive and negative perceptions of mental health professionals including the test for independence between two categorical variables.

Table 7: Descriptive Information Central Study Variables

	Frequency (<i>n</i>)	Percentage %
Mental Health Policy		
Positive	52	47.7
Negative	57	52.3
Major Barriers Preventing Expansion of Community- based Mental Health Services		
Positive	62	56.9
Negative	47	43.1
Financial and Human Resource Allocations		
Positive	58	53.2
Negative	51	46.8
Biomedical Approach and Feasibility of an Integrated Community-based Model		
Positive	58	53.2
Negative	51	46.8
Human Right and Dignity		
Positive	57	52.3
Negative	52	47.7
Critical Partnerships		
Positive	55	50.5
Negative	54	49.5

4.4.1. Association between a Good Policy and the Appropriateness of the Policy

This section focuses on Pearson’s Chi-square test for independence which was conducted to test the relationship between mental health professional’s perceptions about the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) as a good policy and its appropriateness for mental health care.

It was hypothesised that there is no significant difference between the proportion of mental health professionals that reported that the mental health policy is good and those that reported that it is appropriate for the country.

Table 8: Association between a Good policy and Policy Highly Appropriate

Chi-square Test

	Value	df	Asymptotic Significance (2-sided)
Pearson’s Chi-square	120.488 ^a	9	.000
Likelihood Ratio	81.186	9	.000
Linear-by-Linear Association	38.555	1	.000
N of Valid Cases	109		

As shown in Table 8, Chi-square performed indicated a significant relationship between a good policy and its appropriateness for mental health care in a developing country [χ^2 (9, $n=109$) = 120.5, $p < .000$]. We could therefore conclude that mental health professionals identified a good policy as one that is appropriate for the South African context where mental health resources are largely inadequate to address the large gap in mental health care, despite the fact that a significant percentage of mental health professionals were unsure about the appropriateness of the policy. A mental health service user’s perception of the policy was stated as:

It is a strategic long-term plan of where government wants to get to and how they are going to do it. It is supposed to include all the role-players – they did a pretty good exercise of talking to all the role-players. There is a lot of meat in it It is

the government's attempt to make a plan for us (EC Service - user RS, March 2016).

4.4.2. Perceptions of Mental Health Policy Categories and Financial and HR

Category

To test this categorical variable, Pearson's Chi-square test for independence was conducted to test the relationship between mental health professionals' perceptions of mental health policy categories and financial and human resource category significance as illustrated in Table 9.

Table 9: Relationship between Perceptions Mental Health Policy Categories and Financial and HR Categorical Variables

Chi-Square Test

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson's Chi-square	.066 ^a	1	.797		
Continuity Correction ^b	.004	1	.948		
Likelihood Ratio	.066	1	.797		
Fisher's Exact Test				.849	.474
Linear-by-Linear Association	.066	1	.798		
N of Valid Cases	109				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 24.33.

b. Computed only for a 2x2 table

It was hypothesised that there is no significant difference between the proportions of mental health professionals that reported perceptions of mental health policy categories and financial and human resource category significance.

Chi-square showed no significant relationship between mental health professionals' perceptions of mental health policy in relation to the financial capacity and human resource capacity and in the delivery of mental health care [$\chi^2 (1, n=109) = .004, p < .948$]. This means that the percentage of mental health professionals' perceptions of the relationship of mental

health policy to those mental health professionals' perceptions of the financial and human resource capacity in delivering mental health care was not statistically different.

4.4.3. Major Barriers or Constraints Preventing the Effective Expansion and Improvement of Community Mental Health Services

This section tested the significance in the relationship between how well mental illness is understood and mental illness being highly stigmatised as major barriers or constraints preventing the effective expansion and improvement of community mental health services.

Table 10: Association between How Well Mental Illness is Understood and Mental Illness being Highly Stigmatised

Chi-square Test			
	Value	df	Asymptotic Significance (2-sided)
Pearson's Chi-square	40.650 ^a	16	.001
Likelihood Ratio	37.397	16	.002
Linear-by-Linear Association	1.396	1	.237
N of Valid Cases	109		

Pearson's Chi-square test for independence was conducted to test the relationship between how well mental illness is understood and mental illness being highly stigmatised. It was hypothesised that there is no significant difference between the proportion of mental health professionals that reported between how well mental illness is understood and mental illness being highly stigmatised

As shown in Table 10, the Chi-square test performed shows a significant relationship between how well mental illness is understood and mental illness being highly stigmatised [χ^2 (16, $n=109$) = 40.7, $p<.001$]. This implies that the percentage of mental health professionals' perceptions regarding the relationship between how well mental illness is understood and the percentage of mental health professionals' perceptions mental illness being highly

stigmatised was significant. Service-users' perception of whether mental illness was well understood and mental illness being highly stigmatised was stated as follows:

You see people are not aware of mental illness; people are not told about this illness. (*WC Service-user AC, March 2016*).

People need more information about mental disability. I think the community at large – they really don't know and need to be educated and like he says mental illness is psycho-social. They see us as people talking about strange things, they see us as funny people like you're mad and you'll find out that we're being discriminated against – the stigma is there (*KZN Service-user PD, April 2016*).

If you go to the rural areas they stigmatise psychiatric patient everyone says that person is a witch. (*EC Service-user - PD, March 2016*)

4.4.4. Major Barriers and Human Rights and Dignity Categorical Variables

Table 11 illustrates that the Chi-square test performed identified no significance in the relationship between major barriers and human rights and dignity categorical variables.

Table 11: Association between Major Barriers and Human Rights and Dignity Categorical Variables

Chi-square Test					
	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson's Chi-square	.373 ^a	1	.541		
Continuity Correction ^b	.174	1	.676		
Likelihood Ratio	.373	1	.541		
Fisher's Exact Test				.567	.338
Linear-by-Linear Association	.370	1	.543		
N of Valid Cases	109				
a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 22,42.					
b. Computed only for a 2x2 table					

As shown in Table 11, Pearson's Chi-square test for independence was conducted to test the relationship between perceptions between major barriers and human rights and dignity categorical variables. It was hypothesised that there is no significant difference between the

proportion of mental health professionals that reported on the relationship between major barriers and human rights and dignity categorical variables. The Chi-square test showed no significant relationship between mental health professionals' perceptions between major barriers and human rights and dignity categorical variables [$\chi^2 (1, n=109) = .174, p<.676$]. This means that the percentage of mental health professionals' perceptions of the relationship between major barriers and the percentage of mental health professionals' human rights and dignity was not statistically significant and thus confirmed the hypothesis.

4.4.5. Relationship between the Major Barriers and Biomedical and Integrated Community-Based Model Categorical Variables

Pearson's Chi-square test for independence was conducted to test the relationship between mental health professionals' perceptions of the relationship between the major barriers and biomedical and integrated community-based model categorical variables.

Table 12: Association between Major Barriers and Biomedical and Integrated Community-based Model Categories

Chi-square Test

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson's Chi-square	5.425 ^a	1	.020		
Continuity Correction ^b	4.560	1	.033		
Likelihood Ratio	5.460	1	.019		
Fisher's Exact Test				.022	.016
Linear-by-Linear Association	5.375	1	.020		
N of Valid Cases	109				

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 21,99.

b. Computed only for a 2x2 table

It was hypothesised that there is no significant difference between the proportions in the relationship in mental health professionals' perceptions of the major barriers and the

proportion of mental health professionals who identified biomedical and integrated community-based model categories.

The Chi-square test indicated that there is a significant relationship between mental health professionals' perceptions of the major barriers and biomedical and integrated community-based model categorical variables.

Pearson's Chi-square test identified a significant relationship in the major barriers and biomedical and integrated community-based model categories [$\chi^2 (1, n=109) = 4.560, p < .033$] as illustrated in Table 12 (p. 182). This implies that the percentage of mental health professional respondents' perceptions of the relationship between the major barriers and biomedical and integrated community-based model categories was significant. It therefore further suggests that the focus on bio-medical interventions in the absence of other community interventions is considered a major barrier to recovery.

4.4.6. Relationship between the Medical Model and the Use of Psychiatric Medication as the Preferred Treatment Option Variables.

Pearson's Chi-square test for independence was conducted to test the relationship between the medical model and the use of psychiatric medication as the preferred treatment option variables.

Table 13: Relationship between the Medical Model and the Use of Psychiatric Medication as the Preferred Option

Chi-square Test

	Value	df	Asymptotic Significance (2-sided)
Pearson's Chi-square	36.933 ^a	12	.000
Likelihood Ratio	33.425	12	.001
Linear-by-Linear Association	4.327	1	.038
N of Valid Cases	109		

a. 13 cells (65.0%) have expected count less than 5. The minimum expected count is .14.

It was hypothesised that there is no significant difference between the proportions in the relationship in mental health professionals' perceptions of the relationship between the medical model and the use of psychiatric medication as the preferred option

The Chi-square test performed indicated a significant relationship between the medical model and the use of psychiatric medication as the preferred option of [χ^2 (12, $n=109$) = 36.9, $p < .000$] as illustrated in Table 13 (p. 183). This means that the percentage of mental health professionals' response concerning the relationship between the medical model and the use of psychiatric medication was statically significant. It therefore underscores the focus of medication as the preferred treatment option when intervention is framed within the medical model. Focus group participants supported the findings:

I get monthly injections and then I get tablets for the side-effects. So it is mainly prescribed medication (*WC, Service -user KT, March 2016*)

It does not happen often. Look they only give us tables that they have and then you have to come back again. It messes your whole system up. You must start all over again. I waited about a month for my tablets. I get sick if I don't get the tablets. (*NC Service user, GH, April 2016*).

4.4.7. Relationship between Mental Health Professionals' Perception of the Link between Poor Socio-Economic Conditions and Increased Mental Illness and Poverty

Pearson's Chi-square test for independence was conducted to test the relationship between mental health professionals' perception of the link between poor socio-economic conditions, poverty and increased mental illness, and the increase in demand for mental health services as illustrated in Table 14 (p. 185).

Table 14: Relationship between Poor Socio-Economic Conditions and Poverty and Mental Health

Chi-square Test

	Value	df	Asymptotic Significance (2-sided)
Pearson's Chi-square	199.208 ^a	16	.000
Likelihood Ratio	95.685	16	.000
Linear-by-Linear Association	47.356	1	.000
N of Valid Cases	109		

a. 19 cells (76.0%) have expected count less than 5. The minimum expected count is .04.

It was hypothesised that there is no significant difference in the relationships between the proportions of mental health professionals' perceptions of the relationship between poor socio-economic conditions that increased mental illness and the link between poverty and the increase in demand for mental health services. The Chi-square test indicated that there is a significant association between the relationship between poor socio-economic conditions that increased mental illness and the link between poverty and the increase in demand for mental health services [$\chi^2 (16, n=109) = 199.2, p < .001$] as shown in Table 14. This implies that a proportion of the mental health professionals perceived a causal link between poor socio-economic conditions that predispose people to mental illness and the increase in need for mental health care. Focus group respondents noted the following:

Money for grants. The disability grant is too little (*LP, Service user, K S, April 2016*).

I had worked at the place for 15 yrs. When I got my sickness [mental illness] the insurance would not pay out. I wasn't sick enough for them, but there was a person with gout got medically boarded (*EC, Service user, R S, March 2016*)

We have a right to go into the employment sector. I feel that we need a salary to have some basic needs like [a] lunch bar, buy perfume, washing powder, buy roll-on, chocolate or a packet of chips. If you are working for the whole month and you only get R15 what do you do with that? (*KZN, Service user, F H, April 2016*)

4.4.8. Relationship between the Social Model Approach and Patient-centred Care

The Chi-square test for independence was conducted to test the relationship between the social model approach and patient-centred care as shown in Table 15.

Table 15: Relationship between the Social Model Approach and Patient-centred Care

Chi-square Test

	Value	df	Asymptotic Significance (2-sided)
Pearson's Chi-square	54.897 ^a	9	.000
Likelihood Ratio	51.908	9	.000
Linear-by-Linear Association	23.822	1	.000
N of Valid Cases	109		

a. 11 cells (68.8%) have expected count less than 5. The minimum expected count is .13.

It was hypothesised that there is no significant difference between the proportions in the relationship of mental health professionals' perceptions of the relationship between the social model approach and patient-centred care. The Chi-square test indicated that there is a significant relationship between the perceptions of mental health professionals regarding the social model approach and patient-centred care, [$\chi^2 (9, n=109) = 54.9, p < .000$] as illustrated in Table 15. This means that mental health professional respondents identified patient-centred care as being central to social approaches to mental health interventions and thus this relationship was found to be statistically significant.

The patient-centred or person-centred approach to intervention is critical for better recovery outcomes. The Health Foundation (2014) noted that:

In person-centred care, health and social care professionals work collaboratively with people who use services. Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care. It is coordinated and tailored to the needs of the individual. And, crucially, it ensures that people are always treated with dignity, compassion and respect (p. 3).

4.4.9. Relationship between Vulnerability and Discrimination

The Chi-square test was administered to test the relationship between vulnerability and discrimination.

Table 16: Relationship between Vulnerability and Discrimination

Chi-square Test			
	Value	Df	Asymptotic Significance (2-sided)
Pearson's Chi-square	25.074 ^a	9	.003
Likelihood Ratio	19.111	9	.024
Linear-by-Linear Association	5.312	1	.021
N of Valid Cases	109		

a. 12 cells (75.0%) have expected count less than 5. The minimum expected count is .04.

It was hypothesised that there is no significant difference between the proportions of mental health professionals' perceptions of the relationship between vulnerability and discrimination. However, the Chi-square test indicated that there is a significant relationship between the perceptions of mental health professionals regarding vulnerability and discrimination [χ^2 (9, $n=109$) = 25.0, $p<.003$], as illustrated in Table 16. This implies that vulnerable mental health service users are more likely to experience discrimination.

The relationship between discrimination and vulnerability was also identified by focus group participants who reported the following:

My mother is an alcoholic. She was always an alcoholic. We are not taken care of and guys just come into the house and abuse me sexually. And it goes for three days abusing me sexually. (*Limpopo Service-user, SM, April 2016*)

They talk and they talking – they say don't go to them. They'll burn your home in the rural areas; they beat you and they say you're a witch. Everybody is against you. They just don't know... (*Limpopo Service-user, PD, April 2016*)

The special grants that they get are not for them as a person. The family only take them to the pay-point and after that they don't buy them anything. No food and no clothes. It shows that they don't know the extent of the crime in a family where people get the grant

but it gets used as income for the whole family, taking care of everyone. (*Limpopo Service-user, BM, April 2016*)

4.5. Chapter Summary

The findings derived from this study provided critical insights into mental health professionals and service users' knowledge of the National Mental Health Policy Framework Strategic Plan 2013–2020 (2013), its relevance, capacity required to implement, targets, critical partners for successful implementation, funding, and whether this is a good policy appropriate for the South African context.

The findings also highlighted mental health professionals and service users' perceptions pertaining to major barriers and constraints that prevent expansion and improvement in community-based mental health services. These perceptions related to the attitudes of health professionals towards persons with mental illness, the current state of mental health in South Africa and limited human resource capacity that impacts on access to community-based mental health.

Mental health professionals and service users' perceptions provided data about the financial and human resources allocations for mental health in South Africa, and the findings provided information about human resource challenges in mental health, working conditions of mental health professionals and the need to deploy non-specialists.

The findings further revealed the perceptions of mental health professionals and service users regarding the current bio-medical approach to mental health services and how they proposed to improve, modify, strengthen and include a social model of comprehensive mental health at a PHC level. The findings identified that mental health services were still mostly hospital-based with the medical model being the dominant approach to diagnosis and treatment, and unable to cope with the increase in demand for mental health services. The findings provided noteworthy indicators for developing comprehensive community-based mental health interventions at a Primary Health Care (PHC) level and contributed

substantially towards designing a model for poorly resourced and disadvantaged communities.

The consequences of the unavailability of mental health care has significant negative impact on the human rights of mental health users and the findings provided the insights to address these violations and protective measures required.

Finally, the findings supported the critical partnerships required to facilitate comprehensive community-based interventions. The following chapter presents the main findings, conclusions and recommendations.

CHAPTER FIVE: MAIN FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

This study was initiated against the background of significant mental health treatment gaps resulting in limited or no access to care. Despite the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) and South Africa’s commitment to drastically improving and transforming mental health services, little progress has been made. Mental health remains a low priority with significant and disproportionate under-spending on mental health compared to the other health conditions (Mkhize & Kometsi, 2008; Burns, 2009; National Mental Health Policy Framework and Strategic Plan, 2013–2014, 2013). Mental health services remain largely bio-medical in focus with visible scarcity in community-based mental health interventions. These gaps and deficits in mental health have resulted in structural fragmentation and economic disparities in mental health interventions.

In this chapter, a review of the key findings, an overview of key emerging issues and the main conclusions presented in the subsequent sections will be discussed.

This chapter provides recommendations, based on key conclusions from the study and suggestions for an alternative model to facilitate an integrated approach to community-based mental health that includes patient-centred interventions. The proposed model will be presented in the final chapter, namely “A Proposed Model for Comprehensive and Integrated Community-Based Mental Health Services in South Africa to address the shortcomings in mental health care and to increase access for person with mental illness particularly in resource communities”.

5.2. Main Findings

The following are the key findings pertaining to each specific objective of the study. The assumptions underpinned in this study (see Chapter 1, Section 1.5., pp. 8–9) are alluded to in reference to some of these key findings.

Objective 1: To examine how mental health professionals and service-users perceive the effectiveness of the present mental health policy with regards to the implementation of mental health services.

- Despite the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) being the first official mental health policy in South Africa, only 46.7% ($n=51$) of mental health professionals were familiar with the policy, whilst 54.1% ($n=59$) had only read some sections and only 21.1% ($n=23$) had done an in-depth study of the Policy. This raises the question as to how this Strategic Plan can be prioritised if key professionals are not familiar with the policy (See Chapter 1, Section 1.5., pp. 8–9). Furthermore, the majority of service-users who participated in the focus groups had little or no knowledge of the policy at all despite the provincial consultative process. Less than half of the mental health professionals (49%, $n=53$) indicated that it was a very good policy, whereas 42.6% ($n=46$) noted that the policy is highly appropriate for a developing country. The Chi-square test performed indicated a significant relationship between a good policy and its appropriateness for mental health care in a developing country [χ^2 (9, $n=109$) = 120.5, $p < .000$].
- Over half (53.7%, $n=59$) of the mental health professionals were unsure about the competence of the Provincial Department of Health to implement the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) whereas 49.1% ($n=54$) were unsure about whether mental was prioritised within the Department of Health (DOH). A quarter of the mental health respondents definitely disagreed that the Policy was prioritised.
- Even though the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) set out clear targets for implementation, most mental health professionals (59.3%, $n=65$) were unsure about whether the targets for implementation had been

set, whereas 66.7% ($n=73$) were unsure as to whether the Provincial DOH had secured funding to fully implement the policy.

- A significant number of mental health professionals were unsure about the capacity to implement the policy. Of the mental health professionals, 50.5% ($n=55$) were unsure about whether there were sufficient numbers of qualified mental health personnel employed in their province to implement the Policy, whereas 40.4% ($n=40$) disagreed that there were sufficient numbers of qualified mental health personnel employed to implement the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013).
- There was further uncertainty by mental health professionals (54.1%, $n=59$) who indicated that they were unsure as to whether the number of mental health specialist teams had increased significantly in districts because of the new policy.
- There was further doubt by mental health professionals (54.1%, $n=59$) as to whether health professionals were adequately trained in mental health at Primary Health Care (PHC) facilities to give effect to the Policy.
- The Chi-square test showed no significant relationship between mental health professionals' perceptions of mental health policy in relation to the financial capacity and human resource capacity and in the delivery of mental health care [χ^2 (1, $n=109$) =.004, $p < .948$].
- With regards to the integration of mental health into the National Health Insurance (NHI), the majority of respondents (67.9%, $n=74$) were unsure as to whether informal health workers at NHI sites were adequately trained in mental health to give credence to implementing the Policy, whereas a significant number (66.1%, $n=72$) of mental health professionals were unsure as to whether mental health interventions were fully implemented at NHI pilot sites as set out in the Policy. An even larger percentage

(75.2%, $n=82$) were unsure about whether informal health workers employed in NHI sites were actively rendering mental health services.

- The majority of mental health professionals (57.8%, $n=63$) were unsure as to whether mental health service users actively participated as significant role-players in the implementation of the Policy despite the Policy's recognition of the role of service users in providing appropriate self-help and peer-led support groups. Of interest, the majority of mental health professionals (78.9%, $n=86$) agreed that mental health service users were seldom included in mental health policy development, whereas 88% ($n=96$) indicated that service users should be fully included in commenting on legislation that affects their lives.
- Of the mental health professionals, 45.8% ($n=50$) disagreed whereas 49.5% ($n=54$) were unsure about whether traditional healers were regularly consulted in patient case management plans despite the policy's promotion of more meaningful relationships and partnerships with traditional and faith healers.
- Almost half of the mental health professionals (49.5%, $n=54$) disagreed that adequate community-based mental health programmes was available to give effect to the policy, whereas 42.2% ($n=46$) disagreed and 38.5% ($n=42$) were unsure as to whether their Provincial DOH actively collaborated with mental health non-profit organisations (NPOs) to give effect to the policy.
- Almost half the respondents (49.5%, $n=54$) were unsure and a further 35.8% ($n=42$) disagreed that the Policy had substantially increased mental health services in their province.
- The majority of mental health professionals (76.1%, $n=83$) were unsure as to whether the Mental Health Ministerial Advisory Committee had been established; only 47.7% ($n=52$) agreed that a Mental Health Directorate operated in their Province. Despite

72.2% ($n=79$) indicating that Mental Health Review Boards had been established in their provinces, only 62% ($n=68$) agreed that these Mental Health Review Boards were fully functioning.

Objective 2: To ascertain how mental health professionals and service-users perceive major barriers preventing the effective expansion of community-based mental health services.

- The majority of mental health professionals (60.5%, $n=66$) noted that mental health and mental health service users were not well understood by health professionals, whereas 67% ($n=73$) strongly agreed that health professionals often feared working with people who have a mental illness. A significant number (86.4%, $n=94$) noted that mental health service users were often regarded as unpredictable. Despite the majority (66.7%, $n=73$) indicating that it was not difficult to communicate with service users, 57.5% ($n=63$) noted that the service users were not taken seriously. The latter was confirmed by focus group participants.
- A significant number of respondents (88%, $n=96$) agreed that negative attitudes by health professionals towards mental health service users resulted in a lack of empathy. The majority of the respondents (80.7%, $n=88$) agreed that negative perceptions of mental illness by health professionals led to pessimism about patient prognosis.
- Stigma experienced by services users was regarded as a major barrier – the majority (89.9%, $n=98$) of respondents indicated that mental illness remained one of the most highly stigmatised conditions. The Chi-square test showed a significant relationship between how well mental illness was understood and mental illness being highly stigmatised [χ^2 (16, $n=109$) = 40.7, $p<.001$]. Almost all respondents (96.4%, $n=105$) agreed that misconceptions about mental illness increased stigma and discrimination

while stigma always led to increased isolation and exclusion. These findings were confirmed by the focus group participants as well.

- Of the mental health professionals, 78.9% ($n=86$) agreed that dismissive attitudes by health professionals always led to lower prioritisation of mental health resources.
- With reference to access and demand for mental health services, 52.3% ($n=57$) of mental health professionals disagreed that all mental health service users had access to treatment in their communities despite the significant increase in demand for mental health services in their province. This is supported by the fact that 76.1% ($n=83$) indicated that community-based health facilities could not cope with this increase in demand.
- The majority of the respondents agreed that mental health services were mostly hospital-based, whereas a large number (80.7%, $n=88$) of mental health professionals noted that the medical model remained the dominant approach to diagnosis and treatment. Pearson's Chi-square test identified a significant relationship in the major barriers and biomedical and integrated community-based model categories [χ^2 (1, $n=109$) =4.560, $p<.033$].
- More than two-thirds of the respondents (76.1%, $n=83$) of mental health professionals disagreed that there were adequate mental health services in rural areas across provinces. The latter was corroborated by focus group participants.
- A significant number of mental health professionals (71%, $n=77$) disagreed that comprehensive mental health treatment options were always available to mental health service users in their provinces.
- More than half of the mental health professionals (55.1%, $n=60$) disagreed that medication was always available at primary health care (PHC) facilities, whilst 58.7% ($n=64$) indicated that psychiatric medication was always the preferred treatment

option for mental illness. The Chi-square test indicated that there is a significant relationship between mental health professionals' perceptions and the medical model and the use of psychiatric medication as the preferred option.

- With reference to the current state of mental health infra-structure and bed availability, less than half of the mental health professionals agreed that building conditions at many psychiatric facilities were not suitable for satisfactory patient care. The majority of mental health professionals (81.6%, $n=89$) disagreed that beds were always available for patients requiring admission, whereas 72.4% ($n=79$) noted that patients were prematurely discharged. This was confirmed by focus group participants.
- With regard to socio-economic conditions and poverty impacting on mental health, the majority of mental health professionals (83.5%, $n=91$) agreed that poor socio-economic conditions increased mental illness, whereas 73.4% ($n=80$) agreed that there was a direct link between poverty and the increase in demand for mental health services. The Chi-square test indicated that there is a significant association between poor socio-economic conditions that increased mental illness and the link between poverty and the increase in demand for mental health services [χ^2 (16, $n=109$) = 199.2, $p<.000$].

Objective 3: To determine the perceptions of mental health professionals and service-users about the current allocation of financial and human resources and alternative measures required to facilitate effective community-based mental health programmes.

- Relating to the current state of mental health non-government organisation (NGO) funding and human resources, 83.3% of mental health professionals ($n=91$) agreed and supported the findings of the PRIME study (2012) that untreated mental illness was more costly to the economy than the cost of treatment.

- The majority of mental health professionals (79.4%, $n=87$) disagreed that mental health was well funded, whereas 80.2% ($n=89$) disagreed that mental health NPOs were adequately funded. They (77.6%, $n=85$) added that fewer resources were allocated to mental health compared to other medical conditions.
- A significant majority of social workers (71.9%, $n=78$) disagreed that funding provided by provincial government departments was sufficient to support their programmes while their organisations' services were seldom recognised as more cost-effective compared to those delivered by State facilities. Almost all mental health professionals (97.2%, $n=106$) agreed that an increase in provincial health funding would expand comprehensive community-based mental health care.
- With reference to working conditions of mental health professionals, a significant number of mental health professionals (77.1%, $n=84$) agreed that mental health professionals had significantly higher job-related stress compared to other health professionals. The majority of respondents (67%, $n=74$) noted that mental health professionals had significantly higher workloads than other health professionals, whereas a significant number (85.4%, $n=93$) stated that a shortage of mental health professionals increased stress in their jobs. The staff shortages not only negatively impact on the stress levels of health professionals, but also directly impact on their ability to cope with the increased demand for mental health services.
- Relating to the working conditions of social workers, a large majority (81.7%, $n=89$) agreed that it was difficult to retain social workers due to low salaries. Social workers (66.1%, $n=72$) agreed that social workers at their mental health NPOs had significantly higher caseloads than social workers employed in the State sector. The majority (89.4%, $n=97$) agreed that the demand for mental health social work services

had increased significantly in their province. Most social workers (85.4%, $n=93$) agreed that the shortage of community-based mental health services decreased their ability to provide comprehensive services while violence in communities reduced their ability to provide regular home visits.

- The majority of the respondents (94.5%, $n=103$) agreed that adequate salaries needed to be provided to increase job satisfaction of mental health professionals, whilst exactly the same percentage agreed that special allowances should be offered to attract more health professionals to rural areas.
- A large majority (84.4%, $n=92$) agreed that mental health professionals often felt unsupported, whereas a significant number (78.9%, $n=86$) agreed that mental health professionals were seldom given recognition for working in difficult conditions. The majority (78%, $n=85$) disagreed that the working conditions were highly satisfactory.
- A large number of respondents (97.3%, $n=106$) agreed that to strengthen the human resource capacity of mental health professionals to deliver effective community-based mental health services in resource-poor communities, greater recognition needed to be given to them to increase their role and status in these communities.
- With reference to human resource capacity in provinces, over half (50.5%, $n=55$) of mental health professionals disagreed that primary health care professionals were highly skilled in treating mental disorders. They (52.3%, $n=57$) disagreed that there were adequate numbers of non-specialists employed to provide basic mental health, whereas 66% ($n=72$) agreed that the non-specialist health workers focused mainly on general health condition. The majority (67.9%, $n=74$) indicated that peer counselling was seldom used to provide basic mental health care.

- The majority (67.9%, $n=74$) of respondents noted that there were insufficient multi-disciplinary mental health specialist teams (Assertive Community Teams – ACT) in their provinces. A significant number (96.3%) indicated that ACT teams needed to be increased in every district.
- Regarding the need to deploy non-specialists, a large number (93.6%, $n=102$) of respondents agreed that mental health volunteers should be recruited in all districts to actively identify and motivate patients to seek treatment. The vast majority of mental health professionals (96.3%, $n=105$) agreed that task-shifting models should be used to increase basic mental health knowledge of non-specialist health workers, and 82.5% ($n=90$) of respondents agreed that the role and function of non-specialist health workers at NHI sites should be expanded to include mental health. A significantly high percentage of respondents (93.6%, $n=102$) agreed that all nurses, doctors, social workers and occupational therapists needed to be trained in mental health at PHC structures/facilities.
- The vast majority of mental health professionals (91.1%, $n=100$) agreed that the collaboration with traditional healers was important to strengthen mental health services.
- A significantly high proportion of mental health professionals (98.1%, $n=107$) added that human resource capacity in poorly resourced communities could be strengthened by providing increased outreach and support through peer interventions mental health professionals. They (88.9%, $n=97$) indicated that human resource capacity could be further strengthened by increasing partnerships with the mental health NPOs in South Africa.

- Respondents (95.4%, $n=104$) identified 24-hour “on call” psychiatric services as a further human resource strengthening measure to increase information about diagnosis and treatment options for mental health professionals, while the majority of respondents agreed that collaboration with traditional healers would be required to strengthen mental health resources.

Objective 4: To determine mental health professionals and service-users’ perceptions about the present bio-medical approach and feasibility of an integrated community-based model.

- In relation to the strengthening of comprehensive community-based mental health, the majority (94.5%, $n=103$) of mental health professionals agreed that mental health services should be offered mostly at a PHC level, to increase access to treatment. The majority (83.5%, $n=91$) stated that a social model approach to diagnosis and treatment would improve mental health care in contrast to the medical model that is still the dominant approach to care. They (91.7%, $n=100$) agreed that the provision of patient-centred care would significantly improve treatment options. The Chi-square test indicated that there is a significant relationship between the perceptions of mental health professionals regarding the social model approach and patient-centred care [$\chi^2(9, n=109) = 54.9, p<.000$]. The majority (93.5%, $n=102$) of mental health professionals agreed that a range of comprehensive mental health treatment options should always be provided at a PHC level, including the initiation of poverty alleviation programmes to significantly improve treatment outcomes.
- The majority of mental health professionals (94.5%, $n=103$) and focus groups’ participants noted that medication with the least side-effects should always be available at PHC facilities. An equally large percentage (93.5%, $n=102$) indicated that access to medication is a human right.

- The majority (90.9%, $n=99$) of mental health professionals and focus group participants agreed that mental health facilities should be regularly upgraded. It was further identified by the majority of mental health professionals (95.4%, $n=104$) that sufficient beds should always be available.
- Regarding strengthening human resource capacity, a large majority (98.2%, $n=107$) of mental health professionals agreed that additional non-specialist health workers should be employed to provide basic mental health in communities. A large number (92.7%, $n=101$) noted that an additional cadre of human resources, namely peer counsellors, could assist to improve community-based mental care. Mental health professionals agreed that collaboration with traditional healers in treating mental illness was necessary. They agreed (64.2%, $n=70$) that increased referrals to mental health NPOs would improve and maximise community-based support and counselling to service users. A significant majority (92.6%, $n=101$) of respondents agreed that multi-disciplinary district mental health specialist teams should be deployed to cover all districts in their provinces.
- With reference to the additional strengthening measures at PHC level, a significant majority (93.6%, $n=102$) agreed that a comprehensive resource directory of effective community-based mental health treatment options should be readily available in their province. They (96.3%) indicated that mental health interventions should be fully integrated into NHI pilot sites.
- A significant number (95.4%, $n=104$) of respondents noted that increased prevention and awareness campaigns would significantly reduce the demand for mental health care.

Objective 5: To explore mental health professionals and service-users' perceptions about the lack or unavailability of mental health services and its impact on the human rights and dignity of persons living with mental illness.

- The vast majority of mental health professionals (90%, $n=98$) indicated that people with mental illness experienced significant discrimination in our country. These findings were supported by the participants in the focus groups who noted that they experienced multiple levels of abuse that included sexual, physical and emotional abuse as well as institutional and financial exploitation.
- The majority (94.4%, $n=103$) of respondents agreed that people with mental illness were more vulnerable to abuse by society than those without mental illness. The Chi-square test indicated that there is a significant relationship between the perceptions of mental health professionals regarding vulnerability and discrimination [χ^2 (9, $n=109$) = 25.0, $p<.003$].
- The majority of mental health professionals (96.3%, 105) agreed that human rights violations were frequently experienced by people with mental illness, whereas (59.6%, $n=62$) noted that people with mental illness were more likely to be abused by health professionals.
- The majority of mental health professionals (85.3%, $n=93$) agreed that run-down buildings at psychiatric facilities violated the rights of patients to proper care. They (81.6%, $n=89$) agreed that access to medication for mental health service users was a human right. However, more than half (55.1%, $n=60$) indicated that psychiatric medication was not always available.
- Mental health professionals (89%, $n=97$) disagreed that the South African Police Services (SAPS) regularly react to complaints of human rights abuses against mental health services users. A majority (60.6%, $n=66$) disagreed that the SAPS always

upholds the human rights of mental health service users in their provinces. The latter was confirmed by the experiences of focus group participants.

- The majority of the mental health professionals (60.6%, $n=66$) disagreed that mental health service users had full access to justice. The majority (92.7%, $n=101$) noted that self-advocacy was central to treatment.
- The majority (94.4%, $n=103$) agreed that mental health human rights structures should be established to monitor human rights abuses in provinces.

Objective 6: To explore the perceptions of mental health professionals and service-users about the critical partnerships (carers, traditional healers, community leaders, etc.,) needed to implement a sustainable multi-sectoral integrated community-based mental health programme.

- The majority (93.8%, $n=103$) of mental health professionals agreed that mental health service users should fully participate in multi-sectoral mental health forums. They (93.6%, $n=102$) agreed that fully functioning multi-sectoral district-based mental health forums should be established to co-ordinate mental health services.
- The vast majority of social workers (97.3%, $n=106$) agreed that mental health NPOs contributed significantly to community-based mental health programmes. They (96.8%, $n=106$) indicated that mental health NPOs actively promoted patient-centred care interventions using strengths-based approaches.
- The majority of social workers (88.5%, $n=91$) agreed that families of mental health service users received significant support from mental health NPOs, whilst mental health service users received significant support.
- The social workers (96%, $n=105$) agreed that lobbying and advocacy for the rights of persons with mental disability were actively promoted by their mental health NPO, while their organisation strongly opposed discrimination against people with mental

disability while promoting self-advocacy. They (75%, $n=82$) regarded services users as significant role-players in the governance structures of their organisation and peer counselling and therefore critical partners in mental health service delivery.

- Social workers (74.8%, $n=82$) agreed that good partnerships existed between mental health NPOs and psychiatric facilities to strengthen patient care.
- Only (63.1%, $n=69$) of social workers agreed that mental health NPOs were regarded as significant partners by State departments.

5.3. Conclusions Drawn from the Study

Major conclusions drawn from the study, in line with the specific objectives, include the following:

Objective 1: To examine how mental health professionals and service-users perceive the effectiveness of the present mental health policy with regards to the implementation of mental health services.

Mental health professionals and service-users in this study have limited or no knowledge of the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) despite the provincial consultative process. Thus the findings related to an interrogation of the mental health policy must be viewed with some circumspection. This lack of knowledge may also have impacted on mental health professionals' perceptions about the competence of the Provincial Department of Health to implement policy or even assess whether targets have been set.

Their lack of knowledge limits their ability to confidently indicate whether there is adequate provincial funding, as well as mental health specialist teams and qualified mental health personnel employed to fully implement the Policy. The latter has implications for mental health professionals' ability to advocate for better resources. (The fact that mental health professionals are largely unaware of the integration of mental health into the NHI also

has implications for monitoring whether additional mental health resources have been allocated to mental health.

Furthermore, these professionals are largely unaware of the role of mental health service users in policy implementation, self-help and peer led support groups. One could speculate therefore that the advantages of including service users in various forums or even as service providers in their own right may be largely overlooked by a group of professionals who are not familiar with the empowerment of service users.

Despite the policy promoting more meaningful relationships and partnerships with traditional and faith healers, these non-specialists are not regularly consulted in patient case management and remain outside of the formal health care structure. Much more collaboration needs to be done with these non-specialists if one wants to meaningfully address mental illness in the South African context.

Whilst mental health professionals are knowledgeable about the functioning of Mental Health Review Boards, they are not aware of the institutional capacity of the Mental Health Ministerial Advisory Committee that advises the national Minister of Health about the implementation of this policy.

Objective 2: To ascertain how mental health professionals and service-users perceive major barriers preventing the effective expansion of community-based mental health services.

Mental illness and service users are not properly understood by health professionals who often fear working with people who have a mental illness. Mental health service users are still regarded as unpredictable. Even though it is not difficult to communicate with service users, they are often not taken seriously.

Negative attitudes by health professionals towards those with a mental illness may lead to a lack of empathy that impacts on treatment outcomes and fuels their pessimism about the

prognosis. Mental illness remains one of the most highly stigmatised conditions while stigma remains a major barrier in every sphere of life. Dismissive attitudes by health professionals always lead to lower prioritisation of mental health resources.

There is a significant increase in demand for mental health services in South Africa and community-based health facilities are hard-pressed to cope with the increase in demand. Not all service users have access to treatment in their communities. This is particularly evident in rural areas in South Africa where mental health care remains scarce.

Mental health services are mostly hospital-based, while the medical model remains the dominant approach to diagnosis and treatment. This creates a bottle-neck and contributes to pressure on hospital-based interventions.

Even though medication appears to be the preferred treatment option for mental illness, medication was not always available at PHC facilities and confirmed complaints of medication stock-outs at PHC facilities are common.

Building conditions at many psychiatric facilities are not conducive to patient care and the demand for beds often results in premature discharges.

Comprehensive mental health treatment options are scarce and almost unavailable and not always available to mental health service users in their provinces.

There is sufficient evidence (Lund, et al., 2011) that poor socio-economic conditions increase mental illness and that there is a direct link between poverty and an increase in demand for mental health services.

Objective 3: To determine the perceptions of mental health professionals and service-users about the current allocation of financial and human resources, and alternative measures required to facilitate effective community-based mental health programmes.

Treated mental illness impacts positively on the economy in the long run. Despite this, the cost of mental health treatment remains under-funded with fewer resources allocated to mental health compared to other medical conditions.

Provincial government department funding for mental health programmes remain inadequate and mental health non-profit organisation (NPO) services are under-financed despite providing cost-effective services compared to those delivered by State facilities. An increase in provincial health funding could expand comprehensive community-based mental health care.

Mental health professionals have significantly higher job-related stress compared to other health professionals due to contributing factors such as significantly higher workloads than other health professionals and a shortage of mental health professionals. Social workers at mental health NPOs have significantly higher caseloads than social workers employed in the State sector while the demand for mental health social work services has increased. Constrained community-based mental health services are a result of this lack of funding as well as the incidences of violence in communities. Mental health professionals often feel unsupported and are seldom given recognition for working under difficult conditions.

Adequate salaries need to be provided to increase job satisfaction of mental health professionals, whilst special allowances should be offered to attract more health professionals to rural areas.

There are insufficient multi-disciplinary mental health specialist teams (Assertive Community Teams – ACTS) operating in provinces, with limited collaboration with traditional healers and faith healers when treating patients with mental illnesses across the nine provinces.

The deployment of non-specialists such as mental health volunteers, peer counsellors and health workers at NHI sites train all nurses, doctors, social workers and occupational

therapists in mental health at PHC facilities; collaboration with traditional healers and faith healers would contribute to further human resource strengthening measures.

The implementation of 24-hour “on call” psychiatric services to increase accessible mental health information to non-mental health specialists would contribute to strengthening mental health resources.

Increased partnerships with the mental health NPOs in South Africa would further strengthen community-based interventions.

Objective 4: To determine mental health professionals and service-users’ perceptions about the present bio-medical approach and feasibility of an integrated community-based model.

In contrast to focusing on the medical model that is still the dominant approach to care, the social model approach to diagnosis and treatment offers additional complementary interventions to improve mental health care. Strengthening mental health services requires the devolvement of mental health care that should be offered mostly at PHC and within communities to increase access to treatment. A social model approach would facilitate a range of comprehensive mental health treatment options at PHC. These interventions should have an income-generating component that includes poverty alleviation programmes to significantly improve treatment outcomes.

Patient-centred care, which focuses on resilience and recovery models, would significantly improve treatment options, whilst self-advocacy is central to treatment.

The medical interventions at PHC level should include access to medication with the least side-effects.

Mental health facilities require regular upgrades with sufficient available beds to accommodate mental health emergencies and opportunities for service users to be sufficiently

stabilised to prevent premature discharges and the “revolving-door” phenomenon. Adequate community-based interventions play a significant role in reducing pressure on beds.

Additional non-specialist health workers should be employed to provide basic mental health in communities. An additional cadre of human resources such as mental health volunteers, peer counsellors and traditional healers or faith healers could assist to improve community-based mental care.

Increased referrals to mental health NPOs would improve and maximise community-based support and counselling to service users, while multi-disciplinary district mental health specialist teams should be deployed to cover all districts in provinces.

Objective 5: To explore mental health professionals and service-users’ perceptions about the lack or unavailability of mental health services and its impact on the human rights and dignity of persons living with mental illness.

Despite the progressive Constitution of the Republic of South Africa, No.108 of 1996 and Bill of Rights, RSA Mental Health Care Act, No. 17 of 2002, and the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013), people with mental illness experience significant discrimination and multiple levels of abuse in our country. People with mental illness are more vulnerable to abuse by society than those without mental illness. There is a significant relationship between vulnerability and discrimination.

Human rights violations are frequently experienced by people with mental illness. People with mental illness are also more likely to be abused by health professionals.

The lack of access to medication and poor infrastructure, such as run-down buildings at psychiatric facilities, violate the rights of patients to proper care.

There appears to be inadequate human rights protection measures for people with mental illness. The South African Police Services (SAPS) does not regularly react to complaints of human rights abuses against mental health service users and therefore fails to uphold their

human rights. Furthermore, mental health service users do not enjoy full access to justice, leaving them further exposed and vulnerable to abuse.

Mental health human rights structures should be established to monitor human rights violations and ensure that protective measures are accommodated in all provinces.

Objective 6: To explore the perceptions of mental health professionals and service-users about the critical partnerships (carers, traditional healers, community leaders, etc.,) needed to implement a sustainable multi-sectoral integrated community-based mental health programme.

Multi-sectoral district-based mental health forums should be established to co-ordinate mental health services and should include all role players in service delivery, particularly mental health service users and all other non-specialist mental health human resources.

Mental health NPOs contribute significantly to community-based mental health programmes and should therefore be considered as an important partner. They actively promote patient-centred care interventions using strengths-based approaches and provide significant support to service users and their families. The NPOs play a crucial role in lobbying and advocating for the rights of persons with mental disability while also promoting self-advocacy. They regard service users as significant role-players in the governance structures of their organisation and as peer counsellors.

5.4. Key Emergent Issues and Recommendations

5.4.1. National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013)

Despite the comprehensive provincial consultative process engaged in with civil society organisations, mental health professionals and service users, knowledge about the eight catalytic areas for implementation against set targets are limited.

This policy is an instrument aimed at facilitating transformation in mental health. The success of this policy cannot be measured unless mental health professionals and service users actively engage and monitor the implementation. It is recommended that this policy be used as a powerful tool to lobby and advocate for improved funding, collaboration and deployment of non-specialist mental health human resources to decrease the numbers of individuals who currently have no access to mental health. Formal institutional structures and capacity have been established through the Mental Health Ministerial Advisory Committee to ensure that a co-ordinated and less hospi-centric approach to mental health is devolved to communities. Widespread dissemination of this National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) should be a priority. The document could be shortened and crystallised into succinct passages that encourage a wider readership among professionals as well as service users and lay persons. Social media platforms could be used to a greater extent to get this message across and NPOs could lead the way in this regard.

5.4.2. Major Barriers Preventing the Effective Expansion of Community-based Mental Health Services

This study confirms and highlights that mental illness as well as people living with mental illness are still being stigmatised, and the dismissive attitudes by health professionals and others towards mental health service users' impact negatively on treatment outcomes. This once again reinforces the need for awareness programmes, innovative use of social media, radio, and TV programmes, as well as easy-to-read leaflets/brochures that could address this ignorance.

Government tenders for community mental health counsellors could partially address the pressure on hospital-based treatment programmes. NPOs could facilitate training programmes for community mental health counsellors. Whilst stock-outs persist with regards to psychiatric medication, service users need to lobby government like the Treatment Action

Campaign (TAC) did in the early years of South Africa's democracy. The voice of an articulate service user needs to be heard so that those most vulnerable are not left without their much-needed psychiatric medication.

Mental Health activists (professionals, non-specialists, lay persons, and service users) should establish a lobbying and advocacy groups that could take matters to the Constitutional court if needs be regarding the rights of the mentally ill. Pressure should be put on government departments to upgrade mental health facilities both at hospital and community levels.

The barriers identified reveal a dire situation that requires an intervention catalyst to unhinge this impasse. Comprehensive mental health treatment options need urgent consideration and the model identified in the study and discussed in the next chapter provides a creative solution to fast-track and increase access to mental health services using indigenous and local community solutions to mental health.

5.4.3. Financial and Human Resources – Alternative Measures Required to Facilitate Community-based Mental Health

The study confirms that mental health remains under-funded and under-resourced.

Funding provided by provincial government departments for mental health programmes remain inadequate and alternative funding sources are needed. The State has to increase its funding. Figure 28 (p. 121) and Figure 29 (p. 122) reflect a significant decreased in funding to mental health).

Innovative strategies are called for and NPOs should find ways for further cost-effective treatment options that are community-based. Retaining committed mental health staff should also be prioritised and monetary as well as non-monetary incentives could be considered.

The collaboration with non-specialists such as mental health volunteers, peer counsellors, health workers at NHI sites, traditional healers, faith healers, and church groups working in

the field of mental health could be part of a mental health network that could provide additional community-based resources.

There is also a dire need for improved partnerships with the mental health NPOs in South Africa as this would further strengthen community-based interventions. Fragmentation in mental health services could thus be limited by multi-sectoral collaborations and formal structures.

5.4.4. Bio-medical Approach and Feasibility of an Integrated Community-based Model.

The social model approach to diagnosis and treatment in conjunction with aspects of the medical model would undoubtedly improve mental health. This requires the devolvement of mental health care to PHC based within communities, thereby increasing access to treatment. A community-based model would allow for a range of comprehensive mental health treatment options that could be provided through PHC. Such community interventions should have an income-generating component that includes poverty alleviation programmes to significantly improve treatment outcomes.

Patient-centred care should be central in the models of intervention since it would significantly improve treatment outcomes and empower service users to play a direct role in decisions about their treatment. The medical interventions should include access to medication with the least side-effects while psychiatric facilities need to be regularly upgraded with sufficient beds being available.

5.4.5. Human Rights and Dignity of Persons with Mental Illness

Despite the progressive Constitution of the Republic of South Africa, No.108 of 1996 and Bill of Rights, RSA Mental Health Care Act, No. 17 of 2002 and National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013), people with mental illness are

vulnerable and experience significant discrimination and multiple levels of abuse in our country.

There appears to be inadequate human rights protection measures for people with mental illness despite current structures established to monitor human rights violations and ensure that protective measures are put in place in all provinces. This highlights a need to review and establish human rights protection instruments, measures and structures with the necessary judicial powers to intervene when violations are perpetrated. Maybe the time is right for the establishment of a Mental Health Ombudsman.

5.4.6. Critical Partnerships Required to Implement Sustainable Multi-sectoral Integrated Community-based Mental Health

Neither State departments nor mental health civil society organisations are able to provide comprehensive mental health services as independent entities. Multi-sectoral district-based mental health approaches are required to co-ordinate and include all role players, particularly mental health service users, in mental health service delivery. This would bring together both medical as well as social approaches to care, thus supporting integrated comprehensive community-based models that underpin recovery in mental health.

Mental Health NPOs contribute significantly to community-based mental health programmes and contribute a wealth of innovative interventions that promote patient-centred care and strengths-based approaches. Mental health NPOs have a historical record of providing community-based services and have always worked closely with service users, families and communities. They have played a pivotal role supporting self-advocacy initiative and have lobbied for better funding and services over many years. Thus these NPOs can provide the leadership in promoting integrated comprehensive interventions that are cognisant of service users' dignity and autonomy.

5.5. Further Research

This study investigated the mental health deficits and highlighted the dire need to expand and improve mental health care in South Africa based on the perceptions of mental health professionals and service users. The design of an effective and integrated community-based intervention model to reach the vulnerable majority of those living with the most debilitating effects of mental illness was based on these perceptions and on a literature review of best practice models operating in lower and middle-income settings. Further scholarly studies are proposed in the following areas:

- To assess and measure whether the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) has been successfully implemented to increase access to mental health services by 2020.
- To assess the efficacy and a cost-benefit analysis of implementing a comprehensive integrated model.
- To carry out empirical studies to cost mental health care in South Africa with the view to recommending more appropriate funding, ring-fenced within the health budget, to expand community-based mental health interventions.
- To research the role of mental health service users in peer interventions and the training and support required.
- To investigate challenges faced by mental health professionals and examine innovative retention strategies.
- To facilitate an impact analysis of multi-sectoral district-based mental health forums to co-ordinate and reduce fragmentation in mental health services
- To research pragmatic and cost-effective human rights protective measures, instruments and structures to prevent ongoing violations and human rights abuses against people with mental illness.

Finally the major recommendation emanating from this research pertains to the exploration of a comprehensive, integrated community-based mental health service model that will be presented in the penultimate chapter of this thesis.

**CHAPTER SIX: A PROPOSED MODEL FOR COMPREHENSIVE AND
INTEGRATED COMMUNITY-BASED MENTAL HEALTH SERVICES
IN SOUTH AFRICA**

6.1 Introduction

This proposed intervention model promotes the strengthening of patient-centred recovery models of intervention, which is firmly grounded in the empowerment, resilience and social model approaches, for closing the mental health treatment gap in South Africa. Thus it is designed to facilitate comprehensive, integrated community-based care and has been based on intervention models in low-and middle-income countries (LMICs) such as Zimbabwe, Uganda, Brazil and India gleaned from the literature review. Best practice interventions by mental health non-profit organisations (NPOs) as well as some South African Department of Health initiatives have also been considered. The perspectives of mental health professionals, mental health service users as well as key informants and the literature have informed and contributed to this discussion of a new model of intervention.

The proposed model draws on some community strengthening approaches gleaned from LMICs that have tried to work with low budgets and lack of human resources to meet the rising mental health needs and thus could be adapted to the South African situation.

This model integrates bio-medical and psycho-social interventions with innovations to expand community-based mental health initiatives. The latter relies heavily on local and traditional resources, non-government organisations, non-specialist human resources and mental health service users. The findings of this study revealed that the majority of mental health professionals as depicted in Figure 38 (p. 143) agreed that mental health services should be offered mostly at a primary health care (PHC) level. They confirmed that a social model approach to diagnosis and treatment would improve mental health, while patient-centred care would significantly improve treatment outcomes. The results support the need

for the inclusion and integration of a range of mental health treatment options that should be delivered within communities where mental health service users live.

The proposed model would include a synchronisation of various mental health service providers operating at different levels and yet providing a variety of treatment options that are easily accessible, community-based and cost-effective. Thus the **Village Mental Health Care** approach (community care facility) in conjunction with **Mental Health Care NPOs** as well as **State-run hospital-based facilities** could provide comprehensive care; **traditional and spiritual healers** would also have a role to play, whilst the **Assertive Community Teams (ACT)** and **District Health Specialist Teams** could provide accessible mental health care in crisis situations. **Community Mental Health Education and Family Support Groups** would benefit service users in that greater awareness of mental health issues could diminish the stigma and misunderstandings attached to mental illness and caring of family members of service users is essential since they share the burden of the illness most profoundly. **Community-based Psychosocial Rehabilitation (PSR); Service User Self-advocacy initiatives** and **Peer Counselling-Non-clinical Interventions** are all aimed at empowering the person with the mental illness. The person-centredness of these interventions is crucial for positive treatment outcomes. The following sections will provide some insights into these various “components” of an integrated model.

6.2. Village Mental Health Centres – Community Mental Health Centres

Two of the best practice mental health models can be found in India and Uganda. The one model is located in south-western India in the State of Kerala’s Thiruvananthapuram District and the other is found in the Mbarara District, a south-western area about 260 kilometres from the capital city Kampala in Uganda. According to Byaruhanga, Cantor-Graae, Maling, and Kabakyenga (2008), the distances from the Mbarara regional hospital to other districts were far with patients having to walk long distances to receive mental health services. They

added that in some areas the infra-structure and public transport was poor and costly. Patients suffering acute psychotic breakdown and who needed immediate treatment were thus disadvantaged. An onsite, easy-to-reach outreach programme was therefore deemed critical.

The Ugandan model developed consisted of various village-based health care centres. The Mental Health Care Centre 1 was able to provide care to approximately a thousand villagers and this model included elected Village Health Committees that provided mental health prevention and promotion services. These Health Care Centres had no professionally trained staff while the Village Health Committees had basic training on general health issues. The Health Care Centre 2 was run by a parish and employed trained nurses. These nurses also provided prevention and curative health care services. Health Care Centres 4 and 5 provided specialist health services with trained staff in the sub-counties.

The Ugandan model offers an additional benefit to people in remote areas where the primary health care clinic is distant and far. In the South African context, focus group participants confirmed the need for such village/community-based mental health centres:

If there can be programmes for persons with mental illnesses, maybe a centre for people to go there and get assistance during the day and getting support for all the mental services (*Limpopo, Service-user, DM, April 2016*).

We have a plan for our area, there is a building but it is not yet complete. They want to go there during the day and get assistance and then go back home (*Limpopo, Service-user, JM, April 2016*)

So in the support centre, there must be food provided so that they can eat (*Limpopo, Service-user, BM, April 2016*).

The support centre must assist us with self-esteem. It must be lively and support us as normal people with special needs (*Limpopo, Service-user, DM, April 2016*).

We need the support centres. Some of the projects that we already have are income generating (*Limpopo, Service-user, JM, April 2016*).

In the proposed South African model, the Village or Community Mental Health Care Centre activities could be managed by the Village/Community Health Committee who should

receive mental health training and be adequately subsidised by either local municipalities or provincial government.

Byaruhanga et al. (2008) identified the importance of community mental health volunteers in these villages in Uganda. They added that these community volunteers or village health workers were selected by the community members in the village and received basic mental health training and their role included the following:

Identification and referral of patients for treatment; home visits (follow up of patients, assessment of home situation and treatment compliance); provision of basic information to the community concerning the care of mental health patients in the community; encouragement of community social support especially to patients and families; help in the resettlement of patients and their engagement in productive activities; and liaison work between the community and health unit. (p. 124)

The Zimbabwean Friendship Bench Project, a mental health innovation provided by lay “grandmother counsellors” also known as “*gogos*” have provided mental health problem-solving interventions on village or park benches outside primary health care (PHC) clinics to over 27 000 individuals with common mental disorders. These are offered mostly to individuals who would ordinarily not seek assistance. This low-cost intervention has been highly successful. Chibanda, Helen, Weiss, Verhey, Simms, Munjoma, Rusakaniko, Chingono, Munetsi, Bere, Manda, Abas, and Araya (2016) stated that “Patients with depression or anxiety who received problem-solving therapy through the Friendship Bench were more than three times less likely to have symptoms of depression after six months, compared to patients who received standard care ” (p. 2618).

The majority of the mental health professionals in this study strongly agreed that community mental health volunteers should be recruited in all districts to actively identify and motivate individuals to seek treatment. This non-specialist volunteer role is critical in urban, peri-urban and rural communities, and mental health professionals agreed that these

volunteers could assist with early detection and intervention that leads to better prognosis and treatment outcomes.

In the Ugandan model each parish has at least one volunteer who has basic mental health literacy. Even though they are not paid, they are provided with a bicycle and a lunch allowance as an incentive to be able to visit patients in the village.

Focus group participants agreed that volunteers needed some incentives since they were mostly from poverty-stricken South African settlements:

Volunteers – most of them are come from the informal settlements and they don't even have food or money. So they will need money... *(EC, Service-user, PD, March 2016)*

I agree that volunteers should be given a stipend for their dedication for spending time in educating others in mental health *(EC, Service-user, RS, March 2016)*

Community mental health volunteers could also be selected by non-profit mental health organisations from rural and urban areas. This would assist with early identification and speedy referrals by using Psychological and Mental Health First Aid tools.

An additional support to communities would be the employment of village/community health workers (non-specialists) employed by the Department of Health (DOH) within National Health Insurance (NHI) pilot site programmes or attached to non-profit organisation (NPO) programmes. The village/community health worker would be linked to primary health care facilities. The latter category of non-specialist human resource strengthening was also strongly supported in the research findings in which a significant number of mental health professionals supported the need to recruit non-specialist health workers to provide basic mental health care in communities (Chapter 4, Section 4.3.4.4., pp. 148–151).

The village/community health workers would have to receive basic mental health training that includes being able to identify a mental illness, make a rudimentary diagnosis, provide home-based and follow-up care, provide basic psycho-education, and link service users to community volunteers, non-profit organisations and primary health care facilities.

Even though the National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) refers to this cadre of health professionals, little progress has been made to integrate mental health into the role and function of community health workers currently employed within the NHI pilot sites. Their primary focus has been largely on the other chronic diseases.

A participant (service user) in the focus group made some critical observations:

The community health care workers are actually in the national mental health plan and I asked the question why it has not happened – mental health actually missed that boat HIV/AIDs and other groups they got in. It is also spoken about there. The use of ITC – the world is changing and more and more people are getting smart phones and you can get an App [that] can connect the community workers with the rest of the team and that is an important aspect and that App which could also give you data and that data – it won't happen overnight (EC, Service-user, RS, March 2016).

The village/community mental health workers (non-specialists) could have the following responsibilities:

- Home-based monitoring and assessment of the service user;
- Medication adherence monitoring and medication delivery;
- Psycho-education;
- Link and liaise with community mental health volunteers;
- Liaise with mental health non-profit organisations;
- Liaise with peer counsellors;
- Report to and be supervised by PHC.

6.3. Mental Health Non-profit Organisations

Mental Health NPOs play a vital and significant role in the expansion and delivery of community-based mental health interventions. The service delivery objectives of these organisations include the ideal of comprehensive community-based mental health services (see Table 6, p. 172) but a lack of funding constrains their interventions. These NPOs tend to focus mainly on counselling, mental health awareness and promotion, and running protective workshops. Additional Mental Health NPO initiatives should include:

- Co-ordinating community mental health volunteers and “grandmother” counsellors;

- Selecting, training and supervising peer counsellors;
- Implementing PSR groups in districts/communities;
- Collaborating with non-specialist health workers, traditional structures, village committees and PHC clinics;
- Training other NPOs working in resource-poor communities to provide counselling and other psycho-social interventions with back-up tele-mental health social work and or Skype support to these NPOs;
- Strengthening advocacy groups and empowerment networks;
- Providing public education and awareness campaigns in partnership with service user advocacy bodies – these could be initiated through school awareness programmes, embedding mental health in the Life Orientation Curriculum, Mental Health Apps, radio, talking books, mobile clinics and other awareness strategies;
- Offering MindMatters Programmes –comprehensive whole-school mental health intervention and prevention programmes;
- Engaging in lobbying and advocacy for the rights of service users;
- Collaborating with other State or NPOs to ensure holistic service provision;
- Improving collaboration with the SAPS and justice system;
- Initiating collaborative poverty alleviation and food sustainability projects with partners such as Abalimi, SEED, AgriSETA;
- Facilitating employment opportunities through self-employment initiatives, supported employment, Learnerships, transitional employment and independent initiatives;
- Participating in district and provincial multi-sectoral mental health structures to co-ordinate mental health services.

The aforementioned would result in a dynamic, rich and inclusive intervention expansion model for resource-poor settings. Kumar (2011) noted that in India most of the community-based mental health interventions are delivered by the NPO sector.

The majority of the mental health professionals in this study (Figure 41, p. 149) noted that improved partnerships with mental health NPOs would strengthen community-based initiatives.

6.4. Traditional Healers and Spiritual Healers

In South Africa traditional healers are still the first port of call for many who espouse tribal customs (Ensink & Robertson, 1999). Comprehensive interventions would be limited if traditional interventions are ignored. It is important that Western interventions accommodate these traditional practices as it would be in the best interests of mental health service users who believe in traditional healers. Concomitant use of psychotropic medication and herbal remedies could be better managed, reducing the harmful risk to the service user.

The majority of mental health professionals in this research identified the critical role played by the traditional healers and supported collaboration to strengthen mental health resource capacity (See Figure 41, p. 149). Kumar (2011, p. 759) indicated that most people living in rural communities in India would consult their traditional healer. Thus it would be advantageous to train these healers in mental health literacy and symptoms to ensure that more people have access to appropriate mental health care in these communities.

Both Western and traditional methods of intervention need to be integrated and considered to enable holistic care. Traditional healers and spiritual healers are often the first to be contacted when people experience a mental health crisis, and they have a critical role to play in a successful recovery.

6.5. Assertive Community Teams (ACTs)

The deinstitutionalisation of mental health care users has resulted in a decrease in available beds for acute admissions. Thus, due to a lack of beds, patients are prematurely discharged, resulting in the “revolving door” phenomenon. The establishment of Assertive Community Teams (ACTs) has proved invaluable in such a context.

The majority of mental health professionals indicated that there were insufficient ACTs operating at district levels in South Africa (Section 4.3.3.2.6., Figure 36, p. 137) and they recommended that the number of ACTs should be increased (Section 4.3.3.2.7., Figure 37, p. 139). ACTs have had much success in managing mental health service users who are chronically ill, often non-adherent to medication, and presenting with high relapse and readmission status.

ACTs operate under the auspices of the Tertiary Specialist Services and need to work more collaboratively with the community mental health structures and organisations. ACTs play a critical role in patient management and improved functioning. This intervention has proven to be successful in many LMICs, for example Brazil and in the Western Cape Province, South Africa. Burns and Firn (2002) identified the key elements of the Assertive Community Teams (ACT) model, which is a core service team that provides clinical care according to the following *modus operandi*:

- The primary goal is improvement in patients’ functioning.
- The patient is assisted directly in symptom management.
- The ratio of staff-to- patient should be small (no greater than 10–15:1).
- Each patient is assigned a key worker responsible for comprehensive care.
- Treatment is individualised between patients and over time.
- Patients are engaged and followed up over time.
- Treatment is provided in community settings.
- Care is continuous over time and across functional areas.

Botha et al. (2014) stated the following:

Assertive interventions can successfully be modified in under-resourced settings and sustain reductions in inpatient usage over time, while still remaining affordable and feasible within the context of a developing country. Such interventions need not be exclusive and limited to a small number of patients but can be successfully incorporated into existing services and tailored according to the needs of the community and resources available (p. 8).

There have been good mental health outcomes for patients receiving this individualised service, resulting in a significant reduction in relapse and rehospitalisation. However, these patients are seldom linked to peer supporters, mental health NPOs or psycho-social programmes. These should ideally be an extension of the intervention provided by the ACTs to ensure full integration in communities and families, and to maximise the recovery outcomes. In other LMIC models, the role of the ACTs is extended to include visits to health clinics due to limited mental health expertise and the vast distances that people have to travel to access specialised mental health care at regional or tertiary hospitals.

6.6. District Health Specialist Teams

District Health Specialist Teams could fulfil the function of providing additional support to PHCs where there is no mental health expertise. Their role could include training of non-specialist health professionals or assessing patients with more complex or serious mental disorders. They could provide clinical and consultation sessions in the district where required. They could also develop treatment protocols and assist with monitoring of care. They should ideally participate in the inter-sectoral mental health task team. The National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) (2013, p. 31) stipulates that “at least one specialist mental health team would be available in every district” to support PHC staff. Even though the target date for commencement of the latter was 2013/2014, to date these teams are limited or non-existent.

A best practice model in Sobral City, Brazil, has successfully integrated mental health care into PHC as a result of Mental Health Specialist Teams who visit PHC clinics at least once a month (WHO, 2008). The Mental Health Specialist Teams are responsible not only for providing quality mental health interventions, but also for the training and supervision of PHC staff. More complex mental disorders are seen by these teams. They have found that this model of care reduces the burnout experienced by the Family Health Teams at these clinics, while the collaborative intervention between the PHC and Family Health Teams reduced the burden of care carried by these professionals. Sobral City won three national awards for implementing this model that has successfully integrated mental health into PHC. A similar model was implemented in the Macaé and Petrópolis in Brazil and the following was found:

In Macaé, the number of hospitalisations dropped to one third of previous levels. In Petrópolis, hospitalisations were reduced by 45% and emergency cases were reduced by 33%. After three years, at least 50% of patients using psychotropic medication and psychotherapeutic support were being treated by the Family Health Team (WHO, 2008, p. 93).

6.7. Community Mental Health Education

Focus group participants in this study highlighted the need for community mental health education as well as introducing the nature of mental illness into the school curriculum:

I think the community at large they really don't know and need to be educated and like he says mental illness is psycho-social. They know nothing and I do think that it is important for people to know about this. If it was me they would be educated, if people were educated at the same age you understand it can be introduced in every curriculum of schools so that when kids as they are growing up will be aware that there is such a sickness and that anybody can get it. People need more information about mental disability (*Eastern Cape, PD, March 2016*).

There is a lot of things – other people say it is witchcraft – other people say you have demons. You see, people lack of knowledge. The government needs to educate more in the townships, you see (*Eastern Cape, A.C., March 2016*).

Focus group participants suggested ways to increase community education:

Teachers who are qualified to teach in education that don't have jobs should be put into the jobs in the community and provide some education (*KZN, FH, April 2016*).

The focus group participants recommended ways in which this could be done:

There needs to be posters put up that comes from the Department of Health informing people about mental health. I am the kind of person that will read those things. If you put up posters like those which comes from the Department of Health – people will read it. They will also get information about their families who has got it [mental illness]. Now they would know what to look for and what to find and what causes these problems. It might come from their forefathers – it might run in the family. It is something you can't wash away or wish away (*Eastern Cape, CMS, March 2016*).

People should be informed using radio and TV about mental illness (*Western Cape, YW, March 2016*).

They should use YouTube to inform people of schizophrenia. I have used YouTube and found that there are many doctors talking about schizophrenia (*Western Cape, MC, March 2016*).

We need to read more about it [mental illness]. Go to someone and find out about it. The same like, have a campaign about it. *People need to learn before they judge* (*Northern Cape, GH, April 2016*).

The majority of mental health professionals in this study (Figure 42, p. 152) supported the need to increase prevention and awareness campaigns. The lack of mental health knowledge increases stigma and discrimination and often leads to isolation and self-stigma. Targeted mental health education needs to be delivered at multiple levels using a number of creative approaches. Most of the mental health awareness and anti-stigma campaigns are currently implemented by mental health non-profit organisations.

6.8. Family Support Groups

With the advent of deinstitutionalisation and decentralised community-based mental health, more services users with mental illness live at home with their families or “foster” families who become their primary care givers. The onset of mental illness brings with it anxiety,

confusion and uncertainty about future expectations that parents and family members may have about mental illness.

The family's lack of knowledge inhibits appropriate care and understanding, and often they require support to cope with the illness and the management thereof. Parents often self-blame and in traditional communities they may feel that they have been bewitched or cursed.

Focus group participants in this study added the following:

There are definitely families who want to be supported. Yes. There are families who would like to support their sisters and brothers and would really want to know the right way of doing it. My brothers and sisters are very supportive, but sometimes they don't really know what I need. Sometimes I want to say guys this is not what I need, so with family support groups they would be there to support me (*Western Cape, AF, March 2016*).

And another thing, our parents and families need to be educated about this illness because my parents did not see my sickness; they just treated me as a normal person. They did not understand so there were always fights and fights. So our parents need to be educated and informed about this illness (*Western Cape, AC, March 2016*).

Avasthi (2010) stated that “families need information, support, knowledge and specific suggestions for coping with mentally ill relatives. Caregivers must be encouraged to join such groups so that they can seek mutual help, learn from the experience of others, can share their problems, etc.” (p. 113–126). Thus families can often feel isolated and helpless when dealing with their mentally ill offspring and support groups can be help to debunk some myths.

Ponnuchamy, L., Baijumon, K.M., Mathew, S., Udayakumar, G. S., Kalyanasundaram, S., & Ramprasad. D. (2005) stated that “Analysis of the data revealed that members attending the support group meetings expected to get more information about the illness, develop skills to cope with problems at home and learn skills to deal with the ill person. An important finding of the study was that the members developed a ‘feeling of togetherness’ as a result of being a member of a group with common aims” (p. 160).

6.9. Community-based Psycho-social Rehabilitation (PSR)

Participants in the focus groups affirmed the need for more community-based psycho-social rehabilitation groups:

More Rainbow Groups - Community-based PSR support groups are required (*Western Cape, LN, March 2016*).

Then we should have a group coming around every month or every second week to talk to us, to hear our opinions and to speak about the conditions or ask us questions and we can give answers. Even our hospitals should have groups (*KZN, FH, April 2016*).

Every Tuesday we are having a session that gives you support – a support group and I think that type of support is why we're surviving. I encourage more people to come there because we are talking about things that are affecting us. It is run by a social worker (*KZN, MM, April 2016*).

We reach out to people because often people are alone with their pain and feelings and we should reach out more often (*Northern Cape, JVZ, April 2016*).

Wang, Zhou, Yu, Qiu, & Wang (2013) study on PSR training on the treatment of schizophrenia found that those patients who received medication as well as the PSR training did much better than those who received only the medication. The PSR participants had better social functioning and had longer relapse intervals.

“Evidence is mounting that comprehensive approaches which include pharmacological as well psycho-social interventions, impacts positively on symptom reduction but also on the improvement of social skills, occupational status and general quality of life” (Lieberman, 1987, p. 12)

Psycho-social support groups are person-centred and framed within the recovery model in which peers are able to provide meaningful support. A focus group participant made the following observation:

I could also be there for people. I may not be able to give them advice but I can assist (*Western Cape, AF, March 2016*).

Currently the Western Cape is the only province in which 26 community-based psycho-social rehabilitation support groups operate and another one in the North West Province as

part of the PRIME study. Fountain House – a club house for service users that facilitates PSR interventions – is the only one in South Africa operating under the auspices of Cape Mental Health.

6.10. Peer Counselling-Non-clinical Intervention

This model promotes a formal structure for the selection and recruitment of peer counsellors. The findings of this study suggest that the majority of mental health professionals supported peer counselling programmes to strengthen human resource capacity.

Mental Health Peer Counsellors are service users who provide a non-clinical intervention based on their experiences of the mental health care system. Austin, Ramakrishnan, and Hopper (2014, p. 883) stated the following:

Peer advocates represent a variety of mental health histories and diagnoses, but share a general (although not always linear) trajectory of disruptive crisis, diagnosis of illness, stabilization, empowerment and recovery. Through engaging in the mental health system as peers, they consciously evaluate and reevaluate their experience as they interact with the system in a new way. This process of conscious evaluation that melds their service-user insight with their service-provider capital gives peers a more reflexive stance, in that they gain greater awareness of the impact of their lived experiences on their recovery. Peers then bring this unique perspective that we term reflexivity to their work with clients.

This is seen as an adjunct to the bio-medical model and is not a substitute for professional counselling.

Despite the mental ill-health experiences of peer counsellors, they have to be carefully selected in terms of their own recovery journey. They should be able to self-monitor and have the insight to know when the demands of counselling exceed their own mental health capacity.

Peer counsellors are trained in basic mental health issues and self-monitoring and are expected to provide weekly support. They could be recruited from service-user advocacy forums and receive ongoing training and support from mental health non-profit organisations. They could be identified by community health workers in rural areas. The peer counsellor could also play a role in accompanying service users to their psychiatric check-ups and for their medication. Peer counsellors would require regular supervision and support and should be equipped with the necessary mental health toolkit and WhatsApp capabilities to monitor service users within the network.

This is a cost-effective service that does not require paid staff, but users could receive incentives such as stipends or lunch/transport allowances.

6.11. Service Users' Self-advocacy Initiatives

Self-advocacy structures should be established in each village or community. The disability slogan “Nothing About Us Without Us” is a statement of service users’ right to self – determination that should be respected at all costs (Section 2.4.1., pp. 41– 44, on Human Rights Theory). Mental health service users want to actively engage in and participate in matters that affect their lives. Mental Health advocacy forums empower service users to lobby, advocate and promote their equal participation in mental health initiatives that affect them, and afford them the opportunity to comment on service delivery, policy and legislation, and human rights violations. Self-advocacy groups could be established by peer counsellors whilst the technical, administrative and mental health material support could be provided by the mental health NPO. The local community mental health self-advocacy structure should be part of the provincial structure that could be affiliated to the South African Mental Health Advocacy Movement.

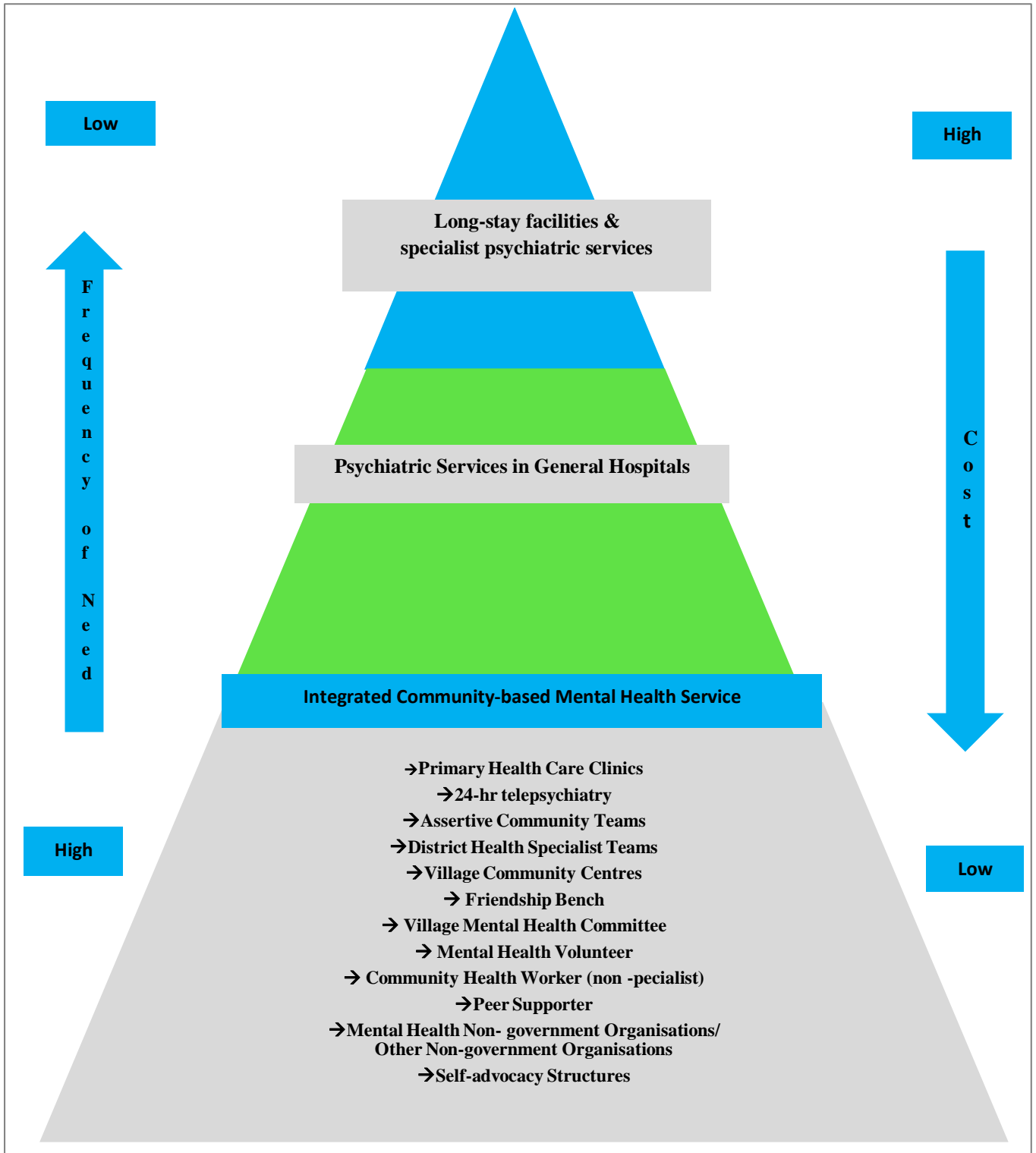
There are approximately six active mental health self-advocacy groups in the country affiliated to the South African Mental Health Advocacy Movement. Basic Needs,

an International Non-Governmental Organisation operating in India, Sri Lanka, PDR Laos, Ghana, Uganda, Tanzania, Kenya and Colombia, implements community mental health programmes that include the full participation of mental health service users. The Basic Needs organisation, as well as the South African Mental Health Advocacy Movement, has trained service users in self-advocacy and provides materials and toolkits to promote the active participation of mental health service users.

6.12. Schematic Presentation of the Model

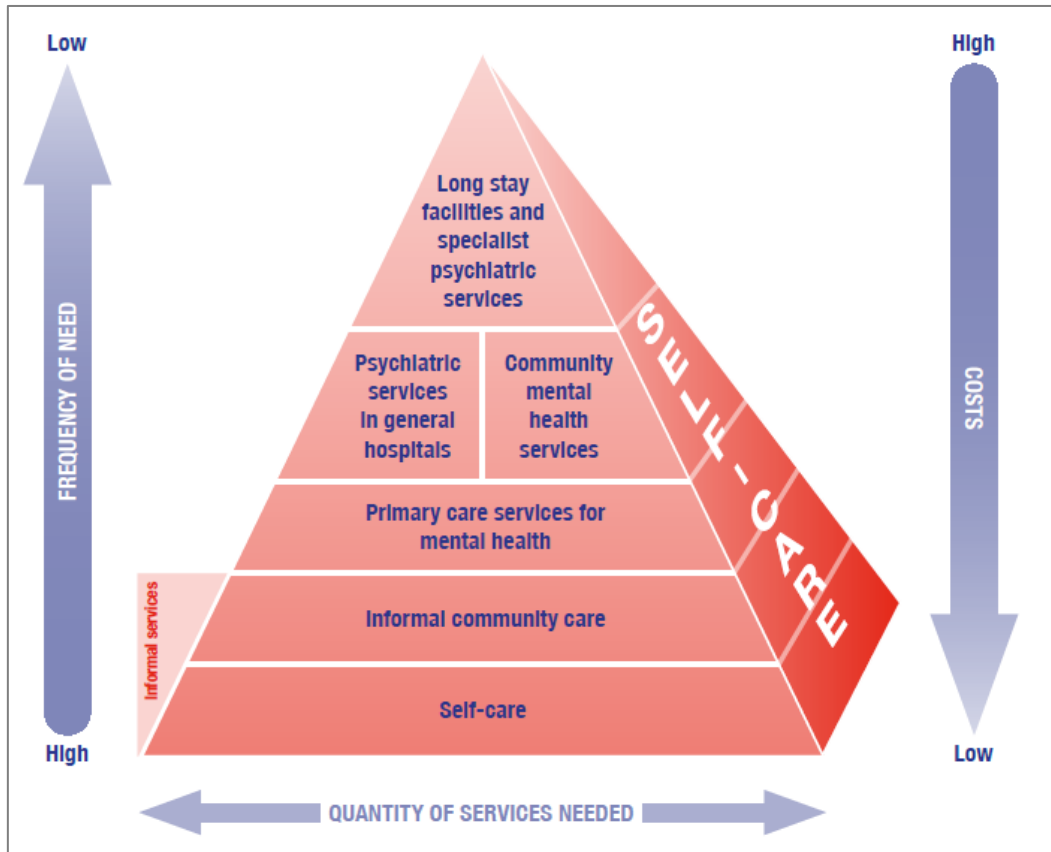
The findings of this study support the need for an expanded, inclusive and integrated community-based patient-centred mental health service that promotes bio-medical as well as psycho-social interventions. Figure 51 (p. 234) illustrates an integrated community-based mental health pyramid of in the proposed model to facilitate increased access to comprehensive mental health interventions, and places the mental health service user at the centre of their recovery journey. The foundation of this model rests on Human Scale Development, Human Rights and Empowerment Theories as represented in Figure 2 (p. 49).

Figure 51: Integrated Community-based Mental Health Pyramid of Care



This model of intervention which is an outcome of this study differs somewhat from the WHO's Model, (Figure 52, p. 236). The **Integrated Community-based Mental Health Pyramid of Care Model** (Figure 51, p. 234) aligns itself with the WHO (2008) model (Figure 52, p. 236) in so far as long-term stay and specialist services would require far less resources due to deinstitutionalisation and the devolution of services to communities. The WHO (2008) model, however, overemphasised reliance on informal community care and self-care. These cannot be implemented in isolation without the necessary support interventions by NPOs, professionals as well as non-specialist mental health workers. The informal community care and self-care can only become a reality for mental health service users if all the necessary pharmacological and psycho-social interventions are accessed in the larger base of the pyramid. The Integrated Community-based Mental Health Pyramid of Care Model (Figure 53, p. 237) therefore proposes a number of integrated, co-ordinated initiatives to maximise self-care and independence towards recovery.

Figure 52: WHO Service Organisation Pyramid for an Optimal Mix of Services for Mental Health.

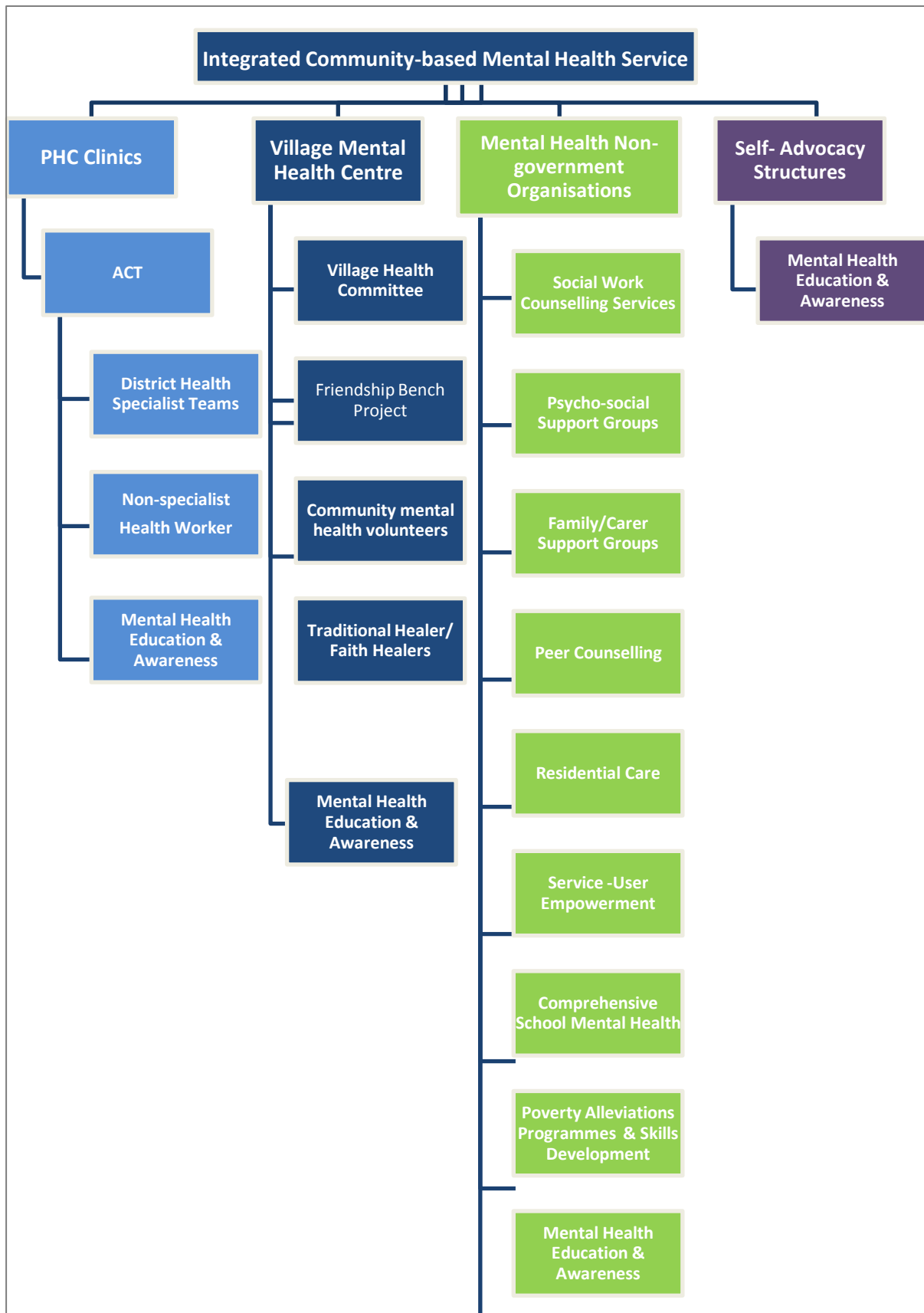


(WHO, 2008:16)

It stands to reason that the frequency of services would be higher at the lower base of such a model and less at the peak while costs would be lower (WHO, 2008:16). Although costs would also be lower in the proposed model (Figure 53, p. 237), there has to be greater initial financial investment with specific ring-fenced health budgets and resource mobilisation to address the interventions at that lower base of that pyramid (See Figure 51, p. 234).

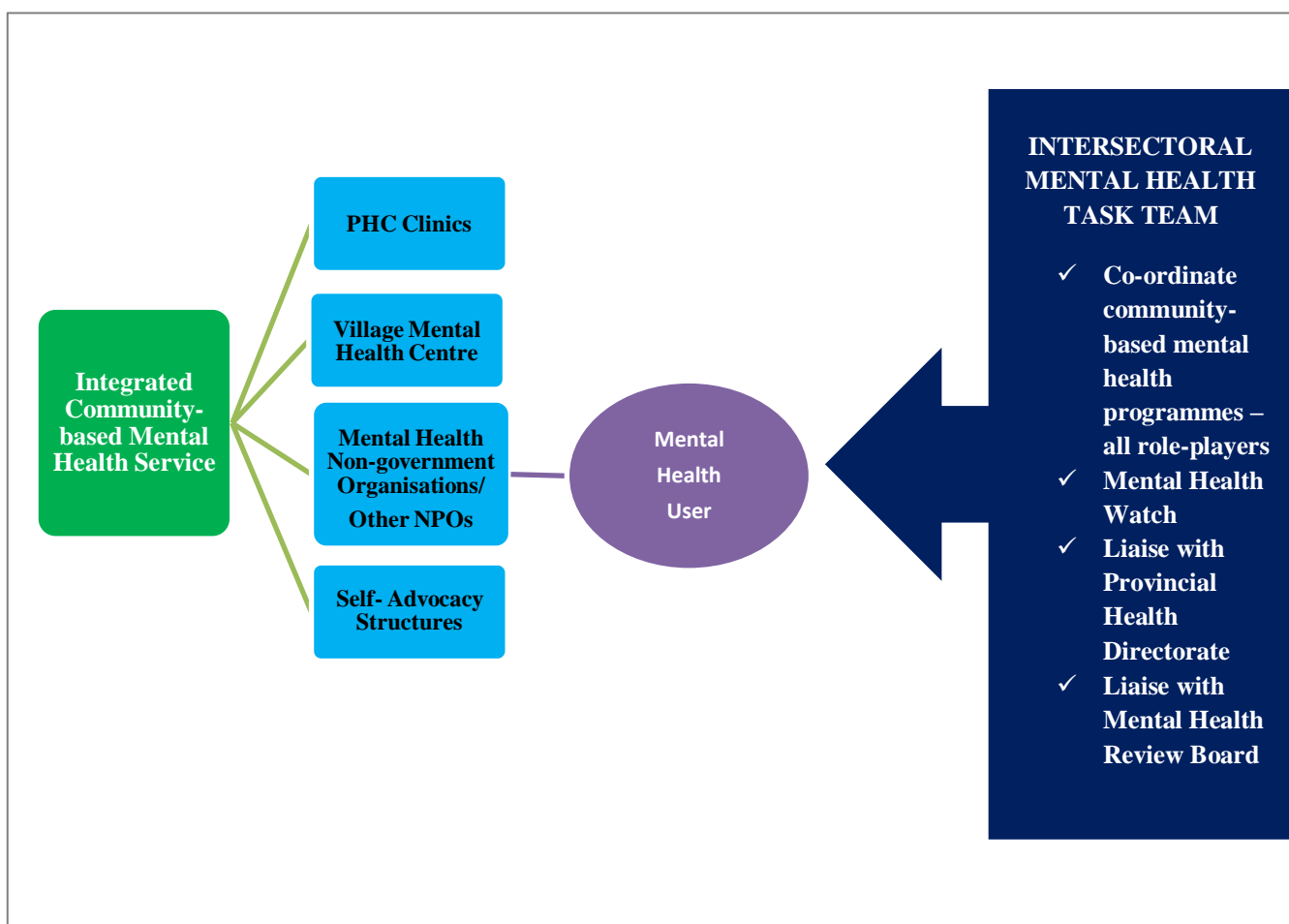
Thus this proposed model depicts the Integrated Community-based Mental Health Service Levels of Service Provision with the accompanying mental health interventions and activities that would be provided at Primary Health Care, village or community health centres, mental health NPOs and self-advocacy structures.

Figure 53: Integrated Community-based Mental Health Service Levels of Service Provision



These mental health interventions would be provided within each community, village or informal settlement and could be co-ordinated by intersectoral mental health tasks teams as depicted in Figure 54.

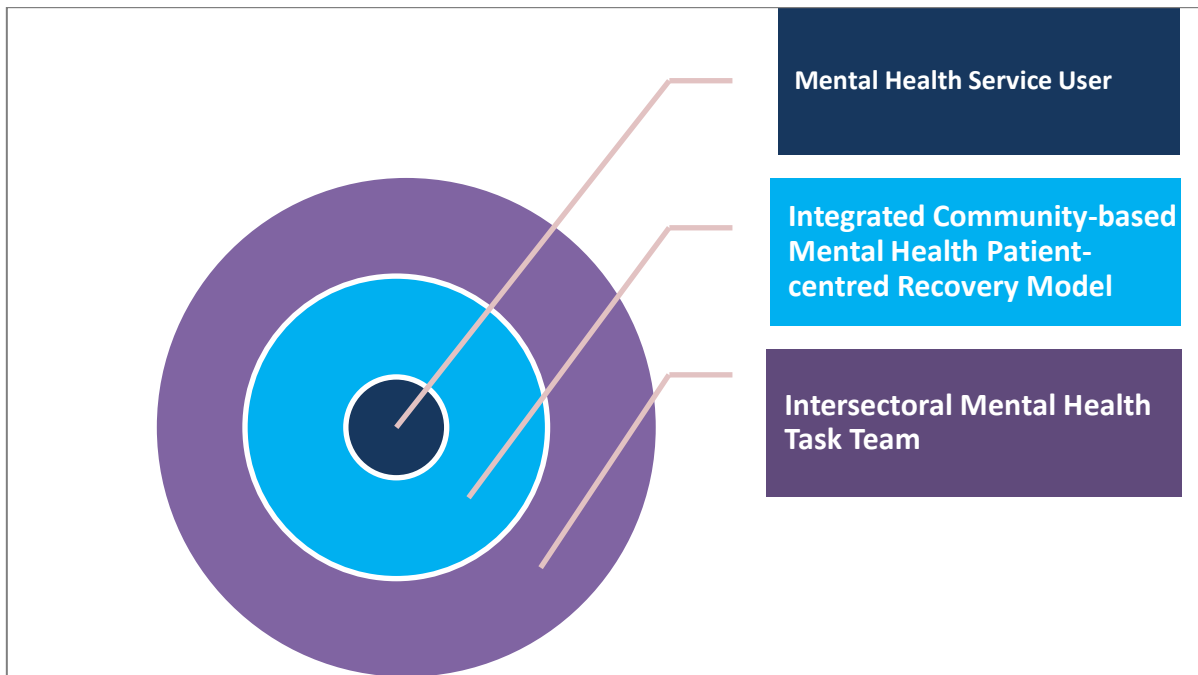
Figure 54: Integrated Community-based Mental Health Service – Intersectoral Collaboration



Three successful inter-sectoral mental health co-ordination structures currently exist in the Western Cape, namely: Eden-Karoo District, Khayelitsha Child and Adolescent Mental Health Forum and in the Eerste River area in the Western Cape. These structures include all role-players such as the Department of Health, Department of Social Development, Non-government mental health organisations and others, local clinics, hospitals and the South

African Police Services, and so forth. Figure 55 depicts the circular relationship that promotes an integrated and comprehensive model that reflects a shift from primary biomedical model to a social model that promotes recovery and inclusion.

Figure 55: Integrated Community-based mental health Patient-centred Recovery Model Circular Relationship



6.13. Key Informants' Opinions about the Model and Additional Recommendations

The researcher forwarded the proposed model of intervention prior to engaging in the telephonic interviews that covered the questions identified in Appendix G (pp. 300–307). The key informants noted the following in relation to:

- The difference they felt this model could make in the recovery journey of service users:

I think we intervene greatly at specialist level when they [service-users] are in an acute crisis and then they disappear from our system. Then we pick them up a year later and maximise inpatient treatment.

I think that it would really help if you had safety nets at a basic level. Then you would avoid all those expensive interventions. The

link between the primary care level and specialist level is weak... Thus we tend to only intervene in crisis with acute care.

The level of functioning and crisis all leads to this increased stigma and intolerance in communities because they get no support.

I feel that this model really addresses the core issues where we give support to the community so that they can sustain the person in the community. Then you don't have this community burnout which we see time and time again where families become less and less involved over time because there is too little support.

Mental health users must have easily accessible safety nets because the challenges are life-long.

It is a human rights issue, and people don't function optimally when we take away that support and their illness becomes much more severe than it needs to be.

(Key Informant MH Review Board, Western Cape)

I think it is important to have structures in the community to give them [service users] the necessary support otherwise they relapse. Many of them are prematurely discharged and we need community support as it will unblock the system.

(Key Informant National Ministerial Advisory Board Member)

- Additional community-based mental health programmes/interventions that should be considered in this model:

Early intervention is crucial at the onset of the illness. We do a lot of education and awareness around managing mental health problems, but we also need specific focus on first presentation and early intervention because then we can improve the prognosis.

The other area that is overlooked is the HIV/Aids-related mental health problems, particularly neuro-cognitive disorders such as dementia and early onset of dementia related to HIV/AIDS.

We also need to manage mental health disorders in our aging population. We tend to focus more on young people.

(Key Informant MH Review Board, Western Cape)

I have this idea that there is an information hub at the clinic for the service users to give them advice and guidance. The nurses and doctors don't have time to do this. They could provide information such as ... what Learnerships are available, how do I draft a CV, how do I go for an interview, their human rights, literacy...

Maybe a Buddy person could be implemented very similar to peer support.

The medication issue – maybe it should be delivered to your nearest pharmacy instead of going back to the clinic. This should be piloted and will prevent the stock-out problem. It will eliminate long waiting periods.

Find a way to reduce the waiting period as employees lose economic productivity and workers lose wages.

Improve the environment of the clinics. It is unhygienic and it needs to be dignified. Make the clinics homely and welcoming, it does not cost money. It will improve quality of service.

The clothing [items] that you receive have holes. This is unacceptable.

The attitude of the nurses is a big problem. They must be sympathetic and respectful.

We need PSR groups so that people are not bored at home all day. Your Fountain House impresses me. It has activities that meet their interests. It reduces hospitalisation and relapse. There has been research on this in the USA. The same should happen at hospital, because people sit around and have nothing to do.

The clinic is a one-stop shop....the perfect place to get advice and support for all your needs.

(Key Informant National Ministerial Advisory Board Member)

- Resources required to implement this model:

I do think that there must be training resources. There is a deficit in appropriate training resources. We should redirect a portion of acute funding to the training. There must be a full commitment to training and support.

Carers need support as well, particularly community health workers.

(Key Informant MH Review Board, Western Cape)

Funding – it won't be that expensive.

Human resources –volunteers could definitely assist.

Task-shifting.

Facilities – space at the clinic.

Training – is a big component.

Psychiatry – training of nurses.

A monthly forum to strengthen collaboration

(Key Informant National Ministerial Advisory Board Member)

- Feasibility of this model with regards to actual implementation:

I think it is very feasible. I think it is a good model for a developing country with limited financial resources. I think it is the right model because the financial resources are located at the safety net level instead of spending the bulk of our budget with acute admissions.

This is reasonable because you're spending your resources at a support level. In the long run, you will save because you are spending your money where it makes the most difference. But I think it is more than spending the money wisely; it is giving people a better quality of life and managing their illness more responsibly, without having huge disruptions in their lives. I think it is

an excellent model, because it not only focuses on quality of people's lives but it is also achievable within our budget.

(Key Informant MH Review Board, Western Cape)

It is very feasible. It is perfect in small towns and rural areas. People will feel valuable.

(Key Informant National Ministerial Advisory Board Member)

- Challenges in implementing the model

There are not enough people with the necessary skills. I think we must develop more people with 3–4 months of training. It must be good comprehensive training instead of the training that is currently offered. The training should be offered in pilot areas and evaluated. We should resist training in all areas in a half-hearted manner and rather focus on 3 areas and do the training thoroughly...

(Key Informant MH Review Board, Western Cape)

Clinic/medical staff maybe find this a big challenge because it's always us and them. However, service users will be in their element.

(Key Informant National Ministerial Advisory Board Member)

- Recommendations to overcome these challenges

There are resources and we have information available – so we need to choose to implement in a few areas where there is poor mental health. Start in pilot areas and do the training comprehensively.

(Key Informant MH Review Board, Western Cape)

Proper community engagement with all stakeholders is crucial so that they feel involved in the model. Create a monthly forum for feedback and discussion with nurses, service users, community and stakeholders.

(Key Informant National Ministerial Advisory Board Member)

- Significant individuals or organisations that should be consulted to ensure that this model is implemented

The NPOs – they are already doing work in this area. The service users – consult with them ... they see a benefit. District non-specialist health teams – we must have their buy-in.

(Key Informant MH Review Board, Western Cape)

A monthly forum to strengthen collaboration – we need to consult with service users, family members, NGOs, nurses, psychiatrists, psychologists and communities.

(Key Informant National Ministerial Advisory Board Member)

- Timeline to roll-out of the proposed model

I would suggest that you look at a five-year roll-out – district by district. I think it is lovely, comprehensive model. It is cost-effective and appropriate for a developing country. It provides a good safety net. It is comprehensive enough to hold people ... It is well thought through. It is doable

(Key Informant MH Review Board, Western Cape)

About a year ...

(Key Informant National Ministerial Advisory Board Member)

6.14. Conclusion

Mental health services in South Africa remain largely fragmented with the majority of mental health professionals agreeing that mental health services were still mostly hospital-based and were predominantly using a bio-medical model. The findings of this study indicated that comprehensive mental health care interventions are lacking, with a lop-sided dependence on medication despite reported “stock-outs”. Furthermore, this existing dominant approach to mental health care does not empower service users to exercise their rights when it comes to decisions that affect their lives.

The proposed **Integrated Community-based Mental Health Care Model** emphasises increased access to mental health services within communities and villages in rural areas that are provided by users of mental health services, other non-specialists, mental health workers and professionals. These interventions are person-centred, readily accessible and cost-effective.

Thus, in conclusion, this proposed model would provide mental health service users with greater access to a wider range of mental health care and could facilitate far better treatment outcomes. The model also aims to ensure the human rights protection of persons with mental disability by increasing access to care. The overall costs to the South African economy could be significantly decreased with more service users able to access some type of employment as

a result of community support systems, less expenditure on psychiatric facilities, and increased “mental health capital” as a result of community awareness and educational programmes.

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APPENDICES A to J

Appendix A: Electronic Survey Administered to Mental Health Professionals

QUESTIONNAIRE

An investigation into mental health care deficits in South Africa:
Exploring an alternative intervention strategy.

By

Ingrid Daniels

Towards the fulfilment of a

Doctoral Degree in Social Development

at the

University of Cape Town

Section A: Consent to participate in this research

This section seeks to gain consent from the respondent to participate in this survey and to ensure that all respondents participate willingly and without any duress. No identifying information will be revealed at any stage of this study. You may choose to exit at any time. Please tick (v) the appropriate bracket.

1) I am completing this questionnaire without any duress and I confirm that I am participating in this survey of my own free will.

Agree

Do not agree

2) I understand that the information that I provide will be strictly confidential.

Understand

Unsure

Do not understand

3) I understand that I can exit the survey at any stage

Understand

Do not understand

Section B: Organisation Details

This section seeks to gather information about your organisation or facility, its professional staff and its geographical location of service provision. Please tick (v) the appropriate bracket.

4) Indicate whether you are employed at a mental health society/NPO or a psychiatric facility

Mental health society/NPO

Psychiatric facility

5) In which province does your organisation or facility offer its services?

Eastern Cape

Free State

Gauteng

KwaZulu-Natal

Limpopo

- Mpumalanga
- Northern Cape
- North West
- Western Cape

6) Indicate the geographic location/s of your organisation or facility

- Rural
- Urban
- Peri-urban

7) Indicate your profession

- Nurse
- Occupational Therapist
- Psychiatrist
- Psychologist
- Social Worker
- Other (Please specify)

Section C: Perceptions of Mental Health in your Province

8) This section deals with your opinion of the perceptions and attitudes of health professionals toward mental health and mental health service users in your province. Please tick (v) one of the brackets next to each statement below.

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
Mental illness is well understood by all health professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health professionals often fear working with people with mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health service users are often regarded as unpredictable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health service users are always difficult to manage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication with mental health service users is always difficult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health service users are seldom taken seriously by health professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Negative attitudes toward mental health service users result in a lack of empathy	()	()	()	()	()
Negative perceptions about mental illness lead to pessimism about the patients prognosis	()	()	()	()	()
Psychiatric patients take longer to improve compared to patients with other health conditions	()	()	()	()	()
Treating patients with mental illness is more stressful than treating patients with other health conditions	()	()	()	()	()
Mental illness is a highly stigmatised condition	()	()	()	()	()
Misconceptions about mental illness increase stigma and discrimination	()	()	()	()	()
Stigma always leads to increased social exclusion and isolation	()	()	()	()	()
Dismissive attitudes by health professionals always lead to lower prioritisation of mental health resources	()	()	()	()	()
Mental health receives less attention due to lower mortality rates compared to other health conditions	()	()	()	()	()
Mental health care is a very low priority in my province	()	()	()	()	()
All mental health service users have access to treatment in their communities in my province	()	()	()	()	()
There is a significant increase in demand for mental health services in my province	()	()	()	()	()
Community-based health facilities cannot cope with the increase in demand for mental health services	()	()	()	()	()
Untreated mental illness is more costly to the economy than the cost of treatment	()	()	()	()	()

Section D: Current State of Mental Health in your Province

9) This question relates to your experience regarding the current state of mental health services in your province. Please tick (v) one of the brackets next to each statement below.

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
Mental health services are mostly hospital-based	()	()	()	()	()
The medical model is the dominant approach to diagnosis and treatment	()	()	()	()	()
The social model is the dominant approach to diagnosis and treatment	()	()	()	()	()

Patient involvement in decisions about his/her treatment is always considered	()	()	()	()	()
Adequate mental health services are available in rural areas in my province	()	()	()	()	()
Comprehensive treatment options are always available to mental health service users in my province	()	()	()	()	()
A range of community-based mental health programmes is always available to patients discharged from the psychiatric facilities	()	()	()	()	()
Psychiatric medication is always available at Primary Health Care (PHC) facilities	()	()	()	()	()
Psychiatric medication is always the preferred treatment for mental illness	()	()	()	()	()
Medication with the fewest side-effects is always prescribed	()	()	()	()	()
Building conditions at many psychiatric facilities are not suitable for satisfactory patient care	()	()	()	()	()
Facilities are always safe for patients requiring seclusion	()	()	()	()	()
Beds are always available for patients requiring admission	()	()	()	()	()
Patients are never prematurely discharged	()	()	()	()	()
Poor socio-economic conditions increase mental illnesses in my province	()	()	()	()	()
Poverty is linked to an increase in demand for mental health services	()	()	()	()	()
Violence in communities increases mental illness	()	()	()	()	()
Violence in communities limits access to mental health services	()	()	()	()	()
Mental health professionals working in violent communities are at greater risk than those working at PHC facilities	()	()	()	()	()
Exposure to violence increases the risk of relapse for services users	()	()	()	()	()
Increase in substance abuse has significantly increased mental illness in my province	()	()	()	()	()
Mental health professionals have significantly higher job-related stress compared to other health professionals	()	()	()	()	()
Mental health professionals have significantly higher workloads than other health professionals	()	()	()	()	()
The shortage of mental health professionals increases stress in my job	()	()	()	()	()

Mental health professionals often feel unsupported	()	()	()	()	()
Mental health professionals are seldom given recognition for working in difficult conditions	()	()	()	()	()
Working conditions of mental health professionals are highly satisfactory	()	()	()	()	()
Primary health care facilities are always safe for staff providing mental health treatment	()	()	()	()	()
Primary health care professionals are highly skilled in treating mental disorders	()	()	()	()	()
Adequate numbers of non-specialist health workers are employed to provide basic mental health care	()	()	()	()	()
Non-specialist health workers focus mainly on general health conditions	()	()	()	()	()
Peer counselling is seldom used to provide basic mental health care	()	()	()	()	()
There are insufficient multi-disciplinary district mental health specialist teams – Assertive Community Teams (ACT) in my province	()	()	()	()	()
There is always collaboration with traditional healers when treating patients with mental illness in my province	()	()	()	()	()
Mental health NPOs play a significant role in delivering community-based services	()	()	()	()	()
Professional staff at psychiatric facilities regularly consult social workers at mental health NPOs to strengthen case management	()	()	()	()	()
Patients are always referred to mental health NPOs for community-based interventions	()	()	()	()	()
A comprehensive resource directory of effective mental health treatment options is available in my province	()	()	()	()	()
The South African government understands that prevention campaigns significantly reduce the direct cost of mental health services	()	()	()	()	()
Mental health services in my province are well funded	()	()	()	()	()
Mental health NPOs are adequately funded	()	()	()	()	()
Fewer resources are allocated to mental health compared to other medical conditions	()	()	()	()	()

Section E: Mental Health and Human Rights

10) This section deals with your opinion of the human rights of mental health service users in your province. Please tick (✓) one of the brackets next to each statement pertaining to mental health service users.

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
People with a mental illness experience significant discrimination	()	()	()	()	()
People with mental illness are more vulnerable to abuse by society than those without mental illness	()	()	()	()	()
People with mental illness are more likely to be abused by health professionals	()	()	()	()	()
Human rights violations are frequently experienced by people with mental illness	()	()	()	()	()
Mental health service users are seldom included in mental health policy development	()	()	()	()	()
Mental health service users should be fully included in commenting on legislation that affect their lives	()	()	()	()	()
Run-down buildings at psychiatric facilities violate the rights of patients to proper care	()	()	()	()	()
Access to psychiatric medication is a human right	()	()	()	()	()
Self-advocacy is central to mental health treatment	()	()	()	()	()
The South African Police Services regularly reacts to complaints of human rights abuses against mental health service users in my province	()	()	()	()	()
The South African Police Services always upholds the human rights of mental health service users in my province	()	()	()	()	()
Mental health users have full access to justice in my province	()	()	()	()	()
All mental health service users should have the right to vote	()	()	()	()	()
Mental health service users should fully participate in multi-sectoral mental health forums	()	()	()	()	()
Mental health human rights watch structures should be established to monitor human rights abuses in my province	()	()	()	()	()
My province has a fully functioning Mental Health Review Board	()	()	()	()	()

The Mental Health Review Board in my province regularly intervenes in human rights abuses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Section F: Mental Health Policy

11) The National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) was adopted in 2013. How have you experienced the implementation of the Mental Health Strategic Plans 2013–2020 in your province? Please tick (v) one of the brackets next to each statement below.

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
I am familiar with the contents of the National Mental Health Policy Framework and Strategic Plan (2013–2020) – (MHPF&SP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have only read some sections of the (MHPF&SP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have done an in-depth study of the (MHPF&SP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This is a very good policy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This policy is highly appropriate for a developing country	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Senior management at Provincial Department of Health (DOH) is fully competent to implement the Mental Health Strategic Plan (MHSP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provincial DOH has prioritised mental health in its general health care plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provincial DOH has a highly effective mental health structure through which the MHSP is implemented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provincial DOH has clearly identified target dates for the implementation of the MHSP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provincial DOH has secured funding to fully implement the MHSP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is sufficient number of qualified mental health personnel employed to implement the MHSP in my province	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are sufficiently trained mental health professionals who can implement the policy objectives of this 2013–2020 plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The number of specialist mental health teams have increased significantly in all districts due to the MHSP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health professionals at PHC facilities have been adequately trained in mental health to give effect to the MHSP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Informal health workers at National Health Insurance (NHI) pilot sites have been adequately trained in mental health to execute the MHSP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health interventions are fully implemented at NHI sites as set out in the MHSP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Informal health workers employed at NHI pilot sites are actively rendering mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health service users actively participate in the successful implementation of the MHSP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traditional healers are regularly consulted in patient case management plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adequate community-based mental health programmes are available to give effect to the MHSP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provincial DOH actively collaborates with all mental health NGOs to give effect to the MHSP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All health professionals are confident that the Mental Health Strategic Plan 2013–2020 will be implemented within the given timeframes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Mental Health Strategic Plan 2013–2020 has substantially increased mental health services in my province	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12) Adequate institutional capacity is required to implement the National Mental Health Policy Framework and Strategic Plan 2013 –2020. Please tick (v) one of the brackets next to each statement below.

	Yes	Unsure	No
The national Mental Health Technical Advisory Committee has been established	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A mental health directorate exists in my province	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A provincial multi-sectoral mental health forum/commission has been established	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A Mental Health Review Board has been established in my province	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A Mental Health Review Board is functioning effectively in my province	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section G: Integrating comprehensive community-based mental health services into primary health care (PHC).

13) Comprehensive community-based mental health services could be improved at a primary health care level in your province by providing the following. Please tick (✓) one of the brackets next to each statement below.

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
Mental health services should be offered mostly at a PHC level to increase access to treatment	()	()	()	()	()
A social model approach to diagnosis and treatment would improve mental health care	()	()	()	()	()
The provision of patient-centred care would significantly improve treatment outcomes	()	()	()	()	()
A range of comprehensive mental health treatment options should always be provided at a PHC level	()	()	()	()	()
Poverty alleviation programmes should be initiated to significantly improve treatment outcomes	()	()	()	()	()
Psychiatric medication should always be available at PHC facilities	()	()	()	()	()
Psychiatric medication with the fewest side-effects should always be prescribed	()	()	()	()	()
Mental health facilities should be regularly upgraded	()	()	()	()	()
Security should be increased at mental health facilities	()	()	()	()	()
Security should be increased at primary health care facilities	()	()	()	()	()
Sufficient beds should always be available for patients needing admission	()	()	()	()	()
Additional non-specialist health workers should be employed to provide basic mental health care in communities	()	()	()	()	()
Peer counselling support programmes should be provided	()	()	()	()	()
Collaboration with traditional healers in treating mental illness is necessary	()	()	()	()	()
Improved partnerships with mental health NPOs would strengthen community-based interventions	()	()	()	()	()
Increased referrals to mental health NPOs would improve community-based support and counselling to service users	()	()	()	()	()
Multi-disciplinary district mental health specialist teams – Assertive Community	()	()	()	()	()

Teams (ACT) should be deployed to cover all districts					
A comprehensive resource directory of effective community-based mental health treatment options should be readily available in my province	()	()	()	()	()
Mental health should be integrated into comprehensive health interventions at all NHI pilot sites	()	()	()	()	()
Increased prevention and awareness campaigns would significantly reduce the demand for mental health care	()	()	()	()	()
Providing 24-hour “on call” psychiatric services in my province would increase access to mental health care	()	()	()	()	()
Fully functioning multi-sectoral district – based mental health forums should be established to co-ordinate mental health services	()	()	()	()	()
Increased provincial health funding would expand comprehensive community-based mental health care	()	()	()	()	()

Section H: Human Resource Capacity

14) This section focuses on strengthening human resource capacity to deliver effective community-based mental health services in resource poor communities. To strengthen and increase mental health human resources in your province the following will be required. Please respond by ticking (v) one of the brackets next to each statement below.

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
Provide regular support for mental health professionals in my province	()	()	()	()	()
Provide adequate salaries to increase job satisfaction of mental health professionals	()	()	()	()	()
Offer special allowances to attract more health professionals to rural areas	()	()	()	()	()
Provide professional growth and development opportunities	()	()	()	()	()
Give greater recognition to mental health professionals to increase respect for their role and status	()	()	()	()	()
Reduce job load to decrease job-related stress	()	()	()	()	()
Provide safe working conditions to increase job satisfaction	()	()	()	()	()
Recruit community mental health volunteers in all districts to actively identify and motivate patients to seek treatment	()	()	()	()	()

Use the Task-shifting Model to increase basic mental health knowledge of non – specialist health workers	()	()	()	()	()
Expand the role and function of all non-specialist health workers to include mental health interventions at NHI sites	()	()	()	()	()
Train all non-specialist health workers in mental health to increase the provision of basic community mental health care	()	()	()	()	()
Train all nurses, doctors, social workers and occupational therapists in mental health at PHC structures	()	()	()	()	()
Increase the number of Assertive Community Teams to provide outreach in every district.	()	()	()	()	()
Implement 24-hour “on call” psychiatric services to increase access to mental health professionals	()	()	()	()	()
Collaborate with identified traditional healers to strengthen mental health resources	()	()	()	()	()
Develop training programmes to increase mental health literacy of traditional healers	()	()	()	()	()
Increase the partnership with mental health NPOs to strengthen community-based mental health services	()	()	()	()	()
Increase outreach support through increased peer interventions	()	()	()	()	()

(This section should only be completed by mental health societies/NPOs)

Section I: The Role of Mental Health NPOs

15) Mental health societies/NPOs have played a significant role in implementing community-based mental health services in South Africa for more than 100years. Please tick (v) one of the brackets next to each statement below regarding the role and challenges of your mental health society.

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
Mental health societies contribute significantly to community-based mental health programmes	()	()	()	()	()
Social workers actively promote patient-centred care interventions	()	()	()	()	()
A strengths-based approach that recognises the abilities of service users is actively promoted	()	()	()	()	()
Families receive significant support from mental health NPOs	()	()	()	()	()

Mental health service users receive significant support from our social workers	()	()	()	()	()
Lobbying and advocacy for the rights of persons with mental disability are actively promoted by our organisation	()	()	()	()	()
Our organisation strongly opposes discrimination against people with mental illness	()	()	()	()	()
Our organisation strongly promotes self – advocacy for service users	()	()	()	()	()
Our organisation employs self-advocate supporters	()	()	()	()	()
Service users are significant role-players in the governance structures of our organisation	()	()	()	()	()
Service users are actively engaged in peer counselling	()	()	()	()	()
Services users are always referred to our NPO from psychiatric facilities	()	()	()	()	()
A good partnership exists between our organisation and psychiatric facilities to strengthen patient care	()	()	()	()	()
Our NPO's role in community-based mental health is always recognised by State departments in my province	()	()	()	()	()
Our NPO is regarded as a significant partner by all State departments	()	()	()	()	()
Funding provided by provincial government departments is sufficient to support our programmes	()	()	()	()	()
State subsidy payments are always paid on time	()	()	()	()	()
Funding of mental health programmes is seldom seen as a priority by donors	()	()	()	()	()
Our services are seldom recognised as more cost-effective compared to those delivered by State facilities	()	()	()	()	()
Our organisation regularly includes government departments in planning of our mental health services	()	()	()	()	()
Provincial government departments seldom consult my organisation when planning mental health services in my province	()	()	()	()	()
It is difficult to retain our social workers due to low salaries	()	()	()	()	()
High turnover of social workers decreases our ability to provide continuity in services	()	()	()	()	()

Our social workers receive regular professional growth and development opportunities	()	()	()	()	()
Our social workers have significantly higher caseloads than social workers employed in the State sector	()	()	()	()	()
The demand for mental health social work services have increased significantly in our province	()	()	()	()	()
Our social workers have significantly higher job-related stress than social workers employed in other sectors	()	()	()	()	()
The shortage of community-based mental health services decreases my ability to provide comprehensive services	()	()	()	()	()
Violence in communities decreases my ability to provide regular home visits	()	()	()	()	()
I always feel unsafe when entering violent communities	()	()	()	()	()
There are few incentives to encourage mental health social workers to stay at NPOs	()	()	()	()	()
The National Mental Health Policy Strategic Plan 2013–2020 clearly identifies the role of mental health NPOs in my province	()	()	()	()	()
Subsidies to our organisation have increased due to the National Mental Health Policy Framework, & Strategic Plan 2013–2020	()	()	()	()	()

**You have reached the end of this survey.
Thank you for participating in this research.**

Appendix B: Electronic Request to Participate in the Study – Mental NPO

From: ingrid@cmh.org.za>

Date: Sun, Sep 27, 2015 at 11:53 AM

Subject: Request to Review – An investigation into mental health care deficits in South Africa: Exploring an alternative intervention strategy.

Dear Mental Health Society Director

As previously discussed and presented to you on 12 March 2014, I am currently completing my PhD in Social Work at the University of Cape Town. The title of my PhD is “An investigation into mental health care deficits in South Africa: Exploring an alternative intervention strategy.”

I have been employed in the mental health sector for over 33 years as a clinician and over the past 15 years as Director of Cape Mental Health, one of the oldest and largest, award-winning mental health non-profit organisations in South Africa.

Having worked in the mental health sector and serving on several local, national and international structures in various key positions I have become increasingly concerned about the serious mental health crisis due to large and extremely worrying treatment gaps in South Africa. The mental health deficits are alarming and estimated to grow significantly over the next decade.

Mental health services are developmental and human rights issues and deficits in service delivery require urgent redress. People with mental illness face discrimination on multiple structural, economic and social levels, with limited access to appropriate mental health services. The study will assess the current state of mental health services in the country with the view to identifying cost-effective community-based treatment options. These intervention options will strengthen the district mental health system and be added to the packages of care offered to fulfil the National Mental Health Strategic Plan 2013–2020 mandate for South Africa. The sole aim is to increase access and strengthen community-based mental health services for many living in marginalised resource - poor areas.

I kindly request your assistance to circulate the electronic questionnaire to all your social workers (including yourself and your managers if you are social workers) and to facilitate access to computers. The questionnaire has been created in a user-friendly online format and should not take more than thirty minutes to complete. Please complete and return by no later than Friday, 30 October 2015.

For a summary of the research proposal please send an email request to my email address ingrid@cmh.org.za.

Thanking you in advance for your contribution.

Kind regards

Ingrid Daniels

Cell Phone: 0828978172

Student No: DNLING 001

Supervisor: Dr Constance O'Brien – Department of Social Development

University of Cape Town

Please click or copy/paste the following link in your browser:

[http://www.surveygizmo.com/s3/2327032/An-investigation-into-the-mental-health-deficits-in-South-Africa-with-a-view-to-exploring-new-intervention-strategies/SG TEST RUN](http://www.surveygizmo.com/s3/2327032/An-investigation-into-the-mental-health-deficits-in-South-Africa-with-a-view-to-exploring-new-intervention-strategies/SG_TEST_RUN)

Note: This link is only for testing purposes and is not intended for live survey use.

Appendix C: Electronic Request to Participate in the Study – Psychiatric Facility

From: Ingrid Daniels [<mailto:invites@mailers.surveygizmo.com>]

Sent: 04 October 2015 06:23 PM

To: Carol Dean

Subject: An investigation into mental health care deficits in South Africa: Exploring an alternative intervention strategy.

Dear HOD/CEO of Psychiatric Facility

My name is Ingrid Daniels and I am currently completing my PhD in Social Work at the University of Cape Town. The title of my PhD is “**An investigation into mental health care deficits in South Africa: Exploring an alternative intervention strategy**”.

I have been employed in the mental health sector for over 33 years as a clinician and over the past 15 years as Director of Cape Mental Health, one of the oldest and largest, award-winning mental health non-profit organisations in South Africa. You can google our work on www.capementalhealth.co.za .

Having worked in the mental health sector and serving on several local, national and international structures in various key positions, I have become increasingly concerned about the serious mental health crisis due to large and extremely worrying treatment gaps in South Africa. The mental health deficits are alarming and estimated to grow significantly over the next decade.

Mental health services are developmental and human rights issues and deficits in service delivery require urgent redress. People with mental illness face discrimination on multiple structural, economic and social levels, with limited access to appropriate mental health services. The study will assess the current state of mental health services in the country with the view to identifying cost-effective community-based treatment options. These intervention options will strengthen the district mental health system and be added to the packages of care offered to fulfil the National Mental Health Strategic Plan 2013–2020 mandate for South Africa. The sole aim is to increase access and strengthen community-based mental health services for many living in marginalised resource - poor areas.

I kindly request your assistance to circulate the electronic questionnaire to all your nurses, occupational therapists, psychiatrists, psychologists, social workers and any other relevant mental health staff and to facilitate access to a computer. The questionnaire has been created in a user-friendly online format and should not take more than thirty minutes to complete. **Please forward my email to the relevant mental health professionals so that they can access the link to complete the questionnaire.**

Click on this link to access the survey:

<http://s-c7b187-i.surveygizmo.com/s3/i-100043517-1088033/>

Please ensure that they **respond by no later than Friday, 30 October 2015.**

For a summary of the research proposal please send an email request to my email address ingrid@cmh.org.za.

Thanking you in advance for your contribution.

Kind regards

Ingrid Daniels

Cell Phone: 0828978172

Student No: DNLING 001

Supervisor: Dr Constance O'Brien - Department of Social Development

University of Cape Town

Appendix D: Endorsement – South African Federation for Mental Health

From: Bharti Patel [mailto:bharti@safmh.org]

Sent: 09 October 2015 07:38 AM

To: Ingrid Daniels; Adelah; Carel Mouton; Christelle van Eeden; Elbie; Elna; Gita Harie; Gloria Pillay (info@zmhs.org.za); Gloria Pillay (pillaygloria5@gmail.com); Jannie Van Zyl (jannie.yonder@gmail.com); Kate Lenehan; Mari Louw; minette; Naku (naku@witsmhs.co.za); Rita Reethram; Sheldine; Tilla; Yvonne; Zininzi

Subject: RE: PHD ELECTRONIC QUESTIONNAIRE

Dear colleagues

Please support the research initiative by Ingrid Daniels towards her PHD.

This research is not only a personal initiative but will also assist the Federation in understanding the service delivery challenges experienced by social work staff.

Thank you to all those who have already completed the questionnaire.

Wishing you all a pleasant Mental Health Day tomorrow!

Kind regards,

Bharti Patel (Ms)

National Executive Director

SA Federation for Mental Health

T: +27 (0)11 781 1852

F: +27 (0)11 326 0625

bharti@safmh.org

www.safmh.org

000–238 NPO / PBO 18/11/13/3099



Don't count every hour in your day

Make every hour in your day count

Appendix E: Western Cape Government – Strategy & Health Support: Approval for Research



**Western Cape
Government**

Health

STRATEGY & HEALTH SUPPORT

Health.Research@westerncape.gov.za

tel: +27 21 483 6857; fax: +27 21 483 9895

5th Floor, Norton Rose House., 8 Riebeeck Street, Cape Town, 8001

www.capecapegateway.gov.za

REFERENCE: **WC_2015RP30_423**

ENQUIRIES: Ms Charlene Roderick

University of Cape Town

Anzio Road

Observatory

Cape Town

7935

For attention: **MRS Ingrid Daniels**

Re: MENTAL HEALTH DEFICITS IN SOUTH AFRICA: TOWARDS A NEW INTERVENTION STRATEGY.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

Valkenberg Hospital

E Malgas

Contact No: 021 440 3260

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (annexure 9) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

Yours sincerely


DR A HAWKRIDGE
DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 25/11/2015

CC

Appendix F: Focus Group Interview Guide for Mental Health Service Users

Focus Group Interview Guide for Mental Health Service Users

Research Title:

An investigation into mental health care deficits in South Africa:
Exploring an alternative intervention strategy.

**Focus group participants are comprised of service user advocacy bodies or groups in the
Western Cape, Eastern Cape, KwaZulu-Natal, Northern Cape and Limpopo Provinces**

By

Ingrid Daniels

Towards the fulfilment of a

Doctoral Degree in Social Development

at the

University of Cape Town

Date

MARCH/APRIL 2016

1. WELCOME

Thank you for agreeing to be part of the focus group. I appreciate your willingness to participate in this very important national study.

[Service users to complete consent forms]

[Ask permission to start recording. *Check that the recorder is switched on*]

[Focus group participants will introduce themselves. They may use fictitious names if they wish]

2. INTRODUCTIONS [by Facilitator and Co-facilitator]

My name is Ingrid Daniels (**Facilitator**) and my (**Co-facilitator**) is I am currently facilitating the focus group to complete the data collection for my PhD in Social Development at the University of Cape Town. The title of the PhD is: **An investigation into mental health care deficits in South Africa: Exploring an alternative intervention strategy** and my supervisor is Dr O'Brien.

I have been employed in the mental health sector for over 33 years as a clinician and mental health advocate. I am the Director of Cape Mental Health, one of the oldest and largest, award-winning mental health non-profit organisations in South Africa for over 16 years. I serve on several local, national and international structures in various key positions including the National Mental Health Ministerial Advisory Committee and I am the Vice-President Programme Development on the World Federation for Mental Health Board.

3. PURPOSE OF FOCUS GROUPS

The focus groups with mental health services users will be held in the Western Cape, Eastern Cape, KwaZulu-Natal, Northern Cape and Limpopo Provinces. It is a wonderful opportunity for mental health services users to voice their opinion about the state of mental health in South Africa and to make a significant contribution towards increasing access and improving mental health treatment in our country.

The focus groups aim to glean the opinions of mental health service users with regards to their lived experiences of mental health care in South Africa. I would like to hear your opinions about barriers in resource allocation, the current state of community-based interventions, the attitudes of mental health professionals and what you would recommend as critical next steps to prioritise and improve mental health services. I would like your opinion on the proposed community-based mental health intervention strategy and model that has emerged as a result of the study thus far and would like to add your recommendations to the emerging model.

GROUND RULES

1. The information provided will be confidential – what is said in this room stays here.
2. I will not identify anyone by name in the research report.
3. Your anonymity is guaranteed.
4. I will require your consent to participate in this study.
5. You may exit the interview at any time without being penalised in any way whatsoever.
6. No intrusive questions regarding your mental state, family history, predisposing factors (reasons) for the diagnosis and/ or any personal information will be required or asked.

7. All private and personal information that may have come to my attention during the research process will be guarded and securely stored.
8. Participants who currently have active symptoms of mental illness or who have been hospitalised within the past 6 months will be excluded from the study. This is a protective measure and aims to shield participants from unnecessary stress.
9. Reasonable breaks will be given as requested
10. I want you to feel comfortable to share your opinions when sensitive issues come up.
11. I would want you to do the talking.
12. I would like everyone to participate during the focus group discussions
13. I may ask your opinion if I haven't heard from you in a while during the discussions.
14. There are no right or wrong answers
15. Every person's experience and opinion is important.
16. Speak up when you agree or disagree.
17. I would like to hear a wide range of opinions.
18. I will be tape recording the group – I would like to capture everything you have to say since your views are very important.
19. Any participant who, during the study, identifies a need for ongoing supportive services will be referred accordingly.

FOCUS GROUP QUESTIONS

SECTION 1: Mental health and human rights.

1. What do you believe are the human rights of persons with mental disability?

Probes:

1.1 What human rights violations/abuses have you experienced?

- What are the reasons for these human rights violations/abuses?
- How does this make you feel as someone living with a mental illness?

1.2 What protection is available to mental health service users against these violations?

- What role has the South African Police Services played in protecting you from these abuses?
- What role has the Mental Health Review Board played in dealing with these human rights abuses in your province?
- What role has the mental health society/ NGO played in protecting you from these human rights abuses in your province?
- What needs to be done to increase and improve protection against these violations?

1.3 What should be done to prevent and address human rights violations?

1.4 How are people with mental illness generally perceived by society?

1.5 What could be done to change society's attitude towards people with mental disability?

1.6 What are your opinions about involuntary admissions?

SECTION 2: Perceptions and attitudes of health professionals toward mental health and mental health service users.

2. What are the perceptions and attitudes of health professionals toward mental health and mental health service users?

Probes:

2.1 How do health professionals react towards you when they hear you have a mental illness?

- What concerns or fears do you think health professionals have when treating people with a mental illness?
- How you are generally treated when going to your clinic or community health centre by the staff?
- How do you feel when health professionals treat you badly?
- How do you think mental health service users should be treated by health professionals?
- How could health professionals be assisted to improve their attitude towards mental health service users?

2.2 What knowledge do you think health professionals at clinics or community health centres have about mental illness?

2.3 What are your thoughts about stigma and discrimination by health professionals toward people with mental illness?

2.4 How were treated at a health facility when you were ill and required hospitalisation?

- What were your fears when you were hospitalised?
- How long did you stay in hospital?
- What is your opinion about how long you should have stayed in hospital?
- What was the condition of the ward where you were admitted?

SECTION 3: Current state of mental health services in your province.

3. What are your views on the current state of mental health in your province?

Probes:

3.1 What mental health services are available in your province?

- Where are most people treated for mental health conditions in your province?
- What distances do you travel to get to the clinic or community health centre?
- What kinds of treatment are given?
- Which health professional/s do you usually see when visiting the clinic or community health centre?
- How often are you seen at the clinic or community health centre for your treatment?
- How often do you think you need to be seen at clinic or community health centre for your treatment?

3.2 What are some of the concerns you have about mental health services in your province?

- How long are the waiting times at the clinic or community health centre when you go for treatment?
- How do these waiting times affect you?

- What have some of your experiences been regarding access to medication?
- How has no access to medication affected your mental health?
- What is your opinion about the availability of beds for mental health emergency admissions?
- How has the lack of beds affected you?

3.3 How would you describe the condition (infrastructure) of psychiatric facilities/ hospitals?

3.4 What mental health services have worked well in your province?

3.5 What role do mental health service users currently play in providing mental health service in your province?

3.6 What role does mental health societies currently play in providing community-based mental health service in your province?

3.7 How does violence in communities affect you?

3.8 What kind of mental health services do you think should be provided to assist with recovery?

SECTION 4: National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013).

4. How has the new National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013) improved mental health services for you?

Probes:

- What positive changes have occurred as a result of the policy?
- What limits the implementation of the policy and strategic plans?
- How have service users been involved in monitoring the implementation of the strategy?

SECTION 5: Improving comprehensive community-based mental health services at a primary health care level in your province.

5. What recommendations would you make to improve comprehensive community-based mental health services at a primary health care level in your province?

Probes:

5.1 What resources are required to improve comprehensive community-based mental health services?

- What training in mental health should be given to non-specialist health workers?
- What role could service users play in strengthening comprehensive community-based mental health services?

5.2 What role can traditional healers play to improve community-based mental health services?

5.3 What is your opinion about integrating mental health into general health care programmes?

5.4 Who should be involved in delivering co-ordinated mental health services?

5.5 What role should mental health societies/NPOs play to improve and expand mental health services?

SECTION 6: Intervention Strategies

**6.1 A proposed model for strengthening comprehensive community-based mental health services has emerged as a result of this study, what do you think should be added to the model.
(Present the model to the participants and add the additional recommendations)**

SECTION 7: Exit question

7. Is there anything else you would like to say about the state of mental health in South Africa and do you have any further recommendations to improve mental health services?

SECTION 8: Concluding comments and thanks

Appendix G: Interview Guide – Key Informants

Interview Guide for Mental Health Review Board and Mental Health Advisory Board

Research Title:

An investigation into mental health care deficits in South Africa:
Exploring an alternative intervention strategy.

by

Ingrid Daniels

Towards the fulfilment of a

Doctoral Degree in Social Development

at the

University of Cape Town

Date

January 2017

1. Introduction

My name is **Ingrid Daniels** and I am currently facilitating this focus group as part of the qualitative data gathering process for my PhD in Social Development at the University of Cape Town. The title of the PhD is **An investigation into mental health care deficits in South Africa: Exploring an alternative intervention strategy.**

Thank you for agreeing to be part of this research. I appreciate your willingness to participate in this very important national study.

1.1. Primary Objective of the Study

To identify effective and sustainable community-based mental health interventions that seek to redefine and deploy innovative human resource capacity, reprioritise budget allocations, strengthen multi-sectoral mental health collaborations and interventions and to recommend mental health interventions that have worked effectively in LMICs. The study aims to identify holistic, integrated and comprehensive community-based mental health interventions that consider the balance between bio-medical and social approaches.

1.2. Research Methodology

A mixed methods approach will be used in the research design using both a qualitative and quantitative approaches both exploratory and descriptive methodologies.

The **quantitative research method** has been used to obtain systematic and quantifiable information from the mental health professionals by completing the electronic survey in all nine provinces in South Africa.

Population

The non-probability purpose sampling methods will be used to select the following participants, namely;

- Heads of psychiatric facilities, social workers, psychologists and psychiatrist at specialist psychiatric hospitals in South Africa.
- Social workers employed at 17 Mental Health Societies affiliated to the South African Federation for Mental Health across nine provinces in South Africa.

The second phase of the study will include a **qualitative method** to obtain the opinions of mental health service users lived experiences of mental health care in South Africa. Their views of the barriers in resource allocation, current state of community-based interventions, attitudes of mental health professionals and illicit their recommendations to re-engineer and prioritise mental health services with the view to closing the mental health treatment gap. Descriptive and exploratory, semi – structured interview schedule questions will be designed.

Purposive random sampling method was used to include mental health service users across six provinces. I have held focus groups in the Western Cape, Eastern Cape, KwaZulu-Natal, Northern Cape and Limpopo provinces of South Africa with mental health service users to explore their opinions about the state of mental health in South Africa and to obtain their views on how we can increase access and improve mental health treatment in our country.

2. Purpose of the Interview:

I would like your opinion on the proposed community-based mental health intervention model that has emerged as a result of the study and circulated to you in advance of this interview.

3. Identifying Data

3.1. Name of Participants

3.2. Job Title/Current Position Held

3.3. Name of the Department

3.4. Address:

4. Improving Comprehensive Community-Based Mental Health Services at a Primary Health Care Level – Intervention Strategies

A proposed model for strengthening comprehensive community-based mental health services has emerged as a result of this study.

4.1. Outline of the proposed Model

See Below

4.2. What difference do you feel this model could make in the recovery journey of service users?

4.3. What additional community-based mental health programmes/interventions should be considered in this model?

4.4. How feasible is this model with regards to actual implementation?

4.5. What resources would be required to implement such a model?

4.6. What do you foresee as possible challenges to such a model being implemented?

4.7. What could be done to overcome these challenges?

4.8. Who do you think should be consulted to ensure that this model is implemented?

4.9. What kind of timeline would you give for a possible rollout of such a model?

5. Concluding Comments and Thanks

6. Thank you for Participating in this study

A PROPOSED MODEL FOR COMPREHENSIVE AND INTEGRATED COMMUNITY-BASED MENTAL HEALTH SERVICES IN SOUTH AFRICA

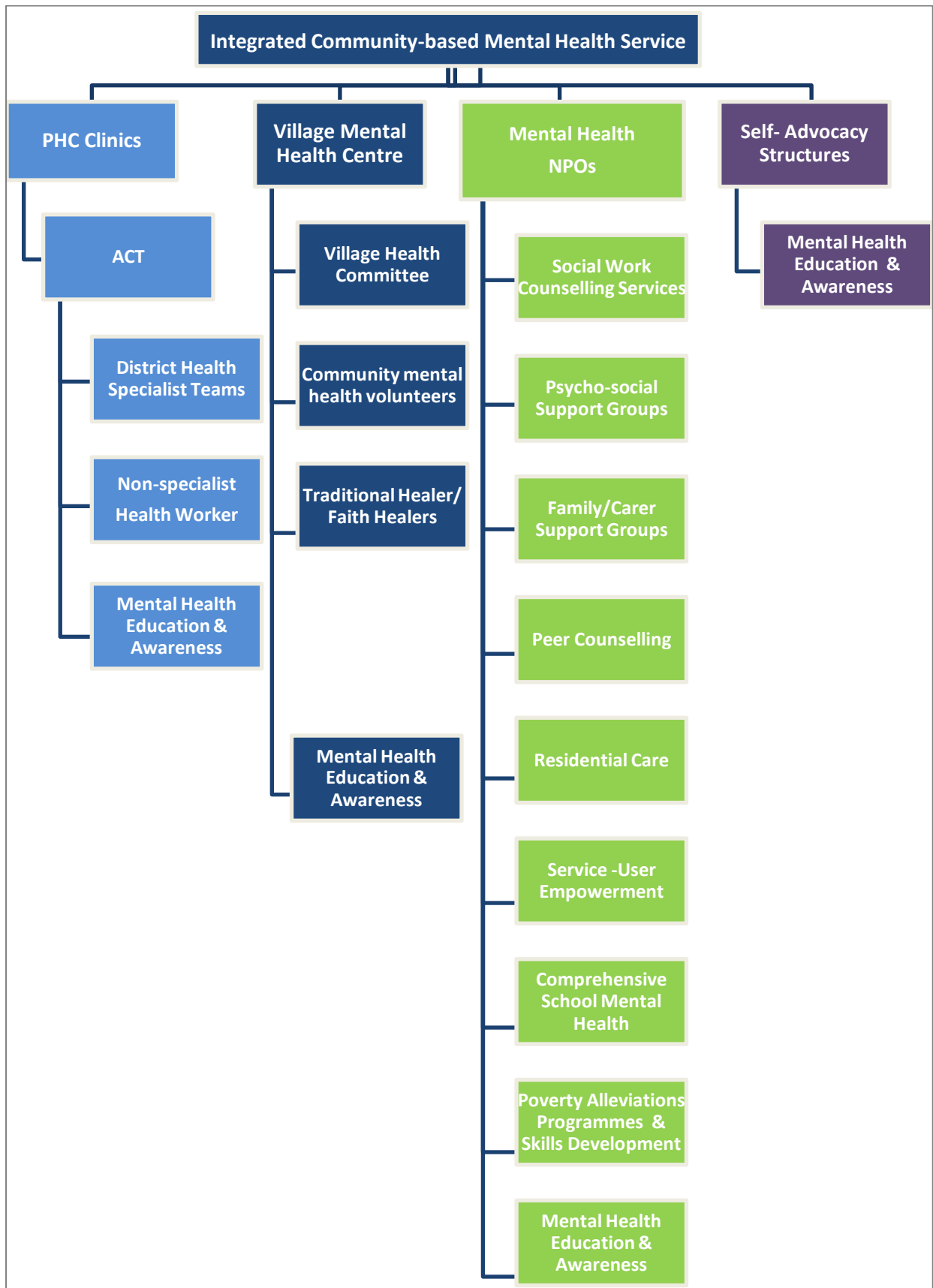
The proposed intervention model has been designed to facilitate comprehensive and integrated community-based mental health services. This model promotes the strengthening of patient-centred recovery models of intervention, which is firmly grounded in the empowerment, resilience and social model approaches, for up-scaling and closing the mental health treatment gap in South Africa.

The model is based on the literature review of intervention models for LMIC settings in India, Uganda, and Brazil. Additional recommendations were received from the research data and current best practice interventions of the 17 mental health non-government organisations affiliated to SAFMH and some Department of Health initiatives in South Africa. The proposed model below draws from some community strengthening approaches and interventions in India, Brazil and Uganda. These countries have similar challenges and deficits regarding the implementation of mental health services. The challenges faced by these countries are similar and include unmet mental health needs in rural areas, low budget allocations for mental health including a dearth in human resource capacity. The lack or absence of these community-based mental health services have resulted in significantly large populations of individuals with mental illness undiagnosed and untreated. These individuals are often stigmatised, discriminated against, isolated and neglected compromising their human rights.

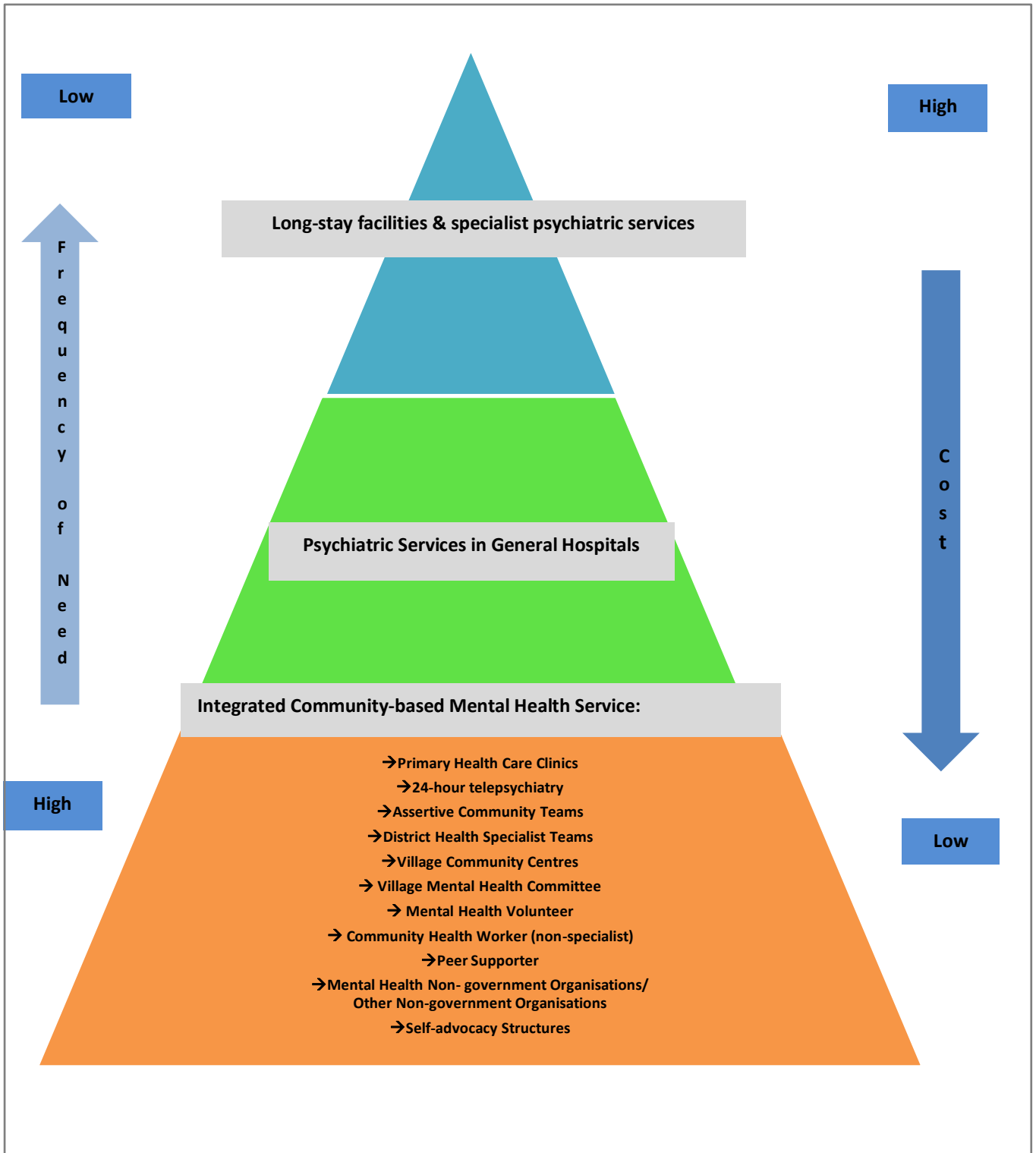
This model integrates bio-medical interventions and includes innovative and expanded community-based mental health initiatives. The latter, relies heavily on local resources, non-government organisations, non-specialist human resource capacity and mental health service users. The findings of this study revealed that the majority of mental health professionals agreed that mental health services should be offered mostly at a PHC level. They confirmed that a social model approach to diagnosis and treatment would improve mental health care while patient-centred care would significantly improve treatment outcomes. The results indicate significant support for a range of mental health treatment options which should be available as part of holistic PHC in communities where mental health service users live.

The model designed therefore includes the following:

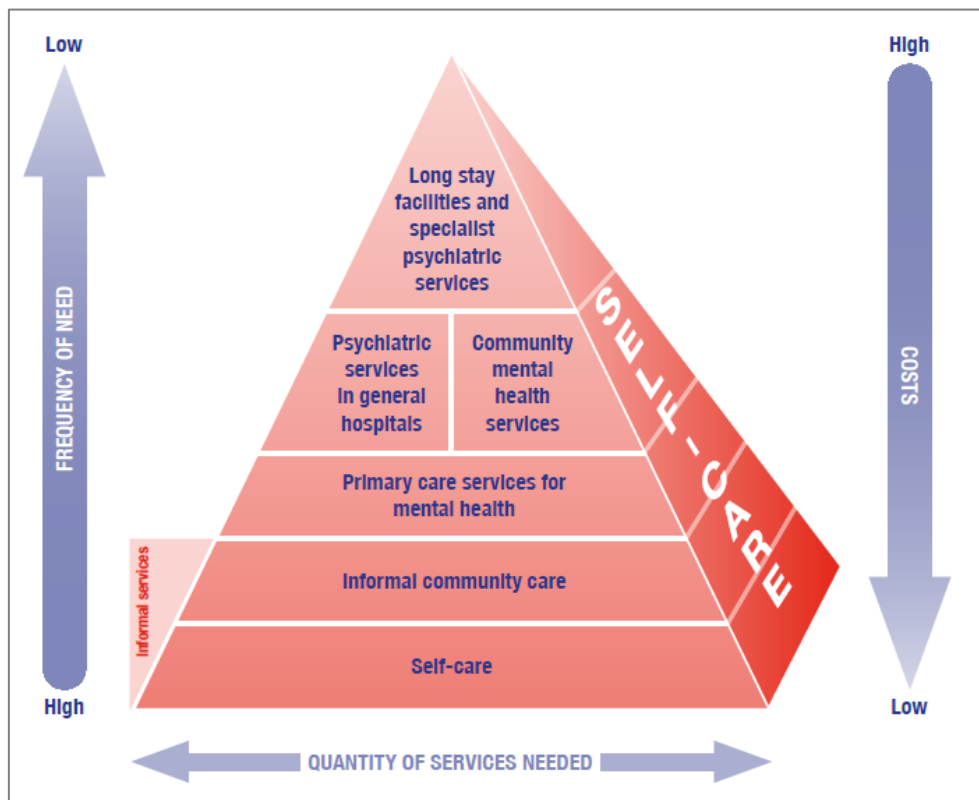
A Proposed Model for Integrated Community-Based Mental Services



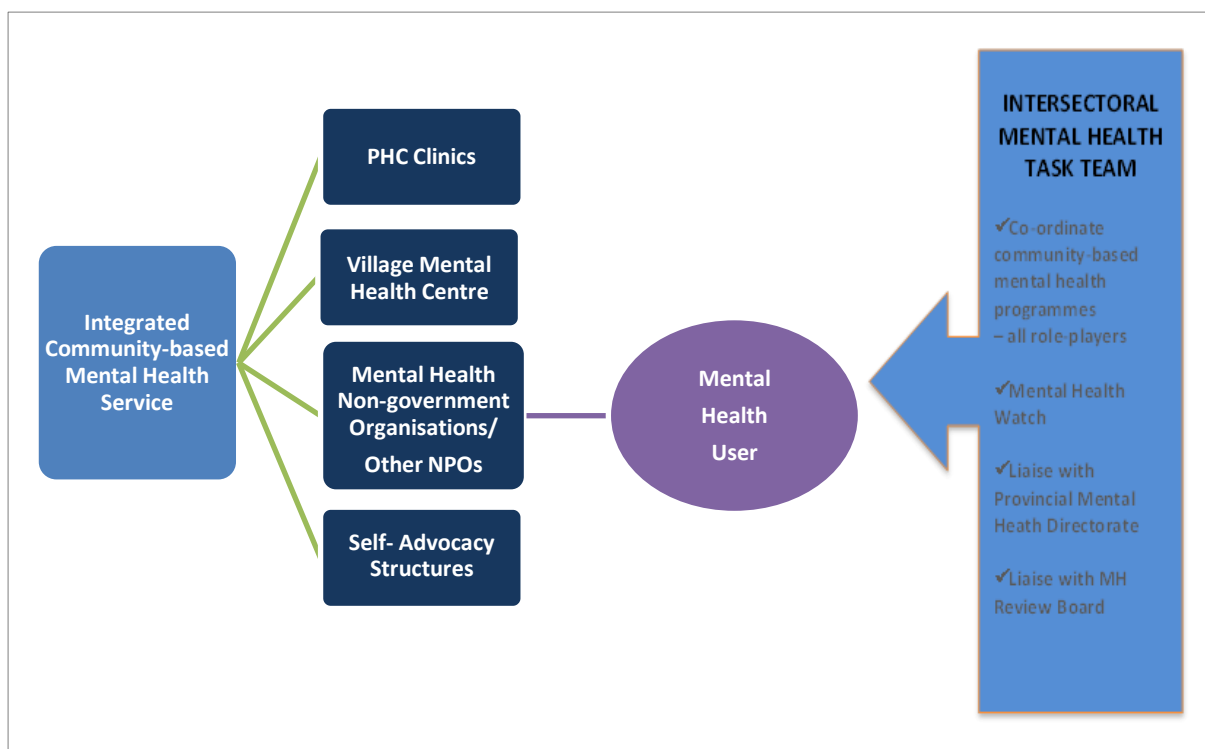
Integrated Community-based Mental Health Patient-centred Recovery Model



WHO Service Organisation Pyramid for an Optimal Mix of Services for Mental Health.



Integrated Community-based Mental Health Service – Intersectoral Collaboration



Appendix H: Informed Consent

CONSENT OF MENTAL HEALTH SERVICE USERS PARTICIPATE IN FOCUS GROUPS

TITLE OF STUDY: An investigation into mental health care deficits in South Africa: Exploring an alternative intervention strategy.

Introduction

My name is **Ingrid Daniels** [*if there are Facilitators and Co-facilitators, note here, e.g., "and my research colleagues are _____ and _____"*] and I am currently completing my PhD in Social Work at the University of Cape Town and I am supervised by Dr O'Brien.

I am hereby requesting your permission to participate in the focus group.

BRIEF INTRODUCTION

Mental health experts and the World Health Organization (WHO) have identified a serious global mental health crisis due to the large and extremely worrying treatment gap particularly in lower- and middle-income countries (LMIC) requiring urgent redress. This situation is no different in South Africa where mental health deficits are alarming and estimated to grow significantly over the next decade.

Despite the lauded National Mental Health Policy Framework and Strategic Plan 2013–2020 (2013), mental health has remained a low national health priority with a seriously skewed bio-medical approach. This approach is fragmented and fails to provide integrated comprehensive mental health care to the majority of poor South Africans who cannot afford private mental health care. Mental health services are located mainly in urban areas while large gaps or limited community-based mental health services are found in rural communities across the country. The situation is furthermore compounded by abject poverty and the serious lack of mental health resources.

Even though mental health has been identified as the third highest burden of disease in South Africa, it remains the most neglected health specialty and competes with medical conditions such as; HIV/AIDS, tuberculosis, etc., for a fair percentage of the health budget, resources and personnel.

There is a dire need to expand and improve mental health services in South Africa by designing cost-effective integrated community-based intervention strategies to reach the vulnerable majority of those living with often debilitating mental illnesses

You are being invited to participate in this study because [*specify reason why prospective subject is being recruited for study, e.g., "you have signed up for the Research Participant Pool (RPP)"*].

Appendix I: Confirmation of Ethic Approval



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Enq: Dr. C. O'Brien

19th November , 2015

CONFIRMATION OF ETHICS APPROVAL FOR INGRID DANIELS' STUDY

The aforementioned PhD candidate is carrying out a study on “**An investigation into the mental health deficits in South Africa with the view to exploring new intervention strategies**”

This letter serves to confirm INGRID DANIELS has had her research proposal approved by the Doctoral Degrees Board (University of Cape Town) and has received ethics approval from the Department of Social Development. The ethics committee consists of the Head of Department together with three academics. The ethics approval form is also submitted to the Doctoral Degrees Board. Should you have any further questions about the ethics approval process I will be happy to respond.

Yours sincerely

A handwritten signature in black ink, appearing to read 'R Mendelsohn'.

Associate Professor Richard Mendelsohn

Acting Head of Department

**Appendix J: Cost Comparisons of Mental Health Service: DoH Western Cape and
Mental Health NGOs**

INTELLECTUAL DISABILITY				
Licensed Homes: Long-term hospital care				
No. Of Beds	Subsidy to sustain this service per person per year	Cost to DOH per person per year if this service not available	Cost to DOH per year if service closed	Saving to DOH per year to sustain this service
175	R 47,520.00	R 127,734.85	R 22,353,598.38	R 14,037,598.38
Step Down: Long-term hospital care				
No. Of Beds	Subsidy to sustain this service per person per year	Cost to DOH per person per year if this service not available	Cost to DOH per year if service closed	Saving to DOH per year to sustain this service
90	R 21,408.00	R 127,734.85	R 11,496,136.31	R 9,569,416.31
Special Care Day Centre: Users will require at least 1 PSS admission and 1 PSR admission per year				
No. Of Beds	Subsidy to sustain this service per person per year	Cost to DOH per person per year if this service not available	Cost to DOH per year if service closed	Saving to DOH per year to sustain this service
781	R 10,752.00	R 19,247.72	R 15,032,466.83	R 6,635,154.83
PSYCHIATRIC DISABILITY				
PSR Groups: Users will require at least 1 acute admission per year				
No. Of Beds	Subsidy to sustain this service per person per year	Cost to DOH per person per year if this service not available	Cost to DOH per year if service closed	Saving to DOH per year to sustain this service
160	R 6,480.00	R 8,399.00	R 1,343,840.59	R 307,040.59
PSR Day Centres: Users will require at least 2 acute admissions per year				
No. Of Beds	Subsidy to sustain this service per person per year	Cost to DOH per person per year if this service not available	Cost to DOH per year if service closed	Saving to DOH per year to sustain this service
50	R 6,480.00	R 10,498.75	R 524,937.73	R 200,937.73
Vocational Day Centres: Users will require at least 1 acute admission per year				

No. Of Beds	Subsidy to sustain this service per person per year	Cost to DOH per person per year if this service not available	Cost to DOH per year if service closed	Saving to DOH per year to sustain this service
90	R 6,153.60	R 8,399.00	R 755,910.33	R 202,086.33
Residential Care Level 1: Users will require at least one extended admission				
No. Of Beds	Subsidy to sustain this service per person per year	Cost to DOH per person per year if this service not available	Cost to DOH per year if service closed	Saving to DOH per year to sustain this service
39	R 14,880.00	R 22,747.30	R 887,144.77	R 306,824.77
Residential Care Level 2: Users will require long-term hospital care				
No. Of Beds	Subsidy to sustain this service per person per year	Cost to DOH per person per year if this service not available	Cost to DOH per year if service closed	Saving to DOH per year to sustain this service
225	R 20,131.20	R 127,734.85	R 28,740,340.78	R 24,210,820.78
Residential Care Level 3: Users will require long-term hospital care				
No. Of Beds	Subsidy to sustain this service per person per year	Cost to DOH per person per year if this service not available	Cost to DOH per year if service closed	Saving to DOH per year to sustain this service
77	R 35,904.00	R 127,734.85	R 9,835,583.29	R 7,070,975.29
No. Of Users	Subsidy to sustain these services		Cost to DOH per year if service closed	Saving to DOH per year if this service is sustained
1687	R 28,429,104.00		R 90,969,959.01	R 62,540,855.01

(Provincial Mental Health Forum, 2009)