Child and adolescent mental health services in the Western Cape of South Africa: policy evaluation, situational analysis, stakeholder perspectives, and implications for health policy implementation

By

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DECLARATION

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CONTENTS

LIST OF TABLES

Chapter 1

Chapter 2

Chapter 3

Chapter 5

Chapter 6

Chapter 7

LIST OF FIGURES

Chapter 1

Chapter 2

Chapter 3

Chapter 4

ABSTRACT

In spite of the need for child and adolescent mental health (CAMH) services across the globe, very little has been done to develop and strengthen CAMH in low- and middle-income countries (LMIC). South Africa is an example of an LMIC where CAMH services have been very limited as a result of various potential factors, including the legacy of apartheid, stigma associated with mental health, and lack of priority of CAMH. In this thesis, we set out to generate an evidence-base about CAMH services in one South African province to inform service strengthening across the full healthcare system through policy development and implementation.

We proposed that a comprehensive understanding of specific services requires a multilevel exploration of 'hardware' (structural) and 'software' (social) elements in the health systems that support these services. We started by reviewing the CAMH policy landscape with an analysis of the current state of policy development and implementation at national and provincial levels in all nine provinces of South Africa. Using the Walt and Gilson policy analysis triangle (1994), we examined the content, context, processes and actors involved in mental health or CAMH-specific policies. We then evaluated the hardware and software elements of CAMHS in the Western Cape Province by performing a situational analysis using the WHO-AIMS version 2.2 of 2005 (Brief version) adapted for the South African context and to CAMHS. We proceeded to seek the perspectives of stakeholders within the province – firstly a SWOT analysis with senior stakeholders, and secondly, qualitative analysis of the perspectives of grassroots service providers, and of parents/caregivers and adolescent service users. We collected information from these stakeholder groups through a stakeholder engagement workshop, focus group discussions and semi-structured individual interviews. Using the World Health Organization (WHO) (2007) and Gilson (2012) health systems frameworks, we reviewed both the hardware and the software elements of CAMH services and concluded with a synthesis of findings to provide a set of recommendations for

policy development and service strengthening based on the evidence generated.

In terms of *service delivery*, findings showed that child and adolescent mental health services (CAMHS) in the Western Cape were provided at all levels of care (primary, secondary and tertiary) and, at least at inpatient and outpatient level, based on catchment/geographical service areas. However, CAMHS were still limited and were provided under very resource-constrained conditions by inadequately trained service providers. In terms of the *health workforce*, CAMHS were provided by a range of professionals including child & adolescent psychiatrists, general psychiatrists, medical officers, clinical psychologists, social workers, mental health nurses, occupational therapists, and speech and language therapists. However, multidisciplinary expertise and psychosocial interventions were only available in specialist CAMHS at tertiary level of care. In addition, the specialist services were all based in the City of Cape Town, with no direct access to specialist CAMHS at secondary levels of care or in any of the rural districts of the province. *Health information systems* were not fit-for-purposes to generate disaggregated data on under-18-year-olds, thus made it extremely difficult to provide a comprehensive view of CAMHS in the province. In terms of *access to essential medicines*, basic classes of psychiatric medications were available at all levels of care, but not consistently so. An exploration of *financing* showed that no ring-fenced or disaggregated budgets were available for CAMHS, thus making it impossible to comment on the appropriateness of funding for the mental health needs of children and adolescents. In terms of *leadership and governance*, a national CAMH policy existed, but no implementation plans had been developed since the publication of the CAMH policy in 2003. Our findings highlighted a lack of dedicated CAMH leadership and governance in the province. We argued that the absence of a clear CAMH leadership structure also explained why provincial plans and strategies had not been developed and implemented over the last two decades. A very consistent finding from our data was a need for a dedicated provincial lead for CAMH.

We concluded the thesis with hardware and software recommendations for policy implementation, service development, training and research.

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STYLE, ABBREVIATONS AND KEY TERMS

A note on spelling and style convention: South African English spelling has been used throughout this thesis with the exception of standard international terminology, e.g. World Health Organization. I have used APA 6th Edition referencing throughout the thesis and compiled all references at the end of this thesis.

ABBREVIATIONS

AIDS: Acquired Immunodeficiency Syndrome

CAMH: Child and Adolescent Mental Health

CAMHS: Child and Adolescent Mental Health Services

CFU: Child and Family Unit

CHC: Community Health Centre

DALYs: Disability Adjusted Lived Years

DCAP: Division of Child and Adolescent Psychiatry, University of Cape Town

DoH: Department of Health

FAS: Foetal Alcohol Syndrome

FGDs: Focus Group Discussions

GBD: Global Burden of Disease

GSAs: Geographic Service Areas

HIC: High-Income Countries

HIV: Human Immunodeficiency Virus

KZN: KwaZulu-Natal

LMIC: Low- and Middle-Income Countries

NCDs: Non-Communicable Diseases

NGOs: Non-Governmental Organisations

NHC: National Health Committee

NHI: National Health Insurance

NPOs: Non-Profit Organisations

PHC: Primary Healthcare

SALT: Speech and Language Therapy

SSIIs: Semi-Structured Individual Interviews

SWOT: Strengths, Weaknesses, Opportunities and Threats

TLC: Therapeutic Learning Centre

ToC: Theory of Change

WCED: Western Cape Education Department

WHO: World Health Organization

WHO-AIMS: World Health Organization Assessment Instrument for Mental Health Systems

KEY TERMS

Adolescent

Barriers

Child

Child and adolescent mental health

Low- and middle-income countries

Mental health

Perspectives

Policy

Policy development

Policy evaluation

Provider perspectives

Services

Service evaluation

Service strengthening

Service user perspectives

Situational analysis

South Africa

Resources

Western Cape Province

Chapter 1: Setting the scene to understand and strengthen child and adolescent mental health services

1.1 Introduction

There is an urgent need to recognise child and adolescent mental health (CAMH) problems as a public health priority, and to give this priority the attention it deserves. Across the globe approximately one in five children and adolescents suffer from one or more mental illness (Kieling et al., 2011; Flisher et al., 2012), thus representing a major cause of morbidity (Polanczyk, 2014). The evidence-base for the burden of child and adolescent mental disorders in low- and middle-income countries (LMIC) is limited (Kieling et al., 2011). Insufficiently skilled human resources, low awareness and low priority, high service load, greater concern for child mortality than morbidity, and journal acceptance biases against LMIC-research may all contribute to this small evidence-base (Patel, Flisher, Nikapota & Malhotra, 2008). The little evidence available shows that poverty and parental unemployment are contextual risk factors for poor CAMH and for developing child and adolescent mental disorders. Brain injuries, consequent neuropsychiatric morbidity, intellectual disability and epilepsy are more common in LMIC than in high-income countries, and these disorders have a significant impact on educational attainment (Patel et al., 2008) and on the likelihood of other mental health disorders.

Mental health disorders have a negative impact on child and adolescent development and well-being. Children and adolescents with mental health problems experience personal and social difficulties, and these challenges cut across family, education and learning, physical health, and conduct behaviour (Sheehan, 2017) For this reason, CAMHS is by definition an intersectoral and multidisciplinary challenge, and solutions to improve outcomes for children and adolescents with mental health problems and their families by definition requires intersectoral and multi-sectoral work. Such interventions include healthcare interventions, school-based interventions, community-based

interventions and justice (Sheehan, 2017; Keiling et al., 2011). Child and adolescent mental disorders also have substantial effects on economic and social outcomes that extend into adulthood and are exacerbated if left untreated (Armstrong & Henshall, 2013; Patel, Flisher, Hetric & McGorry, 2007). However, despite the evidence, there is still a significant global neglect of CAMH compared to other health problems (Flisher et al., 2012; Patel et al., 2007). There is a lack of policy development and implementation for CAMH globally, and especially in LMIC (Shatkin & Belfer, 2004). Shatkin and Belfer (2004) summarised the state of child and adolescent mental health services (CAMHS) and policies and noted "the relatively new development of knowledge in CAMH, lack of appreciation of a developmental perspective related to CAMH disorders, stigma, fragmented advocacy constituency and reluctance of professionals to engage in debates over policy" as factors contributing to lack of policy development and implementation in CAMH (Shatkin & Belfer, 2004, p. 108). There is lack of leadership and governance, lack of funding, dependence on Non-Governmental Organisations, lack of governmental support, privatisation of CAMHS, lack of staff in the public sector and lack of trained workforce for CAMHS (Keiling et al., 2011).

There are also inadequate CAMH resources and very limited available research in CAMH (Juengsiragulwit, 2015; Kleintjes, Lund, Flisher & MHaPP Research Programme Consortium, 2010). This is particularly the case in LMIC. In 2007 the 'treatment gap' or rate of unmet needs in LMIC was greater than 90% (Patel et al., 2007) and so far there is no evidence of much change. There are inequities in the distribution of CAMHS with less coverage in rural and disadvantaged areas and fewer services for children and adolescents. In many countries adolescents are still admitted in adult inpatient units (Dawes et al., 2005; Flisher et al., 2012; Kleintjes et al., 2010; Patel et al., 2007).

CAMHS need to be strengthened to secure the important role of such services in the prevention of mental disorders, the promotion of mental health and well-being of children and adolescents, the reduction of risk factors associated with mental illness, and in the provision of curative services using evidence-based

strategies for those who require treatment (Flisher et al., 2012; Kagee et al., 2014; Patel et al., 2007).

1.2 Health systems and health systems strengthening

A clear understanding of health systems and its components is important in order to consider how best to strengthen CAMHS.

The World Health Organization (WHO) suggests that “a health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. It includes efforts to influence determinants of health as well as more direct health-improving activities” (World Health Organization, 2007, p. 2). Gilson defines health policy as “the formal written documents, rules and guidelines that present decisions about what actions are deemed legitimate and necessary to strengthen the health system and improve health, and also the informal unwritten practices” (Gilson, 2012, p. 28).

The WHO outlined six interrelated building blocks of health systems: 1) service delivery, 2) health workforce, 3) information systems, 4) medical products, vaccines and technologies [also referred to as access to essential medicines and technologies] 5) financing, and 6) leadership and governance (stewardship) (World Health Organization, 2007). These building blocks define what the health systems should include, and the capacity needed to do what it should do. The building blocks also define the WHO priorities and are a means for identifying gaps in a particular system. The key elements of a good health system as set out by the WHO (2007) are summarised in **Table 1.1**.

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Table 1.1 The six building blocks of a health system (adapted from the World Health Organization, 2007)

Building blocks of a health system
Service delivery: Health services can be promotive, preventive, curative, rehabilitative and palliative, and they may be delivered on various platforms such as home, community, and workplace or in health facilities. Good enough health services should provide effective, safe, good quality personal and non-personal care to the needy and should not be wasteful of the available resources. To achieve this, the workforce should be well-trained, the right medicine and equipment should be available, and the services should be adequately financed.
Health workforce: Health workforce refers to all workers whose primary aim is to protect and improve health. These include unpaid and paid workers, private and public workers, as well as lay and professional workers. According to the WHO (2007) a well-performing health workforce should be responsive, fair and efficient. To achieve this, there should be sufficient resources (sufficient staff, equitable distribution of resources, competency) provided in an environment that is favourable to providing quality services (responsiveness and productiveness).
Information systems: The health information system ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.
Medical products, vaccines and technologies (access to essential medicines and technologies): A good health system should ensure a supply of quality, safe and cost-effective medical products, vaccines and technologies, and the cost-effective use thereof.
Financing: A good health financing system ensures that adequate funds for the services are raised and that there is universal coverage for service provision for both users and service providers. Any changes made in financing the services must be tailored to the history, institutions and traditions of that particular context. The financing system should further ensure accountability, transparency and effective use of resources.
Leadership and governance (stewardship): Leadership and governance refer to the role of the government in health and its relation to other actors. The government should oversee the entire health system, the private and public sectors, and reconcile the competition for limited resources among health systems.

Gilson (2012) divides the key building blocks of health systems into ‘hardware’ and ‘software’ elements. The ‘hardware’ refers to structural elements such as human resources, financing, medicines, technology, organisational structure, service infrastructure, and information systems. The ‘software’ refers to ideas and interests, relationships and power, values and norms, as well as the interactions between the hardware and software elements (Gilson, 2012). According to Gilson, the hardware (structural) and the software (social) elements and interactions between these two are the key determinants of a successful and good quality health system.

To strengthen health systems, one should identify the problem areas (within the health systems and policies, what activities are needed to improve the situation, how and by whom, and what resources are needed (World Health Organization, 2007; Gilson, 2012). It is important that all the elements of the health system be evaluated in order to strengthen the system. This thesis set out to address a number of these aspects.

1.3 The South African context

The location of this study is South Africa. We will therefore provide a short background to the context of the country and present a short summary of the state of CAMHS at the start of this project.

South Africa is classified as an upper-middle-income country by the World Bank and has the highest Gini coefficient in the world, indicating the greatest economic disparities of all countries in the world (The World Bank, 2018). Alongside the economic disparities, South Africa also has significant health disparities (Mayosi & Benatar, 2014). In 2019 the country had a total population of ~58.78 million people of which 36.7% were children and adolescents under the age of 18 (Statistics South Africa, 2019). The prevalence rate of CAMH disorders was estimated to be ~17% (Kleintjes et al., 2006) for common disorders including generalised anxiety disorder (11%), post-traumatic stress disorder (8%) and major depressive disorder/dysthymia (8%). Some of the obvious contributing factors in the South African context include poverty, HIV infection, substance use, and high rates of exposure to violence (Kleintjes et al., 2006).

Policy level for CAMH: The last published situational analysis of CAMH was conducted in 2005 by Kleintjes and colleagues (Kleintjes et al., 2010) in four African countries (Uganda, Zambia, Ghana and South Africa), and assessed the CAMH resources and the issues impacting on policy, legislation and service development, and implementation for CAMH. This showed that at a national level, South Africa had mental health policy guidelines and a stand-alone CAMH policy (Department of Health, Republic of South Africa, 2003), and mental health legislation (Department of Health, Republic of South Africa, 1997). However, the national mental health policy did not provide specifically for children and adolescents, and the legislation did not include CAMH issues. The legislation addressed only one out of six provisions recommended by the WHO Legislation Checklist for the protection of minors (Kleintjes et al., 2010) and while it recommended age-appropriate services, there were no implementation plans to support the CAMH policy (Department of Health, Republic of South Africa, 2003). Kleintjes and colleagues concluded that this situation was due to the lack of adoption of the overarching National Policy Guidelines for Improved General Mental Health Care (Kleintjes et al., 2010).

Kleintjes and colleagues also found that at a provincial level, only one of the nine South African provinces (Northern Cape) had a draft Mental Health Implementation Plan. None of the provinces had implementation plans to support the CAMH policy but many were using the national legislation to guide service provision. This situation was also due to the lack of capacity at provincial level. Kleintjes and colleagues made various recommendations including 1) revision and formal adoption of the national mental health legislation, policies and plans, 2) development of implementation plans for CAMHS, 3) integration of CAMHS into general health service, 4) a multisectoral approach, and 5) optimisation of the available human resources through adequate training – including increasing capacity for generalist workers on CAMH (Kleintjes et al., 2010). To develop and implement CAMH policies the Mental Health and Poverty Project (Draper et al., 2009) recommended government commitment, capacity-building of all relevant

service providers, service users and researchers, lobbying for the implementation of CAMH policies and plans, multisectoral collaboration, and awareness raising about CAMH.

Hardware components: Findings from observations made in South Africa on mental health services (including CAMHS) by Dawes and colleagues (2005) showed that the service patterns in CAMH still reflected the apartheid-era. The apartheid-era was a period from 1948 until 1994 whereby the ruling National Party enforced racial segregation, restricted access to economic, medical, and educational resources and employment opportunities for people socially classified as 'non-white', resulting in huge inequalities (Charasse-Pouéléa & Fournier, 2006; Mayosi et al., 2009). Dawes and colleagues (2005) found that CAMHS were not integrated into primary healthcare (PHC). Furthermore, they noted that training for PHC service providers was inadequate, that there was a lack of CAMH teams to provide consultation, coordination and support, and that CAMHS were only situated in the main cities and not accessible in many provinces.

At the resource level in 2005, Kleintjes and colleagues (2010) also found inadequate and inequitable distribution of CAMH resources, with most resources situated in the metropolitan regions of the country. There were limited specialist human resources for CAMH and a lack of training of generalist workers in CAMH.

Software components: Kleintjes and colleagues (2010) explored software elements through qualitative research with senior stakeholders (but not with users or grassroots providers). Software factors influencing the development of CAMHS were identified as stigma, low priority of mental health, and lack of attention to the link between poverty and mental ill-health (Kleintjes et al., 2010). Flisher and colleagues (2012) indicated that there were still significant gaps in knowledge and limited progress in CAMHS in South Africa since the last situational analysis of 2005.

1.4 Aims and objectives of the study

Subsequent to the earlier work as outlined above, almost no studies on CAMHS – which could aid the strengthening of services through planning and policy implementation – have been conducted in South Africa.

Building on the frameworks from the WHO (2007) and Gilson (2012), we propose that service strengthening of CAMH requires a multilevel synthesis of data. That is, a careful understanding is required at all levels relevant to a specific service in order to know how to approach service strengthening. Such a multilevel synthesis should therefore include the evaluation of existing policies and policy implementation, a situational analysis of existing infrastructure, resources and workforce, and a thorough understanding of the perspectives of a broad range of stakeholders – from senior policymakers and CAMH leadership to clinicians who provide and families who receive services at grassroots level. We propose that such a multilevel synthesis could provide an integration and interaction of hardware and software elements as proposed by Gilson (2012). **Figure 1.1** shows a graphic representation of the multiple levels that require integration to understand and strengthen CAMHS.

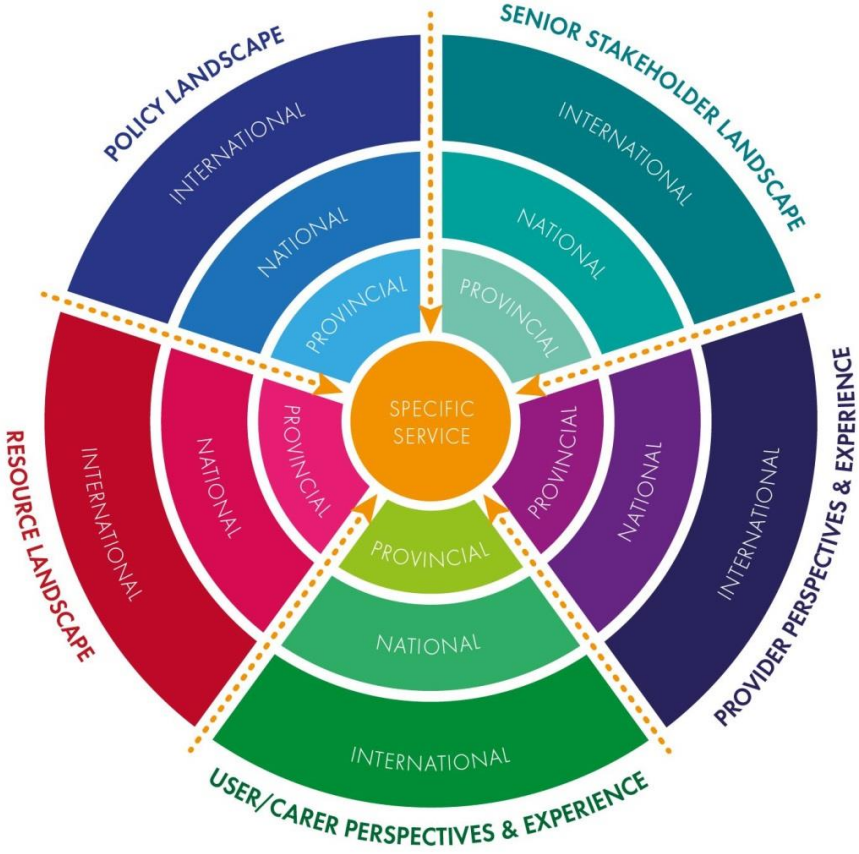

Figure 1.1 The multilevel synthesis required to understand and strengthen child and adolescent mental health services

Aim of the thesis

The overarching purpose of this thesis was to generate an evidence-base that could inform service strengthening of CAMHS in South Africa through policy development and implementation. The specific aim was to examine the current state of CAMHS in the Western Cape Province of South Africa across a range of levels, in order to identify hardware and software strengths and weaknesses in the system. In order to meet this aim we had a number of specific objectives.

Objectives

1. Policy analysis at national level using the Walt Gilson Policy Triangle (1994)
2. A situational analysis of CAMHS in the Western Cape using the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) version 2.2 (2005) framework
3. Exploring perspectives of senior CAMH providers and policymakers in the Western Cape to determine strengths, weaknesses, opportunities and threats (SWOT) for CAMHS through a stakeholder participatory workshop
4. Exploring perspectives of grassroots service providers in Western Cape through semi-structured individual interviews (SSIIs) and focus group discussions (FGDs)
5. Exploring perspectives of CAMH service users in the Western Cape through semi-structured individual interviews (SSIIs) and focus group discussions (FGDs)

Whilst we firmly acknowledge that child and adolescent mental health problems cut across all systems and sectors, for the purpose of this study we made a very pragmatic decision in the context of time, resources and scope of a PhD project to focus this study on the health systems (and mainly the Department of Health) rather than on other or multiple sectors.

We set out to examine the system for CAMH at a particular place and point in time. We selected the Western Cape, firstly because it is one of the better-resourced provinces in South Africa in terms of healthcare (thus making access to health information easier than in the lower-resourced provinces), and secondly, because it is the province in which our own clinical activities are based. We selected the calendar year of 2016 (January – December 2016) as the time period for our study for two main reasons: firstly, it allowed a full 10 years after the previous situational analysis research of CAMH in South Africa and in the Western Cape; secondly, it represented the most recently

completed calendar year since the start of this PhD project. All retrospective data collection (e.g. policies, plans, national census data) was therefore up to and including 2016. All prospective data (e.g. focus groups, semi-structured individual interviews) were collected in 2017.

Ultimately, we were keen to generate an evidence-base that could be used as a road map for strengthening of CAMHS not only in the Western Cape in particular, but more broadly, in the whole of South Africa.

1.5 Structure of the thesis

Chapter 1 introduces the background to the study to justify the aims and objectives of the work. Chapter 2 progresses to a policy analysis of CAMH policies at a national level in order to provide evidence of the current policy landscape in the country. In Chapter 3 we present a situational analysis of CAMHS in the Western Cape to present evidence of the current resource landscape of services. Chapter 4 presents evidence from senior stakeholders about their perspectives of CAMHS and is followed by Chapters 5 and 6 where perspectives and experiences of service providers and service users are explored. In Chapter 7 we synthesise the findings across the multilevel model as outlined in **Figure 1.1**.

Chapter 2: Child and adolescent mental health policy in South Africa: history, current policy development and implementation, and policy analysis

Mokitimi, S., Schneider, M., & de Vries, P.J. (2018). *International Journal of Mental Health Systems,* 12: 36. doi: 110.1186/s13033-018-0213-3

2.1 Introduction

Mental health problems represent a substantial proportion of the global burden of disease. CAMH is slowly becoming recognised as a growing public health priority as exemplified by the WHO resolution on autism spectrum disorders in 2014 (World Health Organization, 2014), recent special issues on CAMH in *The Lancet* (Gore et al., 2011; Patel et al., 2007; Skokauskas et al., 2018), and focus on mental health in the sustainable development goals (Votruba, Thornicroft & FundaMentalSDG Steering Group, 2016). However, this recognition alone is not enough to influence policy development and implementation for CAMHS. There are other contextual factors that are influential in determining policy development and implementation, given that mental health disorders represent the greatest burden of disease in children and adolescents around the world, affecting 10–20% of this age group (Patel et al., 2007; Polanczyk, 2014). Furthermore, the majority of adult mental health disorders develop during childhood or adolescence (Armstrong & Henshall, 2013; Weiss et al., 2012) when they could potentially be prevented, or identified and treated early.

In high-income countries (HIC) one in four to five young people in the general population suffer from at least one mental health disorder in any given year (Patel et al., 2007). There is a relatively small evidence-base for the burden of CAMH disorders in African and other LMIC (Patel et al., 2007). The little evidence available shows that poverty and unemployment are risk factors for poor CAMH and for developing CAMH disorders. Brain damage, consequent neuropsychiatric morbidity, intellectual disability and epilepsy are more

common in LMIC than in HIC, and these disorders impact on educational attainment (Department of Health, Republic of South Africa, 2013). In South Africa various factors such as HIV infection, substance use and exposure to violence increase the risk for mental health problems in children and adolescents even further (Kagee et al., 2014). Based on data from HIC, the overall estimated and adjusted 12-month prevalence rates for mental health disorders in children and adolescents was calculated in one of the South African provinces (Western Cape) and estimated to be 17% in 2006 (Kleintjes et al., 2006).

However, despite the evidence on the burden of CAMH problems, the rate of unmet needs in CAMH is still high, especially in LMIC (Patel et al., 2007). CAMHS have important roles in the prevention of mental health disorders, in the promotion of mental health and well-being of children and adolescents, in the reduction of risk factors associated with mental illness, and in the provision of curative services using evidence-based strategies (Baranne & Falissard, 2018) for those who require treatment (Flisher et al., 2012; Kagee et al., 2014; Patel et al., 2007). Globally, the development, implementation and monitoring of CAMHS start with sound policies and planned service delivery models. Well-considered policies are required to provide a framework for service delivery relevant to contexts, to present appropriate and implementable systems and pathways to care, and to provide a framework for implementation, funding and ongoing monitoring of such systems. Policy therefore provides a road map for programme development, reflects commitment from government and relevant authorities, provides a mandate to support funding mechanisms, and helps to identify those accountable for service provision (Shatkin & Belfer, 2004).

However, there is a lack of policy development and implementation for CAMH globally, and especially in LMIC (Shatkin & Belfer, 2004). Shatkin and Belfer summarised the state of CAMHS and policies and noted “the relatively new development of knowledge in CAMH, lack of appreciation of a developmental perspective related to CAMH disorders, stigma, fragmented advocacy constituency and reluctance of professionals to engage in debates over policy”

as factors contributing to lack of policy development and implementation in CAMH (Shatkin & Belfer, 2004, p.108).

2.1.1 History of child and adolescent mental health policy development in South Africa

South Africa is one of the 14 out of 191 countries recognised by the United Nations to have a clearly articulated national CAMH policy (Shatkin & Belfer, 2004). In South Africa, legislation and policy development is done at national level by the Minister of Health in consultation with a range of stakeholders. The nine provincial Departments of Health (DoH) are then responsible for developing implementation plans with clear targets, indicators, budgets and timelines. Provincial departments are also responsible for monitoring and evaluation of the implemented national policy and legislation. Provincial districts (subdivisions of provinces) are responsible for the local implementation of interventions in accordance to national and provincial priorities (Department of Health, Republic of South Africa, 2013).

A chronology of CAMH-related policy development and processes in South Africa is outlined in **Table 2.1**. The development of the national CAMH policy in South Africa started in 1977 with the Potgieter Commission. This commission recommended intersectoral collaboration, early identification of CAMH disorders at primary healthcare (PHC) level and in schools and increasing capacity of health and education staff to identify CAMH disorders (Flisher et al., 2012).

Table 2.1 The chronology of child and adolescent mental health policy development and processes in South Africa

YEAR	POLICY DEVELOPMENT
1977 (apartheid-era)	The Potgieter Commission emphasised intersectoral collaboration, early identification of CAMH disorders at PHC level and in schools, as well as increasing capacity of teachers and healthcare staff to identify CAMH disorders (Department of Health, Republic of South Africa)
1994 (post-apartheid-era)	The first democratic president acknowledged the importance of children and their vulnerability (Department of Health, Republic of South Africa)
1997	White paper for the transformation of the healthcare system in South Africa (Department of Health, Republic of South Africa, 1997)
	National policy guidelines for improved mental healthcare (Department of Health, Republic of South Africa, 1997)
2001–2003	National policy guidelines for youth healthcare and CAMH (Department of Health, Republic of South Africa, 2003)
2002	National Mental Health Care Act, no.17 of 2002
2003	National CAMH Policy Guidelines (Department of Health, Republic of South Africa, 2004)
	Norms and standards to develop CAMHS (Dawes et al., 2005)
2005	A situational analysis of CAMHS in South Africa (Kleintjes et al., 2010)
2008	The draft of the Strategic Mental Health Plan for the Northern Cape Province finalised by the National multidisciplinary committee (NHC), awaiting adoption as of 2016 (Draper et al., 2009)
2012	The National Mental Health Summit facilitated the adoption of the National Mental Health Policy Guidelines to improve mental healthcare (Department of Health, Republic of South Africa, 2013)
	The Mental Health Summit adopted the “Ekurhuleni Declaration on Mental Health”
2013	The “Mental Health Policy Framework and Strategic Plan” was formally adopted for implementation (Department of Health, Republic of South Africa, 2013)

The policy guidelines for youth health and CAMH were developed between 2001 and 2003, after the guidelines for planning child and adolescent policy in developing countries were developed by Desjarlias and colleagues (Flisher et al., 2012). The national CAMH policy framework of 2003 (Department of Health, Republic of South Africa, 2004) was developed to guide the

establishment of CAMH policies provincially, using a primary care and intersectoral approach. The policy set out a three-tier model for CAMHS and outlined the movement of patients between these tiers. The first point of contact for patients should be at level 1 (informal and formal primary healthcare services), and then move to level 2 or 3 depending on the complexity of the problem. Patients will move between these levels based on the complexity of the problem, the type of assessment, and/or the type of intervention needed (See **Figure 2.1**). Provincial implementation plans to support this policy were recommended as the next step (Kleintjes et al., 2010).

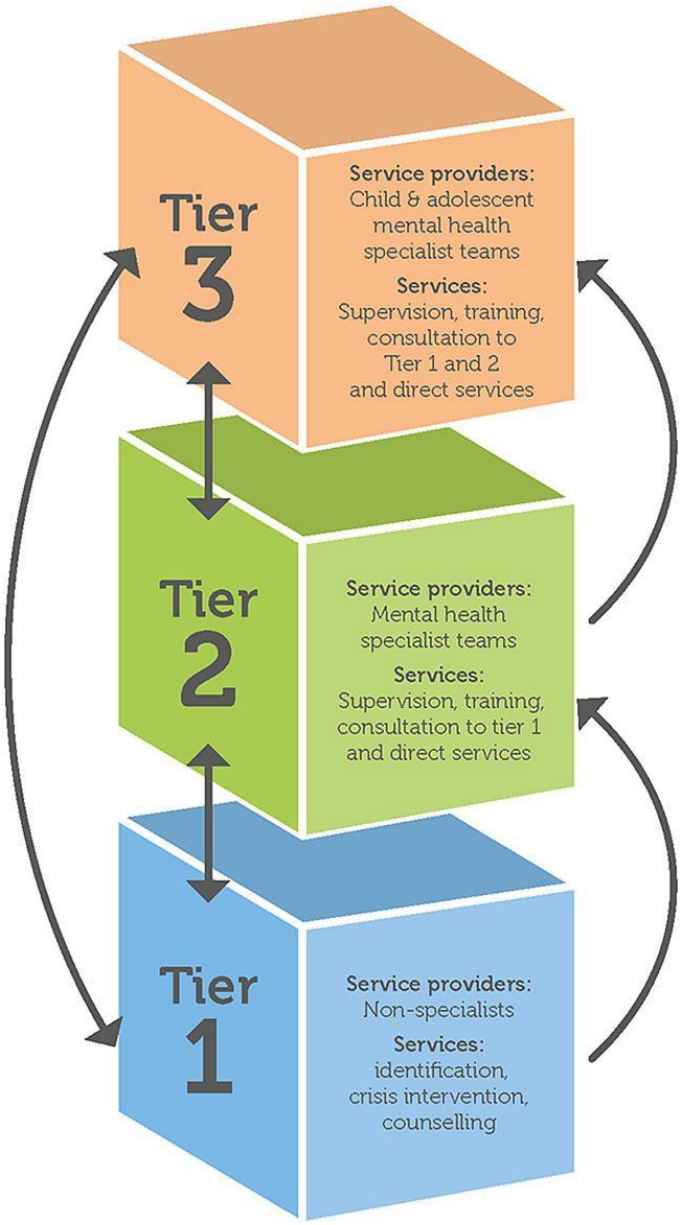

Figure 2. 1 The three-tier model for child and adolescent mental health services in South Africa

The last published situational analysis conducted by Kleintjes and colleagues in 2005 (Kleintjes et al., 2010) in four African countries (Uganda, Zambia, Ghana and South Africa) assessed the CAMH resources and the issues impacting on policy, legislation and service development and implementation for CAMH. This situational analysis showed that, at a national level, South Africa had mental health policy guidelines (Department of Health, Republic of South Africa, 1997), a stand-alone CAMH policy (Department of Health, Republic of South Africa, 2003), and mental health legislation (Mental

Healthcare Act no. 17 of 2002). However, the national mental health policy did not provide specifically for children and adolescents, and the legislation did not include CAMH issues. The legislation addressed only one out of the six provisions recommended for the protection of minors by the WHO legislation checklist, and while it recommended age-appropriate services, there were no implementation plans to support the CAMH policy (Kleintjes et al., 2010). Kleintjes and colleagues concluded that this situation was due to the lack of adoption of the overarching national policy guidelines for improved general mental healthcare (Kleintjes et al., 2010).

The national policy guidelines for improved general mental healthcare of 1997 were formally adopted in July 2013 and led to the development of the National Mental Health Policy Framework and Strategic Plan 2013–2020. The national mental health committee planned to support all the provinces to develop their own mental health plans (Draper et al., 2009).

Kleintjes and colleagues also found in their 2005 study that at a provincial level, only one of the nine South African provinces (Northern Cape) had a draft mental health implementation plan. None of the provinces had implementation plans to support the CAMH policy but many were using the national legislation to guide service provision. This situation was also due to lack of capacity at provincial level (Kleintjes et al., 2010). The draft was under construction at the time of the work by Kleintjes and colleagues in 2005. The final draft of the Northern Cape strategic mental health plan was completed in 2008 and was still awaiting formal adoption in February 2017 (Draper et al., 2009).

A recent review paper (Schneider et al., 2016) investigated potential barriers to the implementation of the national mental health policy (Department of Health. Republic of South Africa, 2013). These barriers include concerns about the feasibility and sustainability of policies; other activities and policies required to ensure full integration of mental healthcare into the health system, lack of financial and human resources; the limited number of evidence-based psychosocial treatment protocols for disorders such as depression and anxiety; limited awareness of and negative attitudes towards mental health

disorders; and the low level of health system readiness to integrate mental healthcare (Schneider et al., 2016).

To develop and implement CAMH policies, Draper and colleagues (2009) recommended government commitment, capacity-building of all relevant service providers (service users and researchers) to lobby for implementation of CAMH policies and plans, multisectoral collaboration, and raising awareness of mental health. Whilst there has been some progress at a national level and some provincial activity occurred, the development and implementation of CAMH policy was noted to be still lacking in 2010 (Kleintjes et al., 2010).

The purpose of this study was two-fold: firstly, to determine whether South African provinces have developed provincial CAMH policies and implementation plans based on the national CAMH policy; and secondly, to perform a policy analysis of all identified CAMH-related policy documents.

2.2 Methods

2.2.1 Search strategy

In order to identify all publicly available policy documents related to CAMH, two search strategies were used. Firstly, web-based searches were performed on the national and all provincial Departments of Health websites. Searches were conducted from June to September 2016. All potentially relevant information was downloaded for analysis. Search terms included “child”, “adolescent”, “mental health”, “policy development”, “policy implementation”, “integrated school health services”, “intellectual disability”, “CAMH policy”, and “health policy”. We searched for the latest versions of the provincial stand-alone mental health and CAMH policies, and for broad, inclusive or comprehensive general health documents.

In parallel with the web-based search, a stakeholder-based search strategy was used. Key staff at the National Department of Health, academics involved in mental health policy, and senior clinicians in CAMH were contacted to obtain the names and contact details of responsible individuals and policy

stakeholders at national and/or provincial level. All identified policy stakeholders were contacted both telephonically and by email by the first author (SM) to obtain the most recent policy-related documents.

2.2.2 Data extraction and analysis

The Walt and Gilson 'policy triangle model' (Walt & Gilson, 1994) was used as framework for extraction and analysis of identified policy documents. Walt and Gilson's triangle model is a useful model for analysing a variety of health issues including mental health issues. It focuses on the content of policy, range of actors, context and processes, and the interaction between these elements in policymaking and policy implementation. The model provides a framework for understanding the process of health policy reform and to plan for effective implementation (Walt & Gilson, 1994). The model can be used retrospectively and prospectively. **Figure 2.2** shows the policy triangle model as adapted from Walt and Gilson (Walt & Gilson, 1994).

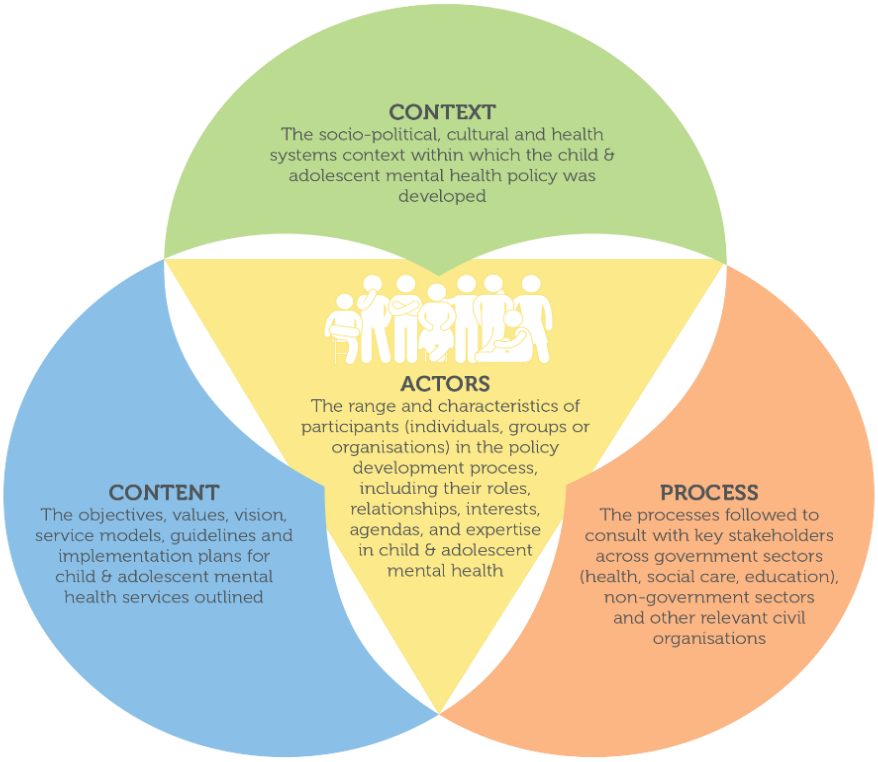

Figure 2.2 The Walt & Gilson policy triangle model (Walt & Gilson, 1994)

All obtained provincial documents were read and data extracted – focusing on the content, the context, the process of policy development as well as the actors involved in developing the policy. Apart from initial contacts made to access the documents, no formal interviews were conducted to obtain additional information.

2.3 Results

2.3.1 Policy documents identified

Table 2.2 provides a short definition of the types of policy-related documents identified and **Table 2.3** lists all documents identified. **Figure 2.3** shows the geographical distribution of the identified policy-related documents across the nine South African provinces and indicates the number of children and adolescents (< 18 years) per province.

Table 2.2 Short definitions of the different types of policy-related documents identified

Policy document	Explanation of the document
Stand-alone Mental Health Policy	Defines the vision for the future mental health of the population, specifying the framework which will be put in place to manage and prevent priority mental and neurological disorders.
Stand-alone CAMH Policy	Defines the vision for the future mental health of the children and adolescents, specifying the framework which will be put in place to manage and prevent priority mental and neurological disorders.
CAMH Plans	Is a pre-formulated detailed scheme to implement the vision and objectives defined in the CAMH policy. It includes the concrete strategies and activities to be implemented and specifies targets to be achieved by the government. It clarifies the roles of the different stakeholders in implementing the activities of the mental health plan.
Mental Health Legislation	Regulates mental healthcare and coordinates access to services. It sets out the rights and duties of patients and service providers and explains how the property of mentally ill persons may be dealt with in a court of law.
General Health Policy	Defines the vision for the future health of the population, specifying the framework which will be put in place to manage and prevent priority health disorders.
Strategic Plan	Outlines the broad strategic goals for the department.
Annual Performance Plans	Sets out a framework to align strategic plans and annual performance plans. Puts emphasis on the outcomes-oriented monitoring and evaluation approach.

Table 2.3 The National and provincial policy documents identified from the nine South African provincial Departments of Health websites

Policy Document	**National Level**	**Provincial Level**								
	South Africa	**Western Cape**	**Eastern Cape**	**KwaZulu-Natal**	**Northern Cape**	**Limpopo**	**Mpumalanga**	**Free State**	**North West**	**Gauteng**
Stand-alone Mental Health Policy	Mental Health policy framework and Strategic Plan 2013–2020 Department of Health, Republic of South Africa, 2013)	X	X	X	X	X	X	Provincial Mental Healthcare Policy. (22 Jan 2001) 2004 year of review: 2009 #outdated	X	X
Stand-alone CAMH Policy	Child and Adolescent Mental Health policy guidelines 2003 (Department of Health, Republic of	X	X	X	X	X	X	X	X	X

Policy Document	**National Level**	**Provincial Level**								
	South Africa	**Western Cape**	**Eastern Cape**	**KwaZulu-Natal**	**Northern Cape**	**Limpopo**	**Mpumalanga**	**Free State**	**North West**	**Gauteng**
	South Africa, 2003)									
CAMH Plans	None	X	X	X	X	X	X	X	X	X
Mental Health Legislation	Mental Health Act no. 17 of 2002									
Other Comprehensive General Healthcare Documents										
General Health Policy		Healthcare 2030: The Road to Wellness (Department of Health, Western Cape Government, 2014)	X	X	X	X	X	X	X	X

Policy Document	National Level	Provincial Level								
	South Africa	Western Cape	Eastern Cape	KwaZulu-Natal	Northern Cape	Limpopo	Mpumalanga	Free State	North West	Gauteng
Strategic Plan			X	Strategic Plan 2015–2019 (Department of Health, KwaZulu - Natal, 2015)	X	X	X	Free State Strategic 5-year Plan 2010/11–14/15 (Department of Health. Free State Province, 2010) #outdated	X	X
Annual Performance Plans			Annual Performance Plan 2013/14–15/16	X	X	Annual Performance Plan 2008/09–2011(March 2008) (Departments of Health & Social	Annual Performance Plan 2016/17 (Mpumalanga Department of Health, 2016)		X	X

Policy Document	National Level	Provincial Level								
	South Africa	Western Cape	Eastern Cape	KwaZulu-Natal	Northern Cape	Limpopo	Mpumalanga	Free State	North West	Gauteng
						Development. Limpopo, 2008) #outdated				

X: denotes that the provincial document could not be found . #: denotes an outdated document

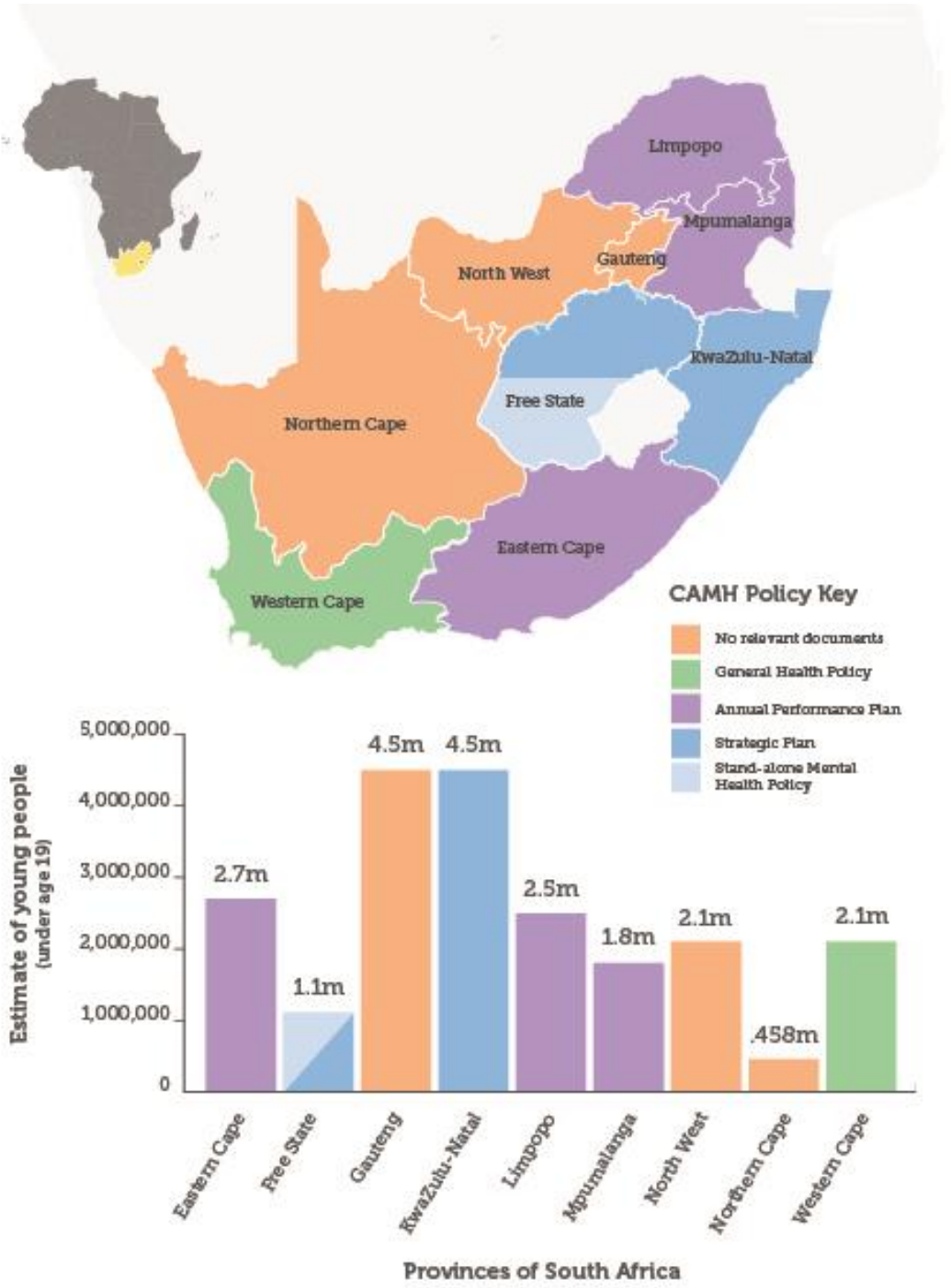

Figure 2.3 The geographical distribution of the identified policy-related documents across the nine South African provinces and the estimated number of children and adolescents (< 19 years) per province

1. Mental health policy

At national level, a mental health policy (Department of Health, Republic of South Africa, 2013) existed and children and adolescents were implicitly included in this policy. The Free State had an outdated stand-alone mental health policy (Department of Health, Free State Government, 2004) which was due for review in 2009. The updated version could not be accessed from the provincial website. The other eight provinces had no mental health policies.

2. Child and adolescent mental health policy

At national level, a CAMH policy (Department of Health, Republic of South Africa, 2003) was still in place. We were not able to identify a stand-alone provincial CAMH policy in any of the nine South African provinces, and there was no evidence of efforts to integrate the national CAMH policy into provincial general health policies.

3. Implementation plans

None of the nine provinces had implementation plans to support the national CAMH policy. Two provinces (Western Cape and KwaZulu-Natal) acknowledged in their general health policies and plan the need to separate children and adolescents from adults, and to strengthen CAMH capacity within the general service platforms. The other seven provinces had no documented implementation plans to support the national CAMH policy.

4. Strategic plans and annual performance plans

Only the annual performance plan 2016/17 of Mpumalanga showed evidence of proactive strategies to promote mental health and increase the number of patients screened for mental disorders and increasing the number of mental health teams. There was no specific mention of CAMH in the Mpumalanga or any of the other provincial strategic/annual performance plans.

2.3.2 Policy analysis using the Walt and Gilson policy triangle

1. The content

The content of all identified policy-related documents is summarised in **Table 2.4**. The outdated Free State mental health policy mainly focused on general mental health and did not make specific reference to children and adolescents. All of the nine provinces mainly focused on general health and strengthening PHC services using intersectoral collaboration, focusing mainly on Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), Tuberculosis (TB), and maternal and child health. There were no specific references to children and adolescents with mental health problems, and no clear guidelines for service provision for CAMH. The needs of children and adolescents with mental health problems were provided for within the general health population. Only the Western Cape, KwaZulu-Natal (KZN) and the Eastern Cape made specific reference to child and adolescent mental health disorders and the need to develop services for them.

Table 2.4 Content analysis of the provincial mental health and general health policy documents

	Free State		Western Cape	Limpopo	KwaZulu-Natal	Mpumalanga	Eastern Cape
Mental health and comprehensive general health document	Mental Healthcare Policy and Procedures Policy. 2004. Due for review: 2009 #outdated	5-year Strategic Plan 2010/11–2014/15 #outdated	Healthcare 2030: The Road to Wellness	Annual Performance Plan 2008/09–2011 #outdated	Strategic Plan 2015–2019	Annual Performance Plan 2016/17	Annual Performance Plan 2013/14–2015/16
Year	2009	2010	2014	2008	2015	2016	2013
Content focus	Emphasis is on provision of mental health services at all levels of care, using intersectoral collaboration between correctional services; justice; social development; education; NPOs, and groups of beneficiaries	Seven strategic goals: 1. Provision of strategic leadership and creation of social compact for better health outcomes 2. Improving the quality of healthcare services 3. Reducing the burden of disease 4. Revitalisation of physical infrastructure	Focuses on strengthening PHC and district hospital services as well as integration of services. CAMH falls into general health plans. The document focuses on reducing HIV and TB; improving healthy lifestyle; preventing injuries and violence; improving maternal and child	Policies and programmes are mainly focused on PHC, district healthcare, hospitals and resource management. The main focus is on reducing morbidity and mortality arising from communicable diseases; vaccination of preventable	Provision of sustainable, coordinated and integrated comprehensive health system at all levels using the PHC approach through the district health system.	Reference is made to promoting mental health and increasing the number of patients screened for mental disorders and increasing the number of mental health teams.	The focus is on re-engineering PHC and strengthening of Emergency Medical Services, pharmaceutical and hospital services.

	Free State		Western Cape	Limpopo	KwaZulu-Natal	Mpumalanga	Eastern Cape
		5. Improving human resources management 6. Overhauling the healthcare system and improving its management 7. Research and development	health; strengthening child health, and improving mental health	childhood diseases; diseases of lifestyle; HIV/AIDS and TB; trauma; and violence against women and children			
Service provision plans and clear guidelines for CAMH	No specific reference to children and adolescents	Some mention of mental health services and plans	No acknowledgement of the need to separate children with mental health disorders from adults and to develop service for them in future	No	Acknowledges CAMH disorders but unclear service provisions	No	Some recognition of CAMH disorders but no clear plans for service provision

Note: Northern Cape, Gauteng and North West provinces were excluded as no relevant documents were identified

2. The context

The context within which these general health policies were developed is summarised in **Table 2.5**. The contexts varied but were mainly based on the need to mitigate the challenges with HIV and AIDS, TB and maternal and child mortality, the demand for quality general health services, and the need to adhere to the Millennium Development Goals (MDGs). No reference was made to CAMH.

Table 2.5 Context analysis of the provincial mental health and general health policy documents

Province	Free State		Western Cape	Limpopo	KwaZulu-Natal	Mpumalanga	Eastern Cape
Policy Document	Mental Health Care Policy and Procedures Policy. 2004 Year of review: 2009 #outdated	5-year Strategic plan 2010/11–2014/15 #outdated	Health Care 2030	Annual Performance Plan 2008/09–2011 #outdated	Strategic Plan 2015–2019	Annual Performance Plan 2016/17	Annual Performance Plan 2013/14–2015/16
Year	2009	2010	2014	2008	2015	2016	2013
Context	Mental Health Care Act, No.17 of 2002 framework part of the legislative mandate	The need to address service delivery challenges comprehensively	The policy is driven by : 1. Changes in the external environment (demography, socio-economic determinants of health, burden of diseases and its associated risk factors such as	The plan is based on the five-year strategic plan aligned to the departmental Service Transformation Plan that provides long-term vision for the provision of health services in the province	The National Development plan 2030; the medium strategic framework 2014–2019; the provincial growth development plan 2030; the 2015 cabinet *lekgotla* resolutions; other	To put systems in place to ensure effective service delivery	Taking responsibility to support the nationwide effort in the realisation of MDGs; to mitigate HIV/AIDS and TB, as well as challenges around

Province	Free State		Western Cape	Limpopo	KwaZulu-Natal	Mpumalanga	Eastern Cape
			climate change, advances in technology and limited resources) 2. Changing policy environment and policy imperatives such as MDGs, the 2030 National Development Plan (NDP), the priority national health outcomes and the provincial strategic objectives to improve wellness 3. Need to ensure continuous improvement in patient experience and providing quality health services as well as caring for staff		sector priorities and the burden of diseases, and demand for service shaped the document		maternal and child mortality

3. The process and actors

All nine provinces engaged in a consultative process with various internal and external stakeholders (including non-governmental organisations and private sector) prior to endorsement by the Provincial Cabinet (see **Table 2.6** and **Table 2.7**). Various approaches were used, such as responding to stakeholder needs from the 'bottom-up', responding to national priorities in a 'top-down' approach, and through comprehensive reviews of previous policies, situational analyses, and weighing up of different alternative policies. However, we were not able to find documented evidence that any CAMH experts, service users (parents or children) or CAMH-related non-profit organisations (NPOs) were consulted or included in the process.

Table 2.6 Process analysis of provincial policy development

Province	Free State		Western Cape	Limpopo	KwaZulu-Natal	Mpumalanga	Eastern Cape
Policy Document	Mental Health Care Policy and Procedures Policy. 2004 Year of review: 2009 #outdated	5-year Strategic Plan 2010/11–2014/15 #outdated	Health Care 2030	Annual Performance Plan 2008/09 –2011 #outdated	Strategic Plan 2015–2019	Annual Performance Plan 2016/17	Annual Performance Plan 2013/14 –2015/16
Year	2009	2010	2014	2008	2015	2016	2013
Process	Various options were weighed, i.e. vertical programme, and a decision was taken to choose an option that will embrace the PHC approach and bring services closer to the people within the available resources. The Free State community	Extensive consultation within and between clusters (workshops and task teams) with top management structures, information systems and service delivery components. The document is approved by the acting HOD and the MEC.	The preliminary thought process was shared in a draft document circulated for public comment in 2012, and again in December 2013. Facilitated dialogue sessions were convened with a range of	No relevant data	The strategic plan was formulated through an extensive consultative process with internal and external stakeholders and was endorsed by the provincial cabinet. The process of formulating the strategic plan	No consultation with external stakeholders	Consultation with various stakeholders

Province	Free State		Western Cape	Limpopo	KwaZulu-Natal	Mpumalanga	Eastern Cape
	psychiatric approach was revised to be in line with the PHC approach.		external stakeholders Many submissions were received on both occasions and colleagues raised interesting, relevant and creative ideas. All comments were considered, and the written comments received individual responses. It was endorsed by the provincial cabinet.		was done in four phases: Phase 1: Performance reviews, Phase 2: Strategic vision and strategic priorities 2015 - 2019 , Phase 3: Top-down Bottom-up consultation to refine provincial priorities Phase 4: Finalising and tabling the document		

Note: Northern Cape, Gauteng and North West provinces were excluded as no relevant documents were identified

Table 2.7 Actors involved in development of the provincial mental health and general health policy documents

Province	Free State		Western Cape	Limpopo	KwaZulu-Natal	Mpumalanga	Eastern Cape
Policy Document	Mental Health Care Policy and procedures policy. 2004 Year of review: 2009 #outdated	5-year Strategic Plan 2010/11–2014/15 #outdated	Healthcare 2030: The Road to Wellness	Annual Performance plan 2008/09–2011 #outdated	Strategic Plan 2015–2019	Annual Performance Plan 2016/17	Annual Performance Plan 2013/14 –2015/16
Year	2009	2010	2014	2008	2015	2016	2013
Actors	Assistant manager (Mental Health and substance abuse); manager (personal health); and various unspecified stakeholders from all other departments and at all levels from bottom-up	Top management structures, management structures, acting HOD and MEC	Unspecified internal and external stakeholders (the public, geographic service area management teams, Provincial Cabinet)	The works of the department were coordinated by the head office which provides the legislative interface between the governments, civil society and other relevant unspecified stakeholders, and provides strategic direction and overall management and	Unspecified internal and external stakeholders	The document was developed by the Provincial Department of Health in Mpumalanga, under the guidance of the MEC	Department of Health

Province	Free State		Western Cape	Limpopo	KwaZulu-Natal	Mpumalanga	Eastern Cape
				administration of the department			
Inclusion of child and adolescent mental health experts and users in the formulation of these policies	No data	No data	No data	No data	No data	No data	

Note: Northern Cape, Gauteng and North West provinces were excluded as no relevant documents were identified

4. Comparison of findings to previous analysis in 2010

Table 2.8 shows a comparison of the previous situational analysis (Kleintjes et al., 2010) and the current state of CAMH policy development and implementation at provincial level. The results showed that there is still no provincial mental health or CAMH policies in any of the nine provinces. The national legislation is still used to guide service provision. The Northern Cape provincial mental health policy is still awaiting formal adoption.

Table 2.8 A comparison between the earlier situational analysis (Kleintjes et al., 2010) and the current state of child and adolescent mental health policy development and implementation at provincial level

	Kleintjes et al. (2010)		**Current state of CAMH policy development and implementation (this study)**	
Documents	**National**	**Provincial**	**National**	**Provincial**
Mental Health Policy	National Mental Health Policy Guidelines of 1997 (not formally adopted)	None	National Mental Health Policy Guidelines of 1997 formally adopted in 2013	None
Mental Health Plans	None	Northern Cape Mental Health draft plan	Mental Health Policy Framework and Strategic Plan 2013–2020	None Northern Cape Mental Health Plan finalised 2008 but not yet officially adopted
CAMH Policy	CAMH Policy Guideline 2002	None	CAMH Policy Guideline 2002	None
CAMH Plan	None	None	None	None
Mental Health Legislation	Mental Health Act no.17 of 2002	Mental Health Act no. 17 of 2002	Mental Health Act no.17 of 2002	Mental Health Act no. 17 of 2002

	Kleintjes et al. (2010)		Current state of CAMH policy development and implementation (this study)	
Documents	**National**	**Provincial**	**National**	**Provincial**
Provision for the protection of minors in National Legislation	The legislation addressed only one out of six provisions recommended for the protection of minors by the WHO Legislation Checklist	The legislation addressed only one out of six provisions recommended for the protection of minors by the WHO Legislation Checklist	The legislation addressed only one out of six provisions recommended for the protection of minors by the WHO Legislation Checklist	The legislation addressed only one out of six provisions recommended for the protection of minors by the WHO Legislation Checklist
Inclusion of child and adolescent mental issues in National Legislation	No	No	No	No

2.4 Discussion

The aim of this chapter was to examine the current state of CAMH policy development and implementation in the nine provinces of South Africa, and to perform a policy analysis of all CAMH-related policy documents. We started with a brief history of events that led up to the development of a National CAMH policy. We expected that, after the formal adoption of the overarching National CAMH policy, all provinces would have clear CAMH policies and implementation plans to support the National CAMH policy, but this was not the case. None of the nine provinces had a current CAMH policy or plan. Only the Western Cape and KwaZulu-Natal overtly acknowledged the need for plans to separate children from adults and to attend to the specific needs of children and adolescents with mental health disorders.

Using the Walt and Gilson policy analysis triangle (1994), we examined the content, context, processes and actors involved. In terms of content analysis, none of the nine provinces addressed the specific needs of children and adolescents with mental health disorders. Where CAMH was mentioned, it was very superficial and non-specific. There were no clear guidelines and plans for service provision. With regard to the context under which these provincial policies were developed, drivers were predominantly the burden of HIV and AIDS, TB, and maternal and child mortality, the demand for quality general health services, and the need to adhere to the Millennium Development Goals. Regarding processes involved in policy development, we observed a range of approaches (bottom-up and top-down) used by provinces to engage with often unspecified internal and external stakeholders and with non-governmental organisations to develop policies. However, from the document review, we were not able to identify any clear evidence that any CAMH experts and/or CAMH users (parents and/or young people) were included as actors in the process.

While there has been progress at national level since the last study by Kleintjes and colleagues (2010) with regards to the formal adoption of the overarching national mental health policy, findings at provincial level were essentially unchanged and shows clear evidence of ongoing neglect of CAMH policy development and implementation at provincial level. Examples such as the lack of adoption of the draft mental health plan in the Northern Cape since finalisation in 2008 and lack of explicit inclusion of CAMH in the provincial general health policies raise major concerns about content and implementation of mental health policies in South Africa, and particularly with regard to the mental health of children and adolescents.

We acknowledge that there may be many barriers to policy development and implementation in LMIC. Some of the barriers to the implementation of the national policy identified by Schneider and colleagues (Schneider et al., 2016) included lack of capacity of staff, shortage of staff, inadequate finance, and the burden of mental health disorders, and CAMH disorders.

However, the lack of policy development and implementation in CAMH may exacerbate CAMH problems (Shatkin & Belfer, 2004) and impact negatively on service delivery. Nearly forty per cent (40%) of all South Africans are under the age of 18 years and the mental health burden is of great concern for this sector of the population. There is therefore an urgent need for action to recognise CAMH as a health priority, and for the South African government to mandate the development of appropriate and relevant CAMH policies, implementation and monitoring plans.

These findings highlight an urgent need for each province to develop CAMH policy and implementation plans to give effect to the National CAMH policy. While we acknowledge the barriers to CAMH policy development and implementation (Dawes et al., 2005; Schneider et al., 2016; Shatkin & Belfer, 2004), we advocate that CAMH policy and implementation plans are still required to provide a framework for service delivery which will be relevant to the needs of young people.

One way to do this is for the provincial government to commit to incorporating research findings into planning and policy development. This requires a close relationship and engagement between the provincial government and the researchers. Research on the current state of CAMHS is required in each province. The first step is to conduct a situational analysis of CAMHS at provincial level in order to map the current state of CAMHS, to identify the gaps and the needs. Secondly, the stakeholders in CAMHS, i.e. users and providers should be engaged in order to gather their lived experiences and perceptions of the CAMHS that are offered to them, and to contribute to the recommendations for policy development. Lastly, researchers should engage policymakers with their findings in order to ensure policy planning and implementation.

2.5 Conclusions

In spite of the upper-middle-income status of South Africa, the absence of any provincial CAMH policy and plans were deeply concerning, but sadly in keeping with findings from other LMIC. Findings reinforce the widespread neglect of CAMH even at policy level, despite the well-recognised burden of CAMH disorders.

We acknowledge that we were only able to analyse documents that were publicly available. Documents not officially adopted and those not publicly available were not included in the analysis. It is therefore possible that there may have been relevant documents that are up to date that we could not access. However, we would better argue that, in the spirit of transparency, provincial and national policies should be readily and electronically available to facilitate communication and implementation of policies.

There is an urgent need for development and implementation of provincial CAMH policies and implementation plans in South Africa and in LMIC. Further research will also be required to identify and explore the barriers that continue to prevent CAMH policy and service development, and scale-up.

2.6 Chapter Summary

There is lack of policy development and implementation for CAMH, particularly in LMIC where children and adolescents represent up to 50% of populations. South Africa, an upper-middle-income country is often regarded as advanced in health and social policymaking and implementation compared to other LMIC. It is, however, not clear whether this is the case for CAMH. The study sought to examine the history and current state of CAMH policy development and implementation, and to perform a systematic analysis of all available CAMH service-related policies. A comprehensive search was performed to identify all provincial mental health and comprehensive general health policies across all nine South African provinces. The Walt and Gilson policy triangle

framework (1994) was used for analysis. We found that no South African province had a CAMH policy or identifiable implementation plans to support the national CAMH policy. Provincial comprehensive general health policies addressed CAMH issues only partially and were developed mainly to address the challenges with HIV/AIDS, TB, maternal and child mortality and adherence to the Millennium Development Goals. The process of policy development was typically a consultative process with internal and external stakeholders. There was no evidence that CAMH professionals and/or users were included in the policy development process. Despite South Africa's upper-middle-income status, the absence of any publicly available provincial CAMH policy documents was concerning, but in keeping with findings from other LMIC. Our results reinforce the neglect of CAMH even at policy level, despite the burden of CAMH disorders. There is an urgent need to develop and implement CAMH policies in South Africa and other LMIC. Further research will be required to identify and explore the barriers to policy development and implementation, and to service development and scale-up in CAMH.

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Chapter 3: A situational analysis of child and adolescent mental health services in the Western Cape

3.1 Introduction

The mental health of children is a global health priority, yet it is generally known that services are limited, particularly in low- and middle-income countries (Juengsiragulwit, 2015; Kleintjes et al., 2010). As outlined in Chapter 1, health system strengthening requires an understanding of multiple landscapes: the policy and resource landscape (representing mostly hardware elements of health systems), and the landscape as perceived by stakeholders (which would describe both hardware and software elements of the healthcare system) (Gilson, 2012; World Health Organization, 2007). Hardware typically refers to human resources, financing, medicines, technology, organisational structure, service infrastructure, and information systems, while the software typically refers to ideas and interests, relationships and power, values and norms, and the interactions between all factors and actors (Gilson, 2012; World Health Organization, 2007).

As stated by the WHO (2007) and summarised by Gilson (2012), all the components of a health system should be balanced in order for the system to be responsive to the needs of the community it serves. A good enough health system should have sufficient resources that are equitably distributed, and human resources that have sufficient competencies to respond to the needs of the population (World Health Organization, 2007).

In Chapter 2, we examined one hardware element of CAMHS in South Africa, namely the policy level. As described in the chapter, a national CAMH policy was identified, but no South African province had any provincial CAMH policies, plans or implementation documents, confirming that this aspect of systems hardware was clearly lacking. In this chapter, we progress to a broader situational analysis of the resource landscape for CAMHS.

Whilst we firmly acknowledge that child and adolescent mental health problems cut across all systems and sectors, for the purpose of this study, in the context of time, resources and scope, this situational analysis focused on the health system and mainly the Department of Health, rather than on other or multiple sectors. The geographical focus of our work is South Africa, an upper-middle-income country that has some of the greatest economic and health disparities in the world (Mayosi & Benatar, 2014; World Bank, 2018). A situational analysis conducted by Kleintjes and colleagues in 2005 evaluated key aspects of CAMHS in South Africa, Uganda, Zambia and Ghana. In comparison to the other three sub-Saharan African countries, South Africa had relatively more CAMH resources (Kleintjes et al., 2010). However, only 1.4% of all mental health outpatient services in the country were dedicated to CAMHS, only 3.8% of mental health beds in general hospitals were for CAMHS, only 1% of specialist mental health hospital beds were for CAMHS, and only 1% of day patient facilities in the country were dedicated to CAMHS. There were no specialist CAMH hospitals. The number of psychiatrists (general, and child & adolescent psychiatrists combined) was estimated at 0.28 per 100,000. No data were available on the number of mental health professionals in schools (Docrat et al., 2019). Qualitative data from semi-structured interviews with key stakeholders in the Kleintjes (2010) study proposed three main themes as the reasons for the very low resources for CAMHS: first, the impact of stigma associated with mental health disorders; second, the low priority of all aspects of mental health in low- and middle-income countries; and third, the lack of attention to the link between poverty and poor mental health (Kleintjes et al*.,* 2010). While these proposed reasons are understandable when comparing mental health with physical health services, Kleintjes and colleagues did not attempt an explanation for the underrepresentation of child and adolescent *versus* adult mental health services.

No situational analysis has been performed since the 2010 study by Kleintjes and colleagues and – to our knowledge – no study has conducted a finer-grained situational analysis of CAMHS in South Africa or any other LMIC.

3.1.1 The Western Cape Province of South Africa

In order to perform a more detailed situational analysis of CAMHS, we selected the Western Cape as a case study for our work. The Western Cape was selected for two reasons: Firstly, it is one of the provinces with better resources in terms of health services (Lund et al, 2010; Flisher et al., 2012) and therefore more accessible for research scrutiny in terms of data sources, documents and dedicated staff for mental health. Secondly, it is the base of our own clinical activities in the Division of Child and Adolescent Psychiatry (DCAP) at the University of Cape Town. It therefore represents the immediate and direct health system and services in which we are actors.

In 2016, the year selected for data collection, South Africa had an overall estimated population of 55.9 million (Stats SA, 2016). The Western Cape, one of the nine provinces of South Africa, was the fourth largest both in land size and population. The estimated population was 6.3 million of which 2.1 million (33.9%) were children and adolescents under the age of 19 years. The province has rural and urban areas and is served by one metropolitan municipality (City of Cape Town) and five district councils (West Coast, Cape Winelands, Overberg, Eden and Central Karoo). The metropolitan municipality is divided into four (4) main substructures: The Southern/Western substructure, the Klipfontein/Mitchell's Plain substructure, the Northern/Tygerberg substructure, and the Khayelitsha/Eastern substructure. **Figure 3.1** shows the province and its urban and rural structures, substructures and districts.

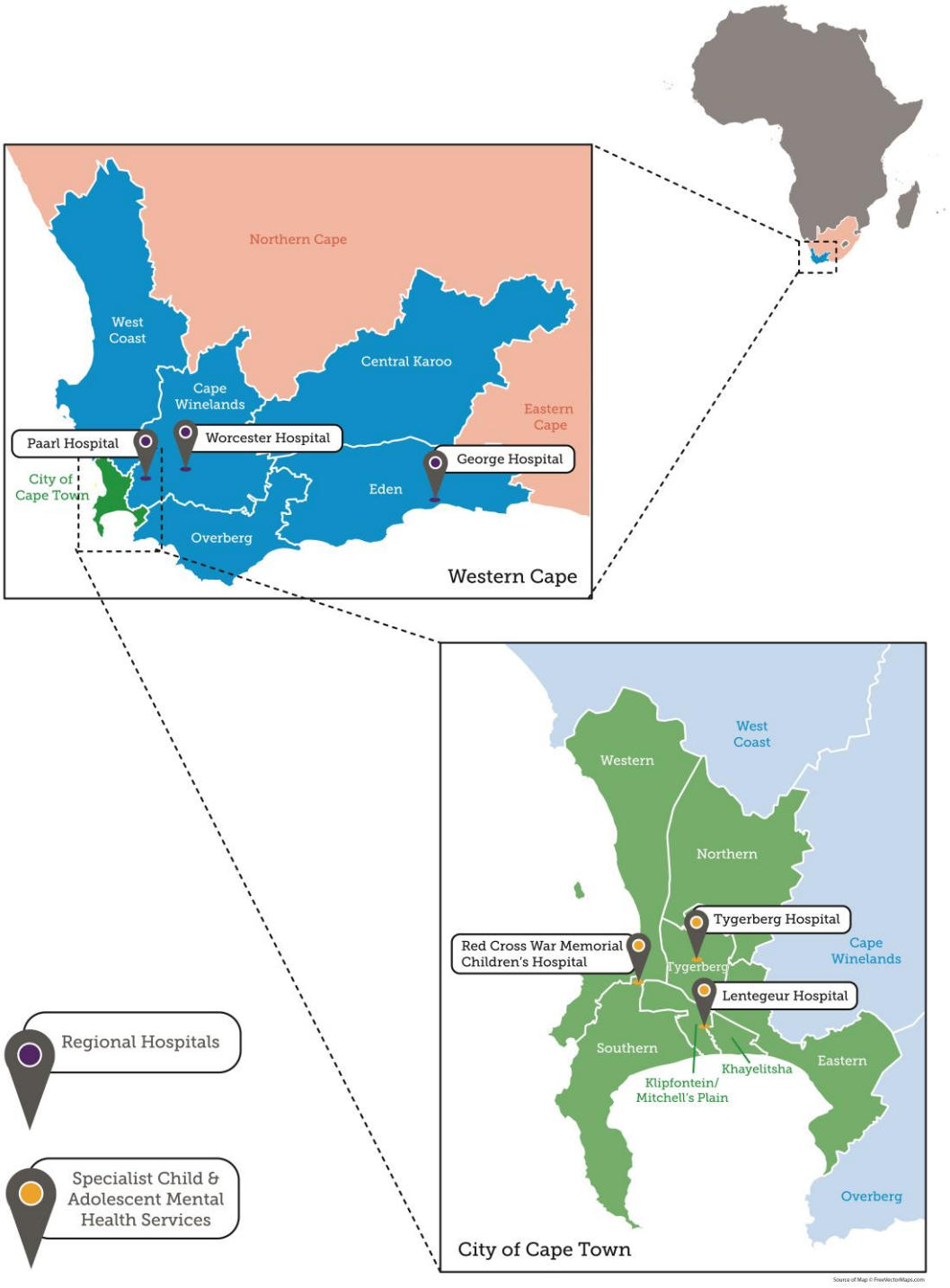

Figure 3.1 Map of the Western Cape Province showing the metropolitan area (the City of Cape Town and its substructures) and rural health districts. Urban areas are indicated in green; rural areas are indicated in blue. The figure also shows the location of regional hospitals and specialist CAMH units

In 2016, 63.8% of the population lived in the City of Cape Town, followed by the Cape Winelands (13.8%), Eden (9.7%), West Coast (6.9%), Overberg (4.6%), and the Central Karoo (1.2%) (Stats SA, 2016). **Table 3.1** shows a more detailed population distribution in the Western Cape by district in 2016. Unfortunately, no disaggregated data were published in the 2016 Census that would allow separation of adolescents (under the age of 19) and younger adults in the 15**–**34-year age groups.

Table 3.1 Population distribution by Western Cape district in 2016 (data from Stats SA, 2016)

2016 Community Survey						
	General population		Children, adolescents and young adults			
			0–14 yrs		15–34 yrs*	
District / municipality	N	%	N	%	N	%
West Coast	436,403	6.9	113,113	25.9	153,472	35.2
Cape Winelands	866,001	13.8	230,708	26.6	316,210	36.5
Overberg	286,786	4.6	74,764	26.1	94,453	32.9
Eden	611,278	9.7	155,008	25.4	207,010	33.9
Central Karoo	74,247	1.2	18,862	25.4	27,936	37.6
City of Cape Town	4,005,016	63.8	1,042,259	26.0	1,331,960	33.3
Total	**6,279,730**	**100.0**	**1,521,601**	**24.23**	**1,977,569**	**39.49**

***The Census data did not provide any disaggregation between adolescents and younger adults in the 15–34-year age groups.**

The overall prevalence of CAMH disorders, adjusted for local population factors, comorbidity and adjusted according to the risk factors in the Western Cape, were estimated to be 17% (Kleintjes et al., 2006). It should be noted that these estimates did not include infant mental health disorders, autism spectrum disorders or neurodevelopmental disabilities other than intellectual disability, suggesting that these rates may be an underestimate of the true prevalence of CAMH disorders in the province. Nevertheless, the estimates certainly highlight the burden of CAMH problems in the province, and the need for service provision.

Previous reviews of services and resources suggested a clear neglect of provision for CAMHS in the Western Cape (Lund & Flisher, 2006; Lund et al., 2010; Kleintjes et al., 2010; Docrat, Besada, Cleary, Daviaud & Lund, 2019). However, as acknowledged by previous authors, due to inadequate information systems, little or no data were available on children and adolescents with mental health problems in primary healthcare settings, general hospital outpatient and inpatient settings, or in specialist CAMH facilities (Lund & Flisher, 2006; Docrat et al., 2019).

3.1.2 Situational analysis and the World Health Organization Assessment Instrument for Mental Health Systems

The WHO-AIMS version 2.2 of 2005 (World Health Organization, 2005) is the WHO framework for conducting situational analyses in LMIC. It was conceptualised and developed by the Mental Health Evidence and Research Team (MER) of the Department of Mental Health and Substance Abuse (MSD) at the WHO, in collaboration with colleagues inside and outside the WHO. The tool is used to collect information on mental health systems with the goal of providing baseline data that can be used to improve mental health systems and to monitor change. The WHO-AIMS framework includes six domains, 28 facets and 156 items to cover key aspects of mental health systems. It includes a brief version that can be used to collect data on a reduced number of variables about mental health systems. Both versions of the WHO-AIMS were developed with general mental health services (as opposed to CAMH) in mind. In fact, the WHO-AIMS framework has only one item specifically on CAMHS (Domain 2, item 2.2.6/Brief version item B13) on the number of children 18 years or younger treated at mental health outpatient facilities, including the proportion of under-19-year-olds treated in comparison to all patients treated. In South Africa, the WHO-AIMS Brief version was previously used to assess CAMHS at national level (Kleintjes et al., 2010), and has been used to assess general mental health services at a regional/provincial level (Petersen et al., 2009).

3.2 Methods

3.2.1 Study design

This was a descriptive situational analysis of CAMHS in the Western Cape Province of South Africa.

3.2.2 Data collection

The Brief version of items from the WHO-AIMS version 2.2 of 2005 was adapted to collect data on CAMHS. We selected 37 items of direct relevance and modified them to focus on CAMHS. **Table 3.2** shows the WHO-AIMS items adapted for this situational analysis. Data were collected for the calendar year January to December 2016. The situational analysis focused mainly on the Department of Health (DoH) and the public health sector, and not on the private health sector or other government departments. WHO-AIMS checklists/survey questionnaires were distributed to key stakeholders in the provincial Department of Health (DoH). Based on the WHO-AIMS table of data sources, relevant documents and records were requested from regional offices, and from individual hospital/clinical facilities in order to complete the questionnaires and fill in any data gaps. The research team established and maintained contact with these key stakeholder groups to follow up on the questionnaires, to identify and assist with any difficulties pertaining to the information required, and to verify the information provided. In addition, electronic searches for relevant information through provincial websites and Web of Science (version 5.34) were performed. After collation of all data, further clarifications were sought between January and May 2020 as a final validation check for any potential additional data that may have become available before preparation of this manuscript.

Table 3.2 Variables of interest adapted from the WHO-AIMS version 2.2 (Brief version) for this situational analysis

WHO-AIMS Domains	Western Cape provincial data collected
1. Policy and legislative framework	1.1 CAMH policies, plans, and legislations (B1, B3, B4) 1.2 Human rights legislation relevant to children and adolescents (B5) 1.3 Financing: Expenditure on CAMHS by the provincial DoH (B6)
2. Clinical services for children and adolescents with mental health disorders	2.1 Existence and functions of a regional CAMH authority (B9) 2.2 Organisation of CAMH services in terms of catchment areas (B10) 2.3 Outpatient services: Availability of CAMH outpatient facilities, and number/proportion of children and adolescents treated for mental health problems through outpatient facilities at primary, secondary and tertiary levels of care (B11, B12, B13) 2.4 Inpatient services: Availability of CAMH inpatient facilities, and number/proportion of children and adolescents treated (B15, B16, B17) 2.5 Availability of CAMH day patient facilities, community residential facilities, forensic facilities, or CAMH hospitals (B14, B18, B19, B25) 2.6 Interventions (medications): Psychotropic medicines appropriate for children and adolescents included on the essential medicines list; free access to essential psychotropic medicines, and availability of medicines in outpatient and inpatient settings at secondary and tertiary levels of care (B2, B8, B28, B29) 2.7 Interventions (psychosocial): Access to psychosocial interventions in outpatient and inpatient settings at secondary and tertiary levels of care (B26, B27)
3. CAMH in Primary Healthcare	3.1 Refresher training in CAMH provided to PHC doctors, nurses or other staff and interaction of PHC with specialist CAMHS (B31–B35) 3.2 Availability of medicines and psychosocial interventions in PHC facilities (B27, B33)
4. Human resources	4.1 Human resources in CAMHS (B38–B41)
5. Public education and links with other sectors	5.1 Public education and awareness campaigns about CAMH (B47)
6. Monitoring and research	6.1 Monitoring CAMHS (B52, B53) 6.2 Research in CAMH (B54)

CAMH = child and adolescent mental health; B items listed in brackets e.g. (B1) refer to items as listed in the WHO-AIMS Brief Version.

3.2.3 Data capturing and analysis

All data sources were collated and numbered as primary sources of findings. Data sources and data source numbers (DSN) are shown in **Table 3.3**. Data were captured on the WHO-AIMS Excel Data Entry program version 2.2 of 2005 for analysis. Analysis was performed through descriptive statistics of variables of interest as outlined in **Table 3.2**.

Table 3.3 Data sources and data source numbers (DSN)

Data Source Number (DSN)	Data source	Website link
DSN01	Policy guidelines. Child and Adolescent Mental Health, 2003	http://www.health.gov.za/index.php/shortcodes/2015-03-29-10-42-47/2015-04-30-08-29-27/mental-health?download=615:policy-guidelines-on-child-and-adolescent-mental-health
DSN02	Healthcare 2030. The Road to Wellness, Western Cape Department of Health	https://www.westerncape.gov.za/assets/departments/health/healthcare2030.pdf
DSN03	Mental Health Act no.17 of 2002. National Department of Justice	http://www.justice.gov.za/legislation/acts/2002-017_mentalhealthcare.pdf.
DSN04	Child Care Act 74 of 1983, National Department of Social Development	https://www.westerncape.gov.za/assets/departments/social-development/child_care_act_74_of_1983.pdf
DSN05	Western Cape Provincial Deputy Director for Mental Health and Substance Abuse	Interview on 9 February 2017 (data available from the author)
DSN06	Provincial Mental Health Directory, Department of Health, 2015	https://pmhp.za.org/wp-content/uploads/DoH-Mental-Health-Resource-Directory-2015.pdf
DSN07	Budget 2016 Summary, Western Cape Department of Health	https://www.westerncape.gov.za/assets/departments/treasury/Documents/Budget/2016/2016_budget_summary_budget_day_3_march_2016.pdf
DSN08	Budget Overview of Provincial Revenue and Expenditure 2016, Treasury of the Western Cape Government	https://www.westerncape.gov.za/assets/departments/treasury/Documents/Budget/2016/2016_overview_of_prov_rev_exp_march_web.pdf

Data Source Number (DSN)	Data source	Website link
DSN09	Budget Estimates of Provincial Revenue and Expenditure 2016, Treasury of the Western Cape Government	https://www.westerncape.gov.za/assets/departments/treasury/Documents/Budget/2016/2016_estimates_prov_rev_exp_march_2016_incl_addendums.pdf
DSN10	Mental Health Services in the Western Cape, Western Cape Department of Health	https://www.westerncape.gov.za/general-publication/mental-health-services-western-cape
DSN11	Division of Child and Adolescent Psychiatry (DCAP), Western Cape Department of Health	https://www.westerncape.gov.za/general-publication/division-child-and-adolescent-psychiatry-dcap
DSN12	Mental Health Hospital Services, Western Cape Department of Health	https://www.westerncape.gov.za/service/mental-health-hospital-services
DSN13	Catchment Areas for Tertiary Child and Adolescent Psychiatry Units in the Western Cape	Data provided by the Head of Clinical Unit, Division of Child and Adolescent Psychiatry (12 March 2020) (data available from the author)
DSN14	Western Cape Mental Health Data and Facilities List 2016, Western Cape Department of Health	Mental Health provincial information system. The information is not publicly available but was provided by the Provincial Data Management Office for the purposes of this study (data available from the author)
DSN15	Tygerberg Hospital Annual Report 2016, Western Cape Department of Health	https://www.westerncape.gov.za/sites/www.westerncape.gov.za/files/tygerberg_hospital_annual_report_2016_web.pdf
DSN16	Court Diversion in the Western Cape Province	https://www.westerncape.gov.za/general-publication/what-diversion
DSN17	Standard treatment guidelines and essential medicines list for South Africa. Hospital level paediatrics, 2017 edition	http://www.health.gov.za/index.php/standard-treatment-guidelines-and-essential-medicines-list/category/456-hospital-level-paediatrics

Data Source Number (DSN)	Data source	Website link
DSN18	First 1,000 Days Campaign, Western Cape Government	https://www.westerncape.gov.za/general-publication/first-1-000-days-campaign
DSN19	2016 Annual Report, Salesian Life Choices	https://www.lifechoices.co.za/sites/default/files/2017-10/lc_annual_report_2016-final_update_2.pdf
DSN20	How to handle bullying, Western Cape Education Department	https://www.westerncape.gov.za/general-publication/how-handle-bullying
DSN21	16 Days of Activism for no violence against women and children, Western Cape Department of Social Development	https://www.westerncape.gov.za/general-publication/what-16-days-activism
DSN22	Web of Science (version 5.34) data search, April 2020	(data available from the author)

3.3 Results

Below we will outline the results for each of the variables of interest shown in **Table 3.2**. Each finding will include one or more data source number (DSN) as reference to the evidence for the finding.

3.3.1 WHO-AIMS Domain 1: Policy and legislative framework

1. Policies, plans, and legislations

Chapter two discussed the fact that there was no provincial CAMH policy document and no provincial plan to give effect to the national CAMH policy (DSN01). There was a general healthcare policy (DSN02) which did not focus on CAMHS. Interestingly, the policy acknowledged the need to separate CAMHS from adult psychiatric services, but did not present any specific plan to do so. There was no province-specific CAMH mental health legislation. The National Mental Health Act no. 17 of 2002 (DSN03) and the Child Care Act 74 of 1983 (DSN04) were used as legal frameworks in the province (DSN05).

2. Human rights legislation relevant to children and adolescents

To ensure that the human rights of all people (including children and adolescents) were met, a human rights review body (Mental Health Review Board) existed. Its functions included acting as licensing directorate for non-profit organisations, mental health programme audits, and monitoring (DSN05–DSN06). All specialist CAMH units had at least one annual external review/inspection of human rights protection of patients (DSN05). In addition, all specialist CAMH inpatient units had admission, discharge, and seclusion policies, complaints and appeals processes, and procedures to ensure the protection of human rights (DSN05).

3. Expenditure on child and adolescent mental health services by the Provincial Department of Health

There was no separate budget for CAMHS, and no budgetary information was presented in a way that could allow disaggregation of adult versus child and adolescent mental health budgets. Primary healthcare budgets were

integrated into the overall District Health Services (Community Health Centres and Community-based services) budget. Secondary care budgets were integrated into District Hospital budgets. Tertiary care budgets were integrated either into Provincial Hospital Services (specialised psychiatric hospitals where some tertiary CAMH specialist units were situated) or into Central Hospital Services (central and tertiary hospitals where two tertiary CAMH specialist services were situated). CAMHS would have been delivered to outpatients at primary care, to outpatients and emergency inpatients at secondary level of care, and to outpatients, emergency inpatients and longer-term inpatients at tertiary level of care.

As shown in **Table 3.4** the overall health services budget in the province for 2016/2017 was just under R20 billion. Of this amount, ~R7.8 billion (39.2%) was allocated to District Health Services, ~R5.6 billion (28.5%) to Central Hospital Services, ~R3.2 billion (16%) to Provincial Hospital Services, of which ~R589 million (2.9% of the total health budget) was allocated to mental hospitals (DSN07–DSN09). Given that none of these groupings provided services exclusively to children and adolescents with mental health problems, it was not possible to identify any CAMH-specific expenditure.

Table 3.4 Western Cape provincial budget for 2016/17 (DSN07–DSN09)

Total health budget in South African Rand	Primary and secondary level	Tertiary level	
	District Health Services	Provincial Hospital Services	Central Hospital Services
R19.983 billion	R7.826 billion (39.2%)	R3.199 billion (16%)	R5.697 billion (28.5%)
		Non-mental health services	Mental health hospitals
		R2.610 billion (13.1%)	R589 million (2.9%)

R = South African Rand; At the time of publication (Aug 2020), R1 was equivalent to US$0.058.

3.3.2 WHO-AIMS Domain 2: Child and adolescent mental health resources

1. Existence and functions of a regional child and adolescent mental health authority

There was no provincial authority exclusively for CAMHS and no provincial director for mental health. There was a provincial deputy director for mental health and substance abuse. The role of the post-holder was to coordinate all mental health services (including CAMHS) within the province to a) ensure development and implementation of the national policy and legislation, b) oversee monitoring of services, c) facilitate equitable budgets for mental health, d) work closely with district health managers, all stakeholders and sectors, and e) evaluate services and policy implementation (DSN05–DSN06). The deputy director reported to the provincial director of health programmes.

2. Organisation of child and adolescent mental health services in terms of catchment areas

CAMHS were provided based on where families lived in the province, referred to as geographical service areas (GSAs) or catchment areas, as shown in **Figure 3.1**. Services were provided across three levels of care: primary (level 1), secondary (level 2) and tertiary (level 3). The basic patient flow for service

organisation was for children and families to start their CAMH 'journey' at level 1 services (their catchment area primary healthcare clinic), where they would be seen by a mental health nurse and, if required, a medical officer (a generally-trained doctor). When primary healthcare teams did not feel able to diagnose or treat the child and family, they would be referred to level 2 (their catchment area district hospital) where they would be seen by a general mental health nurse and, if required, a general psychiatrist. At level 2 children and families may also be seen by paediatric services depending on the reason and pathway for referral. When level 2 teams did not feel able to diagnose or treat the child and family, they would refer them to level 3 services. These are services with multidisciplinary expertise in child and adolescent mental health, including child mental health nurses, psychologists with expertise in child mental health, and subspecialist child & adolescent psychiatrists. We refer to level 3 services as 'specialist CAMHS'. Each specialist CAMH team served a specific metropolitan catchment area, specific district hospitals in that catchment area, as well as a specific rural area and its regional hospital. **Table 3.5** shows the catchment areas for each specialist CAMHS unit (DSN05, DSN10–DSN12).

In 2016 there were three specialist CAMH service units, all based in the metropolitan municipality. The Division of Child and Adolescent Psychiatry (DCAP) (University of Cape Town) was based at Red Cross War Memorial Children's Hospital in the Southern substructure, the Tygerberg Child and Adolescent Psychiatry team (Stellenbosch University) was based at Tygerberg Hospital, a general tertiary hospital in the Northern substructure, and the Lentegeur Child and Family Unit (University of Cape Town and Stellenbosch University) was based at Lentegeur Hospital, a mental hospital in the Mitchell's Plain substructure (DSN10–DSN12).

Table 3.5 Catchment areas for specialist child and adolescent mental health services (DSN13)

Specialist CAMH unit	Metropolitan (urban)		Rural	
	Metro catchment area	**District hospitals**	**Rural catchment area**	**Regional hospital**
Division of Child and Adolescent Psychiatry (DCAP)	Southern Western Portion of Klipfontein	New Somerset Hospital Victoria Hospital False Bay Hospital Groote Schuur Hospital Red Cross District Service	Eden	George Hospital
Tygerberg Child and Adolescent Psychiatry team	Northern Tygerberg Portion of Eastern	Karl Bremer Hospital Eerste River Hospital Tygerberg Hospital district service	Portion of Cape Winelands West Coast	Paarl Hospital
Lentegeur Child and Family Unit (CFU)	Khayelitsha Mitchell's Plain Portion of Eastern Portion of Klipfontein	Khayelitsha Hospital Mitchell's Plain Hospital Helderberg Hospital	Overberg Central Karoo Portion of Cape Winelands	Worcester Hospital

The specialist CAMH service units offered outpatient services to children and families in their catchment areas. Children and adolescents with any mental health problem could be referred by a specialist (psychiatrist or paediatrician) from a relevant catchment area (DSN06, DSN10–DSN12).

In the time period of this study (January–December 2016), the three units had areas of particular expertise: autism spectrum disorder and infant mental health at DCAP, neuropsychiatric conditions at Tygerberg, and substance abuse and rehabilitation at Lentegeur. Specialist inpatient services were

available at each of the three specialist CAMH units but were not based on catchment areas. Instead, they were based on age and/or clinical profile of the child or adolescent. For instance, DCAP had an inpatient unit for children under 12, while Tygerberg and Lentegeur Hospitals had adolescent inpatient units (DSN10–DSN12).

There were also two units that could admit adolescents with intellectual disabilities (IQ below 70), one based at Alexandra Hospital, a mental hospital for people with intellectual disabilities, and the other at Lentegeur Hospital. Both these hospitals were in the metropolitan municipality. The units offered inpatient and outpatient services for older adolescents with dual diagnosis (intellectual disabilities and a mental health problem) alongside adults with intellectual disabilities, and served all the districts of the Western Cape. The exclusion criteria for these units were social problems in the absence of intellectual disabilities and comorbid mental health problems, and patients with forensic histories (DSN06, DSN10–DSN12).

Even though catchment areas and GSAs were clear for general outpatient referrals at primary and secondary levels of care, this was not the case for particular areas of expertise at tertiary level of care, or for inpatient referrals at tertiary level. In addition, there were no specialist CAMHS in any of the rural districts (DSN10–DSN13).

3. Availability of child and adolescent mental health outpatient facilities, and number/proportion of children and adolescents treated for mental health problems through outpatient facilities at primary, secondary and tertiary levels of care

Outpatient services for children and adolescents with mental health problems were available at 317 health facilities spanning primary to tertiary levels of care. Services included limited mobile services and satellite clinics. Only three of all outpatient services (0.9%) were providing dedicated mental health services to children and adolescents. All other facilities (99.1%) were open to all ages (DSN14).

Primary care (level 1): There were 273 primary healthcare facilities (206 clinics, 58 community daycentres and 9 community health centres) that provided general mental health services, where children and adolescents were seen alongside adults. Out of a total of 188,369 patients seen for mental health problems at primary level of care, 8,300 (4.4%) were children and adolescents. **Table 3.6** shows the number of children and adolescents treated in 2016 in primary healthcare facilities per geographic service area. The majority of children and adolescents were treated in the City of Cape Town (6,300/8,300; 75.9%) followed by the Eden District and the Cape Winelands. The Central Karoo had the lowest number and proportion of children and adolescents seen for mental health disorders (DSN14).

Table 3.6 The number and proportion of children and adolescents seen in 2016 in primary healthcare (level 1) outpatient settings for mental health problems in the Western Cape (DSN14)

Geographic service areas	Age distribution		Total (% children)
	>18 years	< 18 years	
City of Cape Town	131,836	6,330	138,166 (4.58%)
Cape Winelands District	16,986	609	17,595 (3.46%)
Central Karoo District	3,066	49	3,115 (1.57%)
Eden District	16,347	850	17.197 (4.94%)
West Coast District	11,834	462	12,296 (3.76%)
Total	**180,069**	**8,300**	**188,369 (4.4%)**

Secondary care (level 2): Mental health services were provided in 34 district hospitals in the province in 2016 (DSN14). There were no separate outpatient CAMH facilities at secondary level of care (DSN06, DSN14). Children and adolescents were therefore seen alongside adult psychiatric patients. Out of 15,755 patients seen for mental health problems at secondary level in 2016, 1,145 (7.27%) were children or adolescents. **Table 3.6** shows the numbers and proportion of children and adolescents seen at outpatient departments per GSAs in 2016 (DSN14). The largest number of children and adolescents were seen in the City of Cape Town (561 of 1,145; 48.9%), followed by the Eden District and the Cape Winelands. However, as proportions of cases, all of the

rural districts saw a greater proportion of under 19's, all in excess of 10% of patients seen (see **Table 3.7**).

Table 3.7 The number and proportion of children and adolescents seen in 2016 in secondary care (level 2) outpatient settings for mental health problems in the Western Cape (DSN14)

Geographic service area	Age distribution		
	>18 years	<18 years	Total (% children)
City of Cape Town	10,242	561	10,803 (5.19%)
Cape Winelands District	1,083	132	1,215 (12.19%)
Central Karoo District	162	29	191 (15.18%)
Eden District	2,064	248	2,312 (10.73%)
West Coast District	1,059	175	1,234 (14.18%)
Total	14,610	1,145	15,755 (7.27%)

Tertiary care (level 3): Three specialist CAMHS in the province provided dedicated multidisciplinary outpatient services in 2016. Adolescents with intellectual disabilities and co-occurring psychiatric disorders were seen in the two specialist units for people with intellectual disabilities (DSN10–DSN12).

No formal summary data were available for Tygerberg and Lentegeur outpatient units in 2016 (DSN14). Patient numbers at the Division of Child and Adolescent Psychiatry (DCAP) are shown in **Figure 3.2**, and self-declared ethnic/racial distribution in **Figure 3.3**. A total of 3,639 children and adolescents were seen at DCAP in 2016. The majority of patients were male (63.2%) and the self-declared ethnicity (where provided) was coloured (1,943/2,945; 65.98%), followed by white (578/2,945; 19.63%) and black (424/2,945; 14.29%).

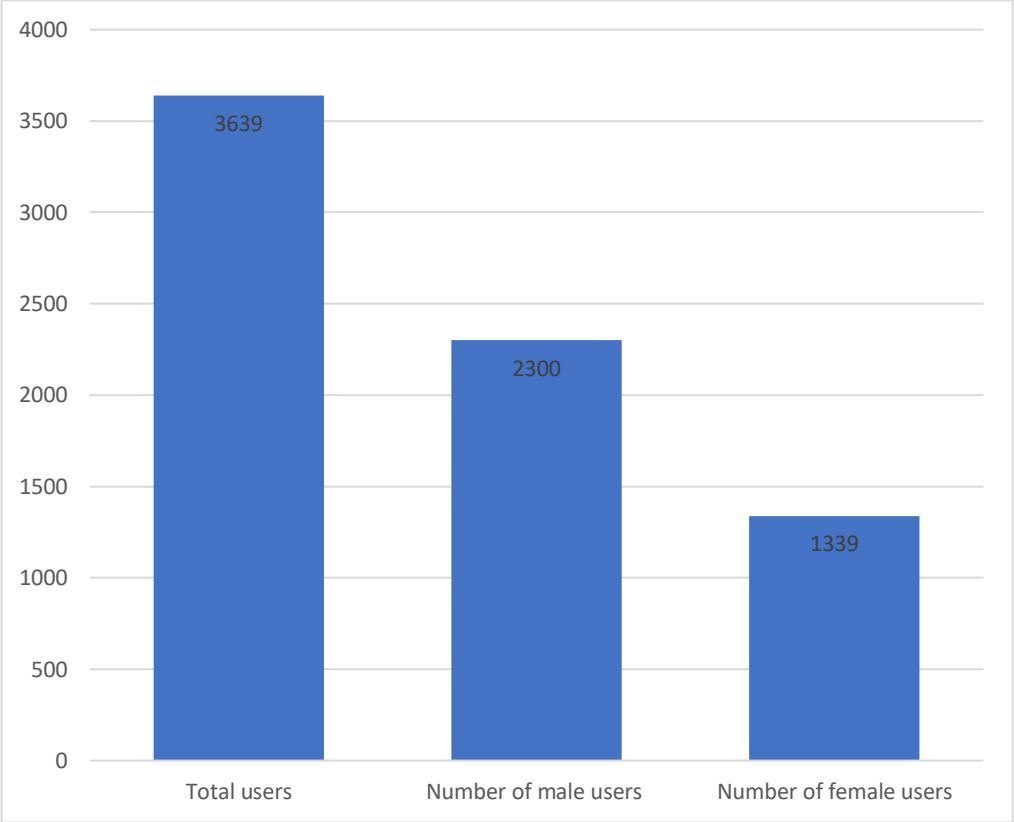

Figure 3.2 Number and sex of children and adolescents treated as outpatients at the Division of Child and Adolescent Psychiatry in 2016 (DSN14)

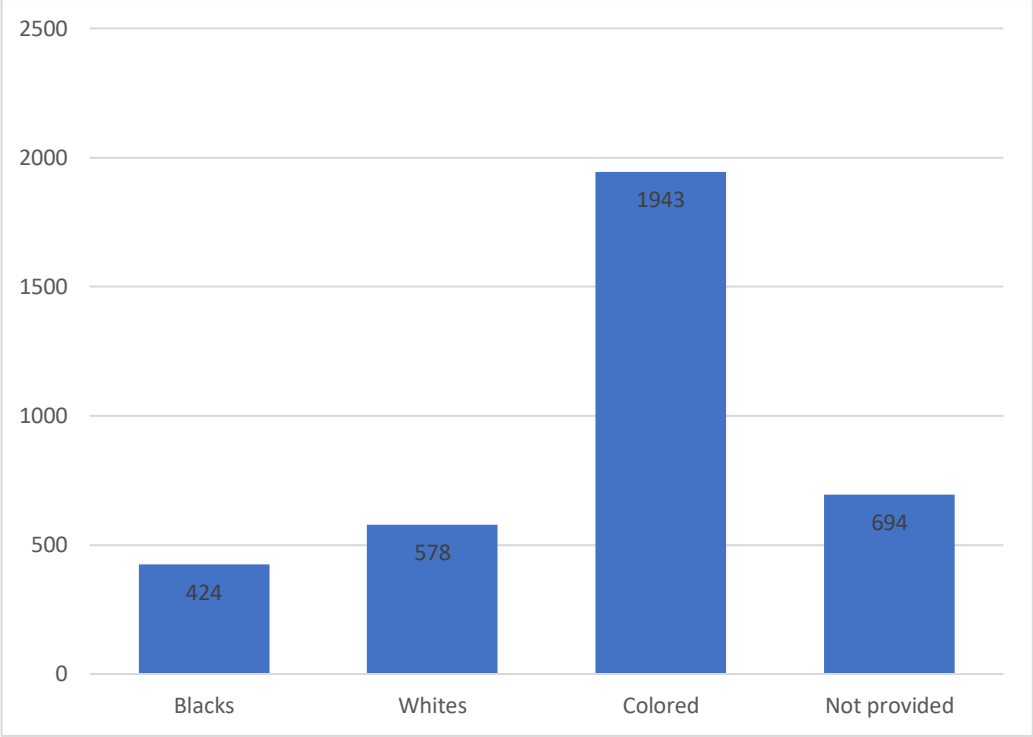

Figure 3.3 Self-declared ethnicity of children and adolescents treated as outpatients at the Division of Child and Adolescent Psychiatry in 2016 (DSN14)

The Alexandra and Lentegeur units for intellectual disabilities treated 3 and 39 children and adolescents respectively with intellectual disabilities and co-occuring mental health disorders as outpatients in 2016 (DSN13).

4. Availability of child and adolescent mental health inpatient facilities, and number/proportion of children and adolescents treated

Child and adolescent inpatient services in 2016 were provided at secondary (level 2) and tertiary (level 3) levels. Emergency cases requiring 72-hour observations were admitted at secondary level and medium to long-term admissions were provided at tertiary level (DSN14).

Secondary care (level 2): Secondary level services were available in 42 health facilities. There were no dedicated beds for children and adolescents with mental health problems in these hospitals. Children and adolescents who required inpatient emergency admission were admitted to paediatric units (up to age 12) or adult psychiatric wards (13–18 years). There were no

disaggregated data for children and adolescents who were admitted to paediatric units or adult psychiatric wards. **Table 3.7** shows the numbers of children and adolescents per geographic service area who were admitted in level 2 inpatient emergency units in 2016. A total of 795 children and adolescents, representing 4.35% of all secondary care mental health admissions, were admitted. The majority of children and adolescents were treated in the City of Cape Town (473/795; 59.5%), followed by the Cape Winelands and Eden Districts (see **Table 3.8**). Interestingly, the rural districts had more than double the proportion of under-18-year-old admissions relative to total population numbers, compared to the City of Cape Town. In the City of Cape Town 3.31% of level 2 admissions were under the age of 18, while in rural districts the proportions were 7.27–9.66% (DSN14).

Table 3.8 Children and adolescents with mental health problems admitted to secondary care (level 2) inpatient facilities per geographic service area in the Western Cape (DSN14)

Geographic service area	Age distribution		Total (% children)
	> 18 years	< 18years	
City of Cape Town	13,824	473	14,297 (3.31%)
Cape Winelands District	1,339	105	1,444 (7.27%)
Central Karoo District	131	14	145 (9.66%)
Eden District	889	82	971 (8.44%)
Overberg District	487	42	529 (7.93%)
West Coast District	795	79	874 (9.03%)
Total	**17,465**	**795**	**18,260 (4.35%)**

Tertiary care (level 3): Children and adolescents were admitted to one of three specialist CAMH inpatient units or to one of two intellectual disabilities inpatient units. Where this was not possible, admission to adult mental health units were made. All tertiary inpatient beds were in the City of Cape Town. A total of 346 children and adolescents were admitted to specialist inpatient units in 2016 (DSN14). The breakdown of admissions is outlined below.

The inpatient unit at DCAP (known as the Therapeutic Learning Centre) was a 6-bedded unit for 6–12-year-olds with complex or severe mental health problems, where children are typically admitted for 3–6 months. The unit admitted a total of 26 patients in 2016. The Tygerberg Child and Adolescent Psychiatry unit had a 16-bedded adolescent inpatient unit. Adolescents were admitted either for short-term diagnostic assessment or for longer-term intervention. The unit admitted 157 patients in 2016. The Lentegeur Child and Family Unit had an 8-bedded adolescent unit, and also admitted adolescents for short-term diagnostic work-up, or short to medium-term therapeutic work. The unit admitted 152 patients in 2016 (DSN14).

Eleven children or adolescents were admitted to adult mental health hospitals: Valkenberg = 8; Alexandra = 2; Stikland = 1 (DSN 14).

5. Availability of child and adolescent mental health day facilities, community residential facilities, forensic facilities or hospitals

Community or other residential facilities

There were no Department of Health day facilities and residential facilities exclusively for children and adolescents with mental health problems. The Department of Social Development provided community residential facilities for children and adolescents with a range of psychosocial challenges including abuse, neglect or other social difficulties. Children and adolescents with mild mental health problems who needed care, were placed in these units. There were 69 of these facilities listed in the Western Cape in 2016, but no data were available on the number of children in these facilities during the year. There were also special care centres and licensed homes for children and adults with severe and profound intellectual and physical disabilities, but no child and adolescent data were available (DSN06).

Child and adolescent forensic and other residential facilities

Child and adolescent forensic mental health services were provided at one of the adult mental hospitals (Valkenberg Hospital) in the City of Cape Town. A consultant psychiatrist, two child & adolescent psychiatrists, and five clinical psychologists provided sessions to the service. CAMH forensic services were

aimed at providing the Department of Justice with criminal capacity/forensic psychiatric assessments for children in conflict with the law (DSN15). Court diversion programmes were also available to provide support for 10–18-year-olds who were both in conflict with the law and had co-occurring mental health needs. These therapeutic programmes were facilitated by a probation officer or social worker and were offered for a period of 3–12 months. Programmes were provided by the Department of Social Development and a range of non-governmental/non-profit organisations (DSN16).

Child and adolescent mental hospitals

There were no dedicated CAMH hospitals in the province in 2016 (DSN06, DSN10).

6. Interventions (medications): Psychotropic medicines appropriate for children and adolescents included on the essential medicines list, free access to essential psychotropic medicines, and availability of medicines in outpatient and inpatient settings at secondary and tertiary levels of care

All mental health facilities (outpatient and inpatient) at secondary and tertiary levels of care had at least one psychotropic medicine of each therapeutic class (antipsychotic, antidepressant, mood stabiliser, anxiolytic, stimulant and anti-epileptic medicines) available (DSN05). These drugs were fluoxetine, citalopram, haloperidol, chlorpromazine, imipramine, risperidone, methylphenidate, lorazepam, lithium carbonate, sodium valproate, carbamazepine, citalopram and biperiden (DSN17). About 4.8 million people (including children and adolescents) (76%) in the Western Cape qualified for free access to healthcare services and for those with mental health disorders, to essential psychotropic medicines if required (DSN09).

7. Interventions (psychosocial): Access to psychosocial interventions in outpatient and inpatient settings at secondary and tertiary levels of care

Secondary level outpatient and inpatient services provided very limited access to psychosocial interventions for children and adolescents (DSN05). All specialist CAMH units provided multidisciplinary care at outpatient and

inpatient level. This involved access to a range of psychosocial interventions appropriate for children and adolescents including psychoeducation, family interventions, counselling, individual psychological therapies, play-based and other evidence-based psychosocial interventions (DSN01, DSN14).

3.3.3 WHO-AIMS Domain 3: Child and adolescent mental health in primary healthcare

1. Refresher training in child and adolescent mental healthcare provided to primary healthcare doctors, nurses or other staff and interactions of primary healthcare with specialist child and adolescent mental health services

The WHO-AIMS specifically seeks to quantify the proportion of mental health training to primary care doctors, nurses and other PHC staff in relation to other training provided in the year. The document also specifically seeks to quantify the number of primary healthcare staff that have received at least two days of refresher training in mental health in the last year. No data were available to answer these specific questions.

Anecdotally, specialist CAMHS provided outreach and support to colleagues at primary care level, including to medical doctors and nurses. Training was provided through workshops and seminars, and clinical consultation through a range of modalities including face-to-face, telephonic consultations, informal meetings, review of individual cases or through discussion of referral issues. However, there was no formal documentation of informal interactions with primary care staff in any health information systems, and the majority of these opportunities were with primary care colleagues in the metropolitan area (DSN11, DSN12, DSN15).

2. Availability of medicines and psychosocial interventions in primary healthcare facilities

All primary healthcare facilities had at least one psychotropic medicine of each therapeutic class (antipsychotic, antidepressant, mood stabiliser, anxiolytic, stimulant and anti-epileptic medicines) available (DSN05). The majority of the population had free access to medications. There was little if any access to

psychosocial interventions for children or adolescents available at primary care level (DSN09).

3.3.4 WHO-AIMS Domain 4: Human resources

1. Human resources in child and adolescent mental health services

No formal data were available on human resources specifically for CAMH. The majority of mental health human resources data represented staffing for all specialties across all ages. There were also no differentiation of data between staffing for outpatient versus inpatient care. **Figure 3.4** shows the overall mental health human resources in the Western Cape in 2016. The majority of staff were mental health nurses (n=1,079; 85.4% of all mental health staff), and there were few specialist psychiatrists (n=51; 4.03% of all mental health staff). Eight of the 51 psychiatrists (15.7%) were qualified as child & adolescent psychiatrists. Trainees (psychiatric registrars and psychology interns) represented 5.38% of the workforce (DSN14).

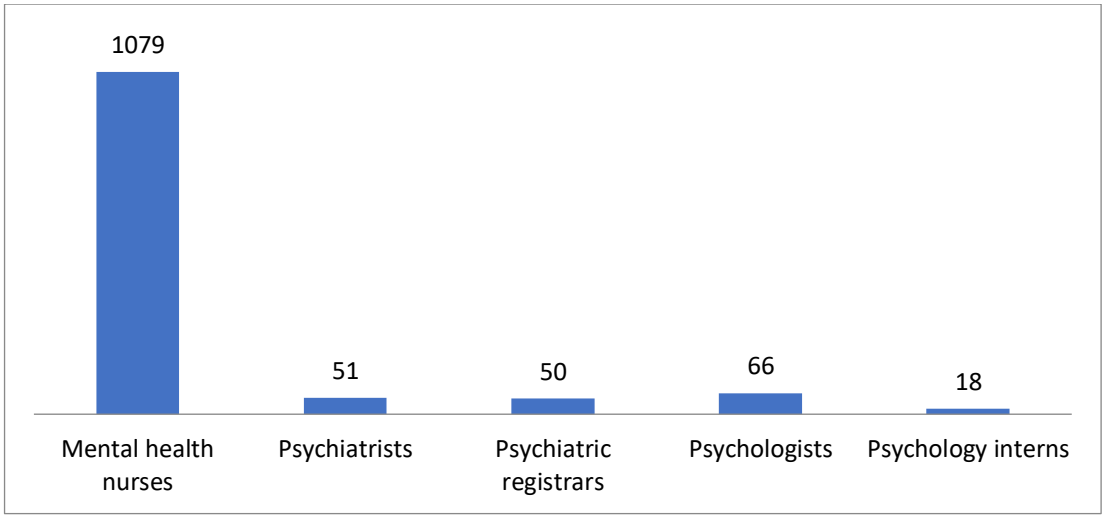

Figure 3.4 Staff proportions for mental health services in the Western Cape in 2016

In the absence of provincial human resources data for specialist CAMH, data were collected directly from the three tertiary CAMH units. **Figure 3.5** provides best estimates of human resources in the specialist CAMH facilities. As shown in **Figure 3.5** all CAMH specialist units had multidisciplinary teams which included child & adolescent psychiatry, psychology, nursing and other disciplines, but there was significant variability in the workforce profile between the specialist units. Psychiatrists and psychologists were appointed on contracts with 'joint conditions' between the Western Cape Government and respective universities, and were allocated 70% of their time to deliver clinical care and 30% of their time for academic activities (including teaching, supervision and research). Staff in other categories were appointed by the Western Cape Government with little to no time dedicated for teaching/ training, supervision and research.

In 2016, there were three posts in the province for psychiatrists to train as child & adolescent psychiatrists. However, there were no vacant positions in the government sector for child & adolescent psychiatrists once qualified. There was therefore no 'pipeline' that could support new child & adolescent psychiatrists to join the state sector. Newly qualified child & adolescent psychiatrists had to move into private practice, work in general psychiatry

posts, or leave the country. There were no funded training programmes for psychologists, nurses, occupational therapists, or speech and language therapists (SALT) to specialise in child and adolescent mental health.

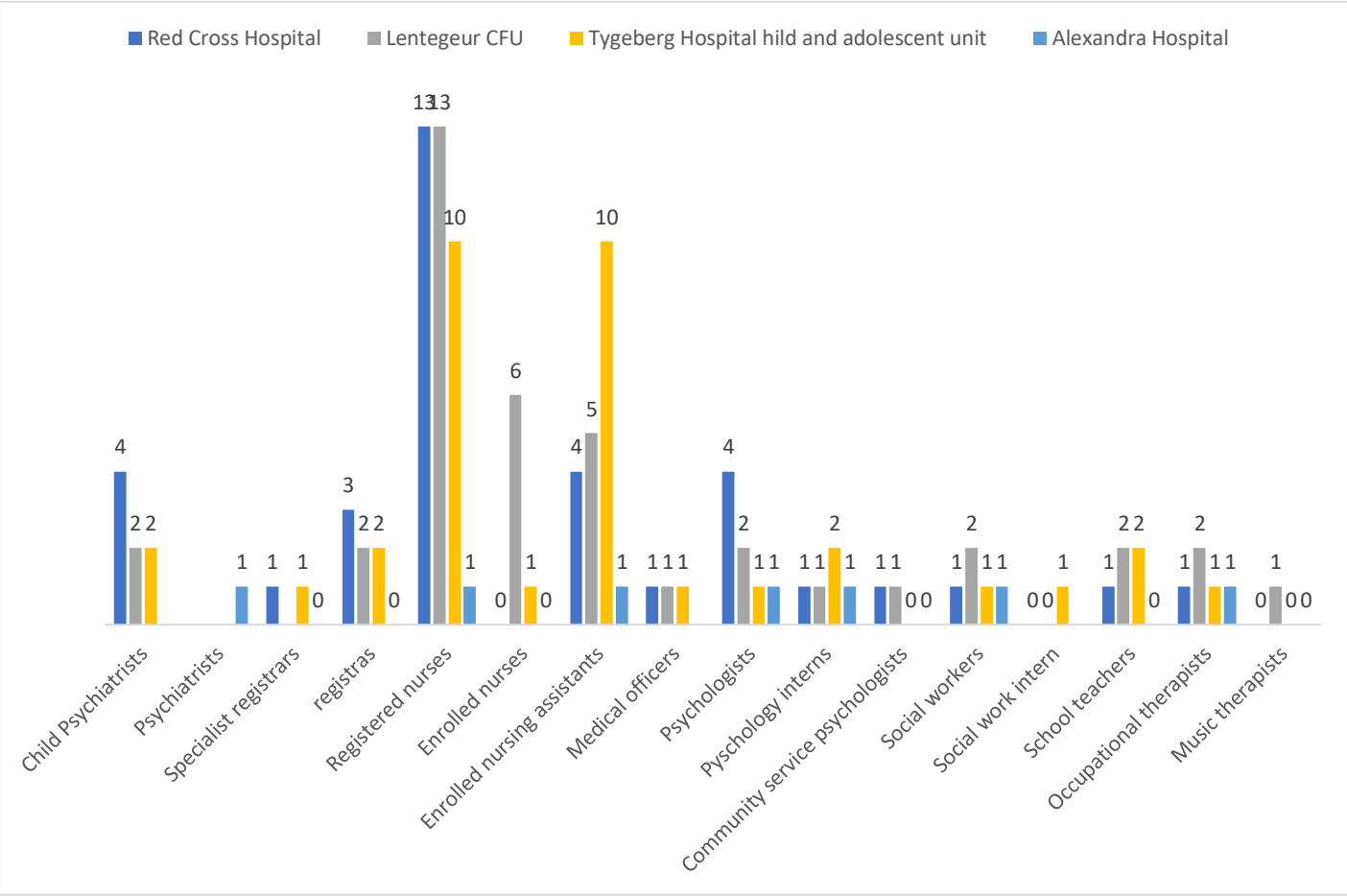

Figure 3.5 Human resources in specialist child and adolescent mental health units in 2016

3.3.5 WHO-AIMS Domain 5: Public education and links with other sectors

1. Public education and awareness campaigns about child and adolescent mental health

There were no formalised intersectoral collaborations between the Department of Health (DoH) and other sectors specifically related to child and adolescent mental health and mental illness in children or adolescents (DSN05).

One initiative, led by the Department of Social Development (DSD) and formally adopted by all provincial government departments, was related to infant mental health. The 'First 1,000 Days of Life' project was a collaborative cross-agency programme involving the DoH, DSD and the Western Cape Education Department (WCED), and was set up to identify and reduce risk factors for maternal and infant mental health problems in the first 1,000 days of life (DSN18).

A number of other projects and campaigns were aimed at promoting child and adolescent well-being. These included a competition launched by the Salesian Life Choices (a youth organisation) to encourage young people to start discussions around health issues and depression (DSN19), an anti-bullying campaign in schools run by the WCED in May 2016 (DSN20) and the International 16 Days of Activism, a campaign aimed at increasing awareness of the negative impact of violence and abuse against women and children (DSN21).

3.3.6 WHO-AIMS Domain 6: Monitoring and research

1. Monitoring of child and adolescent mental health services

There was a formally defined list of individual data items that ought to be collected by all child and adolescent mental health facilities, using CLINICOM and SENJANI information systems (DSN05, DSN14). CLINICOM is a hospital information system that is used in various countries. It records the activities of a range of clinicians in outpatient and inpatient facilities and the data is saved comprehensively in one place. It keeps records of patients treated in medical facilities, medical documentation, laboratory test results, daily course of diseases, patient medication records, examination scheduling by specialists,

rehabilitation and rehabilitation procedures. In South Africa and in the Western Cape, CLINICOM is a computer-based data capture programme used in secondary and tertiary hospitals in the province. All new patients and patient-related activities are expected to be captured on the CLINICOM system by clinic administrators. A sub-component of CLINICOM is used in primary healthcare facilities, to capture data on children and adolescents who present with mental health problems including personal information, inpatient and outpatient attendance, admissions, discharges, clinic, and diagnosis (DSN05). Despite the apparent availability of these information systems, it was not clear to what extent different healthcare facilities completed or utilised them. It was not possible for us to have direct access to the CLINICOM system to extract CAMH-related data. It was equally surprising that summative data, as presented in annual reports were never disaggregated to present findings on children and adolescents separately from information on adults. There were no DoH or mental health reports in 2016 that included references to CAMH (DSN05). To our knowledge, there has never been a dedicated report from the provincial Department of Health on child and adolescent mental health.

2. Research in child and adolescent mental health

The three (3) specialist CAMH units were linked to two universities (University of Cape Town and Stellenbosch University) and provided infrastructure and supervision for research in CAMH. In 2016 there were five research programmes, all led from the University of Cape Town, but with collaborations at Stellenbosch University. The programmes included the Adolescent Health Research Unit, the Centre for Autism Research in Africa, a Tuberous Sclerosis Complex Research Programme, a staff research development programme, and an Infant Mental Health research programme.

We performed a brief literature search for all publications relevant to CAMH published in 2016 by authors from the Western Cape or on participants from the Western Cape. We used Web of Science (version 5.34) Core Collection and the following search terms: “child AND adolescent AND mental AND health AND South Africa”; “autism AND South Africa”; “ADHD AND South

Africa"; "adolescence AND South Africa"; "infant AND mental AND health AND South Africa" and "tuberous sclerosis". We then refined searches by selecting affiliations with institutions in the Western Cape. All identified abstracts were reviewed for relevance to CAMH. A total of 44 abstracts were identified. After removal of duplicates and abstracts not directly relevant to CAMH, a total of twenty-six (26) articles were included (DSN22). A brief thematic grouping identified two articles on infant mental health, four on autism or ADHD, seven on adolescent mental health and five on tuberous sclerosis complex (TSC). It was of interest that a further 6 articles related to mental health aspects of HIV/AIDS, with the remaining 3 focusing on other themes of particular relevance in a South African setting: child abuse, foetal alcohol spectrum disorder (FAS), and cultural adaptation of an instrument to identify psychopathology. **Table 3.9** provides a summary of the research relevant to CAMH and published in 2016 as identified by our search.

Table 3.9 Publications of research relevant to child and adolescent mental health that included authors from the Western Cape or a focus on the Western Cape in 2016 (DSN 22)

Research theme	Topic of research	Reference (First author, journal, volume: pages)
Infant Mental Health	Infant mental health and early childhood	Worthman, *Social Science and Medicine*, 154: 62–69
	Reflective practice in infant mental health	Berg, *Infant Mental Health Journal*, 37: 684–691
Autism and ADHD	Autism in Africa	de Vries, *Current Opinion in Neurology*, 29: 130–136
	Performance of South African children on the CSBS, a tool for autism	Chambers, *International Journal of Language and Communication Disorders*, 51: 265–275
	Theory of mind in autism	Hamilton, *Journal of Child and Adolescent Mental Health*, 28: 233–241
	Management of ADHD in children and adolescents: clinical audit of ADHD assessment and treatment	Vrba, *Journal of Child and Adolescent Mental Health*, 28: 1–19
HIV/AIDS	HIV-associated neurocognitive disorders in 6–16-year olds	Hoare, *Neurology*, 87: 86–93
	The impact of household HIV on child development	Sherr, *Child Care Health and Development*, 42: 890–899
	Mental health resilience in children who lost parents to HIV/AIDS	Collishaw, *Journal of Abnormal Child Psychology*, 44: 719–730
	Social support for children affected by HIV/AIDS	Sharer, *Aids Care – Psychological and Socio-Medical Aspects of AIDS/HIV*, 28: 110–117
	Resilience in HIV-affected adolescents in South Africa	Bhana, *Aids Care – Psychological and Socio-Medical Aspects of AIDS/HIV*, 28: 49–59
	Correlates of emotional and behavioural problems in children with perinatally-acquired HIV	Louw, *Aids Care – Psychological and Socio-Medical Aspects of AIDS/HIV*, 28: 842–850
Adolescent Mental Health	Mental health inequalities in adolescents	Das-Munshi, *PloS One*, 11: 5
	Adolescent substance abuse	Weybright, *Journal of Adolescence*, 49: 158–169

Research theme	Topic of research	Reference (First author, journal, volume: pages)
	Impact of family structure on adolescent psychological profile	Davids, *Journal of Psychology in Africa*, 26: 351–356
	Social protection and adolescent health	Cluver, *PloS One*, 11: 10
	Parenting programme to prevent abuse of adolescents	Cluver, *Trials*, 17: 328
	Reducing adolescent abuse in LMIC-	Cluver, *BMC Public Health*, 16: 567
	Factors associated with readmission of adolescents discharged from inpatient units	Pieterse, *Journal of Child and Adolescent Mental Health*, 28: [incomplete]
Tuberous Sclerosis Complex (TSC)	Clinical trial of everolimus for epilepsy in TSC	French, *Lancet*, 388: 2153–2163
	Everolimus for neurocognitive problems in TSC	Randell, *Trials*, 17: 398
	Long-Term use of everolimus for SEGA in TSC	Franz, *PloS One*, 11: 6
	Towards an improved understanding of TSC-Associated Neuropsychiatric Disorders	Leclezio, *Advances in Autism*, 2: 1–8
	Everolimus for renal angiomyolipomas in TSC	Bissler, *Nephrology, dialysis and transplantation*, 31: 111–119
Other themes	Fatal child abuse	Mathews, *South African Medical Journal*, 106: 22–25
	Theory of mind in children with FASD	Lindinger, *Alcoholism – Clinical and Experimental Research*, 40: 367–376
	Cultural adaptation of the DISC-IV for Sotho-speaking South Africans	Skinner, *Journal of Ethic & Cultural Diversity in Social Work*, 25: 1–19

3.4 Discussion

The aim of this study was to perform a fine-grained situational analysis of CAMHS in the Western Cape as a ‘case study’ for similar services in the rest country. Items from the WHO-AIMS 2.2 (Brief version) were adapted to capture information about the six (6) fundamental domains of the CAMH health system in the province.

In terms of policy and legislative frameworks for CAMHS (WHO-AIMS Domain 1) we had previously reported the absence of any provincial CAMH policies or implementation plans (Mokitimi, Schneider & de Vries, 2018; Chapter 2). We identified reasonable human rights policies and procedures for children. Interestingly, we were not able to identify any disaggregated budgets for CAMHS. It was therefore not possible to comment on financing of CAMHS in the province. It was of note that the budget for mental hospitals represented only 3% of the total health budget in the 2016/17 financial year. The CAMH budget would therefore have been a fraction of that 3%.

Policy development reflects commitment from the (provincial) government and relevant authorities towards the services, and provides a mandate to support funding mechanisms (Shatkin & Belfer, 2004). Lack of this important hardware element for CAMHS in the Western Cape therefore raises questions about the commitment of the provincial government and authorities towards CAMHS and its strengthening. The lack of dedicated funding for CAMH was a second related concern. Our observations are underlined by the findings of Docrat and colleagues (2019) who found disproportionately low expenditure on CAMHS in comparison to adult mental health services. Adequate provision of resources in a health system requires adequate financing to ensure that the needed resources are provided, and good enough service is delivered (World Health Organization, 2007).

In terms of clinical services for CAMH (Domain 2), there was no dedicated CAMH authority. This signals a lack of dedicated leadership and governance of CAMH. Leadership and governance in a health system is important to ensure coordination of the services and equitable allocation of available resources (World Health Organization, 2007). Outpatient, but not inpatient, services were broadly organised in terms of catchment areas and across three levels of care (primary, secondary and tertiary). It was with great difficulty that we were able to disaggregate clinical data to identify that 8,300 under-18-year-olds were seen for mental health problems at primary, and 1,145 at secondary level. This represented 4.4% and 7.27% respectively of all people seen for mental health problems at primary and secondary levels of care. We were only

able to find outpatient tertiary data for one of the three specialist CAMH units, where 3,639 children and adolescents were seen in 2016. A total of 795 under-18-year-olds were admitted to inpatient units in secondary care (representing 4.35% of all secondary care mental health admissions) and a total of 346 in specialist CAMH inpatient units.

It was of concern to observe that all mental health services for children and adolescents at primary and secondary levels of care were mixed with adults. We were particularly concerned by the admission of eleven under-19-year-olds to adult mental hospitals. At all levels of care ,separate CAMHS should exist and adaptations are required to meet the needs of children and adolescents (World Health Organization, 2007; Flisher et al., 2012). Adult psychiatric environments are not conducive to the mental health and well-being of children and adolescents. It can jeopardise the safety of young people and can be frightening and traumatising, having a direct negative impact on the quality of care for children and adolescents (Gerson & Havens, 2015). International and national guidelines have previously recommended dedicated child and adolescent mental health services (World Health Organization, 2007; Flisher et al., 2012) and even the Western Cape General Health Policy (Department of Health. Western Cape Government, 2014) set out a plan to separate children and adolescents from adult psychiatric services. However, the findings presented here suggest that no implementation of these guidelines had taken place by the end of 2016.

A total of 63.8% of the Western Cape population lived in the City of Cape Town in 2016 (Stats SA, 2016). Interestingly, 76.3% of all under-19-year-olds seen in primary care lived in the City of Cape Town. In contrast, at secondary care level, only 48.9% of the same age group outpatients and 59.5% of inpatients were in the metropolitan area. In the rural districts, by contrast, a greater proportion of under-18-year-olds were seen at secondary care facilities. All specialist CAMH units were based in the City of Cape Town. We therefore interpret these results as suggesting that the lack of easy and close access to specialist CAMHS in the rural districts of the province may have added

additional service pressure at secondary level of care. This would be a very important empirical question to explore in future health systems research.

In terms of access to interventions, levels 1 and 2 primarily provided access to medication treatment, with little or no psychosocial support. Only at specialist CAMH level did children and adolescents have access to a range of medication, psychosocial treatment and the support of multidisciplinary teams.

Domain 3 of the WHO-AIMS focuses on CAMH in primary care (level 1). Even though 8,300 children and adolescents were seen in primary care settings, and despite the fact that there was anecdotal evidence of refresher training on CAMH for primary care staff, there were not data sources that could quantify access to refresher training on CAMH to PHC staff. As alluded to earlier, primary care staff had access to psychotropic medications on the essential drugs list, but very little if any access to psychosocial support. It is therefore of concern that we were not able to find clear data or evidence of consistent and sustained support to service providers, particularly at primary levels of care, where the majority of children and adolescents will first present with potential mental health problems. This observation is of particular importance in the context of South African prioritisation of public health and primary healthcare services.

It was difficult to access data on human resources for CAMH (Domain 4 of the WHO-AIMS) given that all CAMH staffing data were combined with adult mental health staff data in formal provincial datasets. Direct collection of data from specialist CAMH units allowed the basic description of the multidisciplinary staffing in these units. Data indicated high clinical and teaching activity in specialist CAMH units, but very limited dedicated resources for staff training and capacity-building, for instance, in training posts in CAMH.

In the 2016 data we could only identify one clear example of a joint initiative across Provincial Government Agencies (Health, Education, Social Development, Justice), focused on CAMH. The ‘First 1,000 Days of Life’ was cited as a positive initiative around maternal mental and physical health, and

infant mental health. There was little evidence of other joint initiatives between sectors (WHO-AIMS, Domain 5).

Domain 6 captured information on monitoring and research. Even though all levels of care apparently had information systems to collect data on patient care, we were not able to access any of the primary data collected through the CLINICOM system, and were not able to get access to any data where under-18-year-old mental health activity data were clearly disaggregated from other mental health data. This raised the question about how 'fit for purpose' the health information systems in the Western Cape may be for CAMH. Based on our observations, the existing information systems may not be able to provide adequate and sufficiently nuanced information to help identify the problem areas in CAMH services, in order to inform the planning for responsive services and programmes (World Health Orgnization, 2010), or for research on CAMH.

We were encouraged to see active research in CAMH in 2016 across a number of broad thematic domains, and that a significant proportion of CAMH research was on topics of particular resonance in the African context (e.g. HIV/AIDS, FASD, resilience, and child abuse).

Taking together the findings in the situational analysis, we identified a number of the gaps that will require urgent action. **Table 3.10** shows an overview of our findings. Gaps were identified in all health systems domains, and at all levels of the healthcare system. These included the previously identified lack of policy development and implementation for CAMHS, lack of resources (financial, governance, infrastructural and human), lack of public education, and lack of access to information services that could support monitoring and research in CAMHS.

Table 3.10 Health system gaps in child and adolescent mental health in the Western Cape as identified in this situational analysis

WHO-AIMS Domain	Gaps in CAMHS
Domain 1 Policy and legislative framework	• No provincial CAMH policy or implementation plans • No dedicated financing for CAMHS
Domain 2 Clinical services for children and adolescents with mental health disorders	• No dedicated leadership and governance structure for CAMH • No dedicated CAMH services and lack of psychosocial interventions at secondary level • No specialist CAMH services in rural districts
Domain 3 CAMH in primary healthcare	• Inadequate documentation on training of professionals on CAMHS at primary care level • Lack of dedicated resources at secondary and tertiary care levels to support and train colleagues at primary level, particularly in rural districts • Lack of psychosocial interventions at primary care level
Domain 4 Human resources	• Limited information systems to access human resources data on CAMH • Limited human resources for CAMH at secondary and tertiary care levels
Domain 5 Public education and links with other sectors	• Limited public health campaigns on CAMH • Limited intersectoral collaboration about CAMH
Domain 6 Monitoring and research	• Lack of disaggregated and accessible information systems for CAMH

In recent work by Docrat and colleagues, a national survey of mental health costs was performed, using data for the same period as used in our study (2016/17). Apart from finding that the public mental health budget represented only 5% of the overall public health budget, they estimated that ~7.5% of the total uninsured population required some form of outpatient mental health care, and ~0.89% required inpatient mental health services (Docrat et al.,

2019). Applying the same estimates to CAMH, we would have expected 157,500 children in the Western Cape to have required outpatient and 18,690 inpatient care. The data identified in this situational analysis identified a fraction of such expected numbers across all levels of care: 6.3% (9, 922.50/157,500) of expected outpatient visits and 7.2% (1,346/18,690) of expected inpatient admissions. It is therefore very sobering to imagine that existing mental health services across all levels of care reached fewer than 10% of children and adolescents who may have needed mental healthcare in 2016. Of those reached, only those who accessed specialist CAMHS were likely to have received comprehensive evidence-based care.

Limitations of the study

The main limitation of this situational analysis was challenges of accessing accurate and disaggregated data through existing health information systems. We therefore acknowledge that our findings may not have been representative of the actual CAMH clinical activity and resources in the Western Cape in 2016. However, we tried to be rigorous and systematic in data collection and presented all data sources in a systematic way to optimise the accuracy of data collected. We recognise the lack of clear and accessible information systems as a limitation of our study, but also note this as a major gap in CAMHS in the province. We also acknowledge that, given the period of data identified and discussed (January–December 2016), these represent an historical analysis and that some of the findings may have changed since 2016. Finally, we acknowledge that we focused our analysis on the Department of Health to the exclusion of all the other sectors (Education, Social Development, Non-Profit etc.) that are also of fundamental importance in CAMH. Broadening out the focus to other sectors and to inter-sectorality would be a very important area for future CAMH research in the South African context

3.5 Conclusions

In comparison to the majority of provinces in South Africa, the Western Cape is seen as relatively well-resourced in terms of health services. Our findings of

very limited hardware for CAMHS (policies, dedicated funding, staffing, training, information systems), and clinical care provision to potentially fewer than 10% of the expected population of children and adolescents in need of mental healthcare, raises significant concerns about CAMHS, not only in the Western Cape, but also elsewhere in the country and in similar low-resource settings. Sadly, our findings are in keeping with previous literature that showed neglect of CAMH in South Africa and other LMIC despite the well-recognised burden of CAMH disorders (Lund & Flisher, 2006; Peterson et al., 2009; Kleintjes et al., 2010; Flisher et al., 2012; Kapp, Petr, Robbins & Choi, 2013). Even though it will be important to expand our research to also explore software elements of the health system (e.g. through the experience of service providers and users), the data presented here are already a clear call for action to find strategies and initiatives that will strengthen CAMHS in the province, the country and in other LMIC.

The WHO-AIMS was developed as a tool for situational analysis of adult mental health services and, in its original form, only have one item about CAMH services. As it stands, it is therefore not of particular use to generate a detailed situational analysis of CAMH in any country. We made a range of adaptations to the BRIEF version of the WHO-AIMS in order to collect much more breadth and depth about CAMH resources in our study. To our knowledge no other country has used a similar approach to generate a situational analysis specifically on CAMH. Given the vital importance of CAMH services throughout the world, but particularly in LMIC settings, development of a bespoke framework for CAMH situational analysis may be a very helpful action by the WHO. The version as adapted by us in this study may provide a useful starting place for such a global process.

3.6 Chapter Summary

CAMHS around the globe need to be strengthened and to do that, knowledge of both the hardware elements (human resources, financing, medicines, technology, organisational structure, service infrastructure, and information

systems) and software elements (ideas and interests, relationships and power, values and norms, and the interactions between all factors and actors) of health systems is required. In this chapter we sought to examine the hardware elements of CAMHS in the Western Cape Province of South Africa. Using the WHO-AIMS version 2.2 of 2005 (amended brief version) a situational analysis of CAMHS was conducted. Data were collected for the calendar year 2016 and focused on the public health sector. The WHO-AIMS Excel Template was used for analysis across the six key health systems domains as defined in the WHO-AIMS. We outlined findings based on best available data, and identified key gaps at all levels of care and in all domains examined. In terms of domain 1, we found no provincial CAMH policy or implementation plans to support the national CAMH policy, and were unable to identify a CAMH-specific budget. In terms of domain 2, there was no dedicated provincial leadership structure for CAMHS, and no dedicated or 'child- and adolescent-friendly' mental health services at primary or secondary care level. At tertiary level, there were only three specialist CAMHS. The majority of CAMH resources and all specialist CAMHS were based in the City of Cape Town, with limited resources in the rural districts. Fortunately, essential medicines were available in all facilities, and the majority of children and adolescents had access to free services. In terms of domain 3 (primary healthcare), data were limited about the extent of training offered to primary healthcare staff, and even though essential drugs were available, little or no psychosocial interventions were available. Domain 4 (human resources) identified a small and variable CAMH workforce across all levels of care. In domain 5 we identified limited public health campaigns focused on CAMH, and little evidence of formal intersectoral collaboration on CAMH. Domain 6 identified significant gaps and challenges in health information systems for CAMH, and outlined the significant challenges of accessing child- and adolescent-specific and disaggregated data that can be used to establish baselines for policy development, monitoring, evaluation and CAMHS research. Overall, the situational analysis denoted significant weaknesses in hardware elements of CAMHS in the Western Cape. Next, it would be important to expand our investigation to an understanding of

hardware and software elements as perceived by different CAMH stakeholder groups.

Chapter 4: Child and adolescent mental health services in South Africa – senior stakeholder perceptions of strengths, weaknesses, opportunities, and threats in the Western Cape Province

Mokitimi, S., Jonas, K., Schneider, M., & de Vries, P.J. (2019). *Frontiers in Psychiatry,* 10: 841. doi: 10.3389/fpsyt.2019.00841

4.1 Introduction

Mental health disorders are the number one leading burden of disease in children and adolescents (Baranne & Falissard, 2018) affecting 10–20% of children and adolescents around the world. Strikingly, the majority of all adult mental health disorders emerge before the age of 18 (Jones, 2013). Mental health disorders in children and adolescents have a negative impact on their development and well-being. Children with mental health disorders often experience challenges in education and learning, in their transition to adult life, and in their potential to live fulfilling and productive lives (Sheehan, 2017). CAMH is therefore increasingly recognised as a public health priority (Kieling et al., 2011; Marquez & Saxena, 2016; Patel et al., 2007; World Health Organization, 2018). In spite of the fact that 90% of the world's children and adolescents live in low- and middle-income countries (LMIC), the evidence-base for the burden of CAMH disorders in LMIC is very limited (Flisher et al., 2012; Kleintjes et al., 2010; Patel et al., 2008; Polanczyk, 2014) and suggests a clear lack of policy development and policy implementation, very limited research, and very limited resources for CAMHS (Juengsiragulwit, 2015; Kleintjes et al., 2010).

Even though there is a clear global need for CAMH policy and service development, it is imperative that an understanding of these global needs is combined with local knowledge about health and care systems, existing resources, and local policies, particularly in LMIC. This requires a multilevel synthesis of available data including a situational analysis of existing

infrastructure, resources and workforce (World Health Organization, 2005), evaluation of existing policies and policy implementation, and multilevel views of existing services and future service needs (World Health Organization, 2005). A key component of local knowledge is therefore to have a thorough understanding of the perspectives of a broad range of stakeholders – from senior policymakers and CAMH leadership, to clinicians who provide and families who receive services at grassroots level. **Figure 4.1** shows a graphic representation of the multiple levels that will require integration to understand and strengthen CAMHS. Levels include the 'policy landscape' (international, national and regional/provincial knowledge, and perspectives on CAMH-relevant policies); the 'resource landscape' (international, national, and regional/provincial knowledge about available infrastructure, human resources, and funding); the 'senior stakeholder landscape' (international, national, and regional/provincial knowledge and perspectives of decision-makers and senior leadership in CAMH); 'provider perspectives and experience' (of those working at the grassroots of service delivery); and 'user/carer perspectives and experience' (of families and young people who seek clinical services in a particular setting). A careful understanding is required at all levels relevant to a specific service in order to know how to approach service strengthening. Such an understanding can identify the strengths, weaknesses, opportunities, and threats (SWOT) affecting the provision of optimal CAMHS.

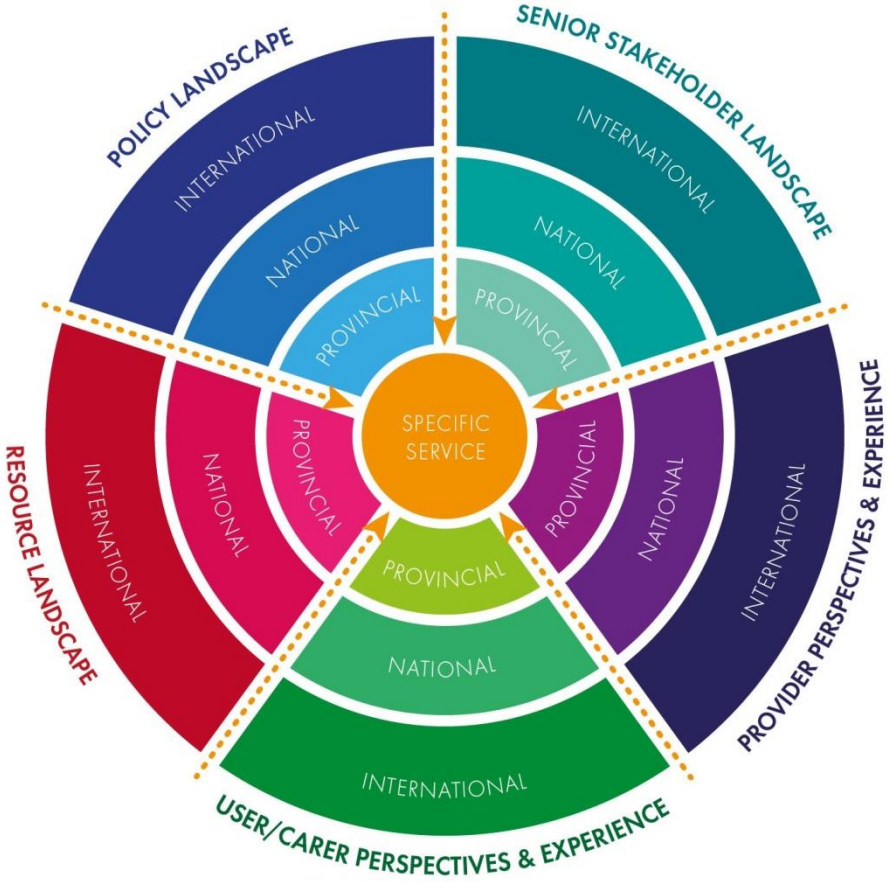

Figure 4.1 The multilevel integration of knowledge required to understand and strengthen child and adolescent mental health services

South Africa is classified as an upper-middle-income country by the World Bank (The World Bank Data Team, 2018). Importantly, South Africa is also recognised as the country with the greatest income inequality in the world (World Health Organization, 2005) and as a result, has some of the greatest health disparities in the world (Mayosi & Benatar, 2014). The 2018 mid-year population estimates showed that the country had a total population of 57.7 million of which 21.8 million (37.8%) were estimated to be under the age of 19 (Statistics South Africa, 2018).

The global prevalence rate of CAMH disorders is estimated to be between 10 and 20% (Patel et al., 2007; World Health Organization, 2018). There are no

prevalence studies on the mental health of children and adolescents in any sub-Saharan African country, including South Africa. However, in South Africa Kleintjes and colleagues (Kleintjes et al., 2006) generated estimates of children likely to have diagnosable CAMH disorders, based on international data. They showed that 17% of children were likely to have a diagnosable CAMH disorder (Kleintjes et al., 2006), with the most common being generalised anxiety disorder (11%), followed by post-traumatic stress disorder and major depressive disorder/dysthymia (both 8%), oppositional defiant disorder (6%), and attention deficit hyperactivity disorder (5%). Of note, no estimates were made for autism spectrum disorder and other main categories of neurodevelopmental disorders.

The most recent situational analysis of South African CAMHS was conducted in 2005 (Kleintjes et al., 2010) and showed that there was a national CAMH policy (Department of Health, Republic of South Africa, 2004), but that none of the South African provinces had a specific CAMH policy or implementation plans based on the national policy. There was inadequate and inequitable distribution of CAMH resources with most services located in the metropolitan areas of the country, limited specialist human resources for CAMHS, and a lack of human resource training of generalist workers in CAMH (Kleintjes et al., 2010). The impact of stigma, the low priority of mental health, and the lack of attention to the link between poverty and mental ill-health were proposed as factors that influenced the lack of developments in CAMHS (Draper et al., 2009).

In a recent investigation, we reviewed all national and provincial mental health policies to establish the current ‘policy landscape’ for CAMH in South Africa (Mokitimi, Schneider & de Vries, 2018; Chapter 2 of this thesis). In South Africa, policy is set at national level, and implementation is delegated to provincial level, in acknowledgement of the highly diverse socioeconomic and sociocultural diversity of the country. Apart from the 2003 national CAMH policy (Department of Health, Republic of South Africa, 2004), no South African provinces had CAMH policies or implementation plans to support the national CAMH policy (Mokitimi, Schneider & de Vries, 2018). The focus of the

provincial health policies was on HIV/AIDS, Tuberculosis, and maternal health and child mortality. Policy documents made little or no mention at all of CAMHS (Mokitimi, Schneider & de Vries, 2018). Our findings therefore confirmed the ongoing neglect of CAMH at policy level, in spite of the burden of CAMH disorders.

As a next step towards an evidence-based, comprehensive CAMH service model in South Africa, it was therefore important to examine the 'senior stakeholder landscape' (see **Figure 4.1**) by investigating local knowledge about CAMHS as perceived by senior and experienced policymakers and service providers. We elected to use the Western Cape as a case study for other low- and middle-income settings, given that it is the location of our clinical and academic activities. The Western Cape is one of nine provinces in South Africa, with Cape Town as the capital city. It has an overall population of 6.6 million (Statistics South Africa, 2018), of which 2.2 million (33.3%) are under the age of 19 (Statistics South Africa, 2018). The Western Cape and Gauteng provinces are better resourced in terms of specialist CAMHS compared to other the South African provinces (Flisher et al., 2012). **Figure 4.2** shows a map of South Africa, indicating the location of the provinces, and the location of specialist (tertiary) CAMHS. Specialist services are available in Gauteng (four service units), in KwaZulu-Natal (one service unit), and in the Western Cape (three service units). There are no state/government-funded specialist CAMHS outside these centres. The enlarged area shows the Western Cape Province and indicates the details of the different health districts and metropolitan sub-structures where the specialist CAMHS are situated.

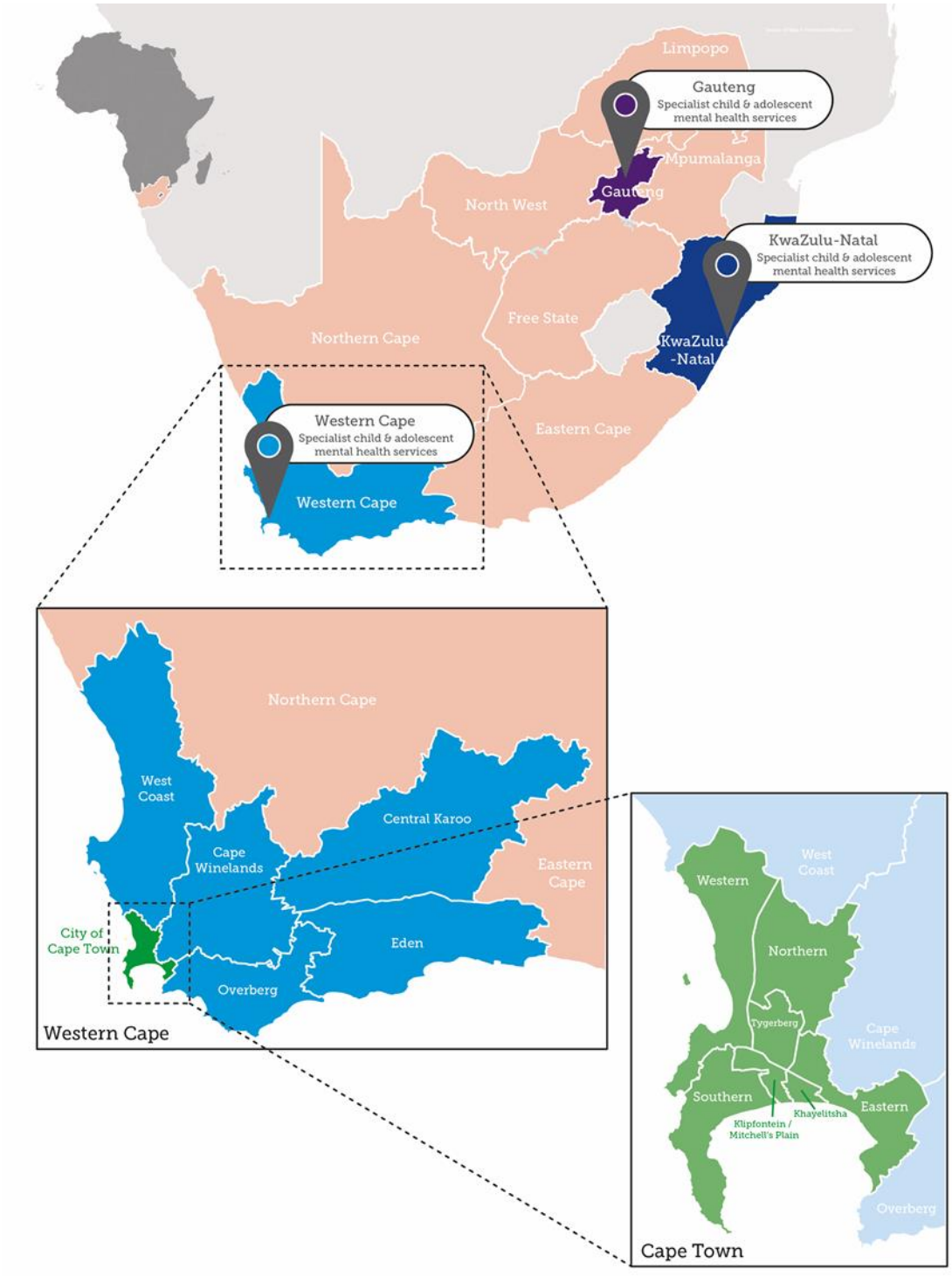

Figure 4.2 A map of South Africa indicating the location of specialist child and adolescent mental health services (indicated as pins on the map). The enlarged area shows the Western Cape Province and indicates the details of the different health districts and metropolitan sub-structures where the specialist CAMHS are situated.

In this study we therefore sought perspectives of senior CAMH service providers, managers, and policymakers from the Western Cape Province of South Africa, to conduct a SWOT analysis of CAMHS. Work by the Nobel Prize-winning economist Thomas Schelling in the 1970s (Schelling, 1971) and popularised by Gladwell (Gladwell, 2000), generated the concept of a ‘tipping point’ defined as "the critical point in a situation, process or system beyond which a significant and often unstoppable effect or change takes place." The construct has been applied in various fields, including sociology and health systems research (Kushner, 2003; Piana, 2012). Gladwell (2000) used the concept of tipping points to refer to potentially small events that could lead to significant change. We therefore set out to identify potential positive and negative ‘tipping points’ that might be able to inform CAMH service strengthening activities from the data.

4.2 Methods

4.2.1 Study design

A qualitative study was conducted with purposively sampled senior CAMH service providers, senior managers, and policymakers from the Western Cape, using a half-day multistakeholder workshop format.

4.2.2 Study participants

Purposive sampling was used to select relevant stakeholders with insight into CAMH issues to ensure representation across a wide range of experienced CAMH service providers and policymakers at all levels of care. We aimed to include policymakers from the Western Cape Department of Health (DoH), senior CAMH managers, and senior practitioners from the three metropolitan sub-structures (Southern/Western sub-structure, Mitchell's Plain/Klipfontein sub-structure, Northern/Tygerberg sub-structure), the rural districts (Cape Winelands, West Coast, Overberg, Eden and Central Karoo), and from all levels of care in the province (community, district, and tertiary care) were

invited to participate. Details of the Western Cape, its rural districts and metropolitan sub-structures are shown in **Figure 4.2**.

A list of all mental health professionals and their contact details was obtained from the Provincial Mental Health Directory (Western Cape Government, 2015). The stakeholders were recruited telephonically and via email. A total of twenty-four multidisciplinary stakeholders were invited to participate.

4.2.3 Setting and data collection

Information sheets containing details about the study and consent forms were emailed to participants prior to a face-to-face workshop held in March 2017. Willing participants who were not able to attend the meeting in person were provided with the key questions and were asked to return written comments for inclusion in data analysis. All consent forms were collected on the day of the workshop. The stakeholder engagement workshop was conducted in a quiet, private space at a central venue.

Participants were divided into three groups of four professionals each. Groups were structured to ensure a mix of professionals from the following categories: policymakers, clinical psychologists, mental health nurses, nursing managers, child & adolescent psychiatrists, and medical officers (medically qualified professionals without formal qualifications in psychiatry). Each small group was asked to perform a SWOT analysis in their group. Following small-group work, each group gave feedback to the large group, which led to additional large group discussions around similarities and differences identified. The lead author facilitated the large group discussions.

South Africa has eleven official languages. English is spoken as primary language by a small proportion of the population (~10%), but it is the accepted language of communication at professional and senior stakeholder level. All participants were asked in advance (prior to the workshop) about their English proficiency, and everyone indicated that they were fluent in English. For this reason, all discussions were held in English. Discussions were audio recorded, and field notes were taken during the discussions and consolidated after the

session. The duration of the stakeholder engagement workshop was three hours.

Four main aspects were discussed: strengths, weaknesses, opportunities and threats in CAMHS in the Western Cape. We conceptualised these as ‘current’ positives (strengths) and negatives (weaknesses) versus ‘future’ positives (opportunities) and negatives (threats). Member checking was done during the discussion process where the facilitator summarised the key points from the discussions and asked the participants to confirm these. Two of the authors (MS, PdV) were observers of the workshop but were not active participants in the discussions.

4.2.4 Data analysis

Audio recordings were analysed using thematic analysis (Maguire & Delahunt, 2017; Nowell, Norris, White & Moules, 2017) through NVivo 11 (QSR) qualitative data software package (Catarina, 2015). Relevant sections were transcribed verbatim in NVivo. Data were coded, and codes were subsequently grouped into themes. The coded transcripts were analysed by running query reports, and primary document tables were produced of the codes and themes to explore the issues from the discussions.

To strengthen the trustworthiness of analysis, data triangulation was performed. Written notes from the workshop were made by the research team and these were compared with the data written by group participants, and the audio recordings from the workshop and corroborated the findings of this study. Furthermore, to ensure objectivity of the data, two researchers (SM and KJ) coded all the data independently. The two researchers met regularly to compare and discuss their findings until consensus and saturation was reached. For this reason, no quantitative measure of agreement was calculated.

4.2.5 Informed consent and ethics approval

This study was approved by the University of Cape Town Human Research Ethics Committee (HREC 188/2016) and permission to conduct the study was received from the Western Cape Department of Health and the Red Cross War

Memorial Children's Hospital. The study adhered to the principles as set out in the Helsinki Declaration (World Medical Association, 2013). All participants were provided with a participation information sheet, and in return they all provided written informed consent before participating.

4.3 Results

Twenty-four stakeholders were invited to participate. Eleven invited professionals did not participate. The reasons for non-participation were stated to be time constraints and occupational requirements. A total of thirteen multidisciplinary stakeholders (twelve face-to-face and 1 written response) agreed to participate in this study. Participants included one policymaker, four advanced senior mental health nurses, two nursing managers, three child & adolescent psychiatrists (consultants), one medical officer (medically qualified professional without formal qualifications in psychiatry), one general psychiatrist, and one senior clinical psychologist. All the participants were experienced CAMH service providers. The years of CAMH service experience ranged from four to twenty years. The results of the multistakeholder engagement workshop are presented below according to the SWOT identified in a thematic analysis.

4.3.1 Strengths

Two main strengths emerged from the analysis. These were recognition of a comprehensive bio-psycho-social approach, and strong specialist CAMH service units. **Table 4.1** provides a summary of the identified themes and subthemes, illustrated with representative quotes from participant transcripts.

Table 4.1 A summary of the themes illustrating the strengths of child and adolescent mental health services

Overarching theme	Subthemes	Illustrating examples/quotes
Comprehensive bio-psycho-social approach	Holistic across ages	*"…combined child and adolescents...holistic across ages...excellent tertiary services"* **[Child & adolescent psychiatrist]**
	More than custodial care	*"…we have a good vision for how CAMH services should exist, that it's more than custodial care…"* **[Child & adolescent psychiatrist]**
Strong specialist CAMH service units	Clearer referral care pathways within CAMH service	*"The referral care pathways are clearer now...like the person staying in Crossroads* cannot just refer a child to the Child and Family Unit …"* **[Child & adolescent psychiatrist]**
	Links between tertiary and primary CAMH services	*"Training is provided for community mental health providers by the tertiary CAMH specialists..."* **[Child & adolescent psychiatrist]** *"Weekly supervision is provided for community mental health nurses on Fridays once a month…"* **[Child & adolescent psychiatrist]**
	Improved training for primary CAMH services	*"There are joint CAMH case discussions at least once a term across the platform..."* **[Child & adolescent psychiatrist]**
	Improved relationship between the three specialist CAMH units	*"...people like us...who still care about it and...I mean there are people...committed...committed workforce. I mean nobody does this for fun..."* **[Child & adolescent psychiatrist]**
	Committed CAMH specialists	*"…There's some highly qualified multidisciplinary teams at all levels …"* **[Child and adolescent psychiatrist]**
	Highly skilled tertiary CAMH services	*"We've got skilled and experienced tertiary layer…"* **[Child & adolescent psychiatrist]**
	Strong academic support and involvement for CAMH services	*"…academic support…I mean they [university] do not just teach, but they do…"* **[Child & adolescent psychiatrist]**

Crossroads: denotes a high-density residential area in Cape Town

1. Comprehensive Bio-Psycho-Social Approach

CAMHS were described as having a 'comprehensive bio-psycho-social approach' meaning the generation of a thorough formulation and intervention plan based on a comprehensive evaluation of the biological, psychological, and social needs of a child and his/her family. CAMHS were seen as 'holistic' because they included preventive, promotive, and curative elements, and were offered at all levels of care – primary, secondary, and tertiary. The services were provided for ages 0–18 years, and assessments and interventions were described as developmentally appropriate to the needs of the child.

2. Strong Specialist Child and Adolescent Mental Health Service Units

The existing specialist units were described as understanding that CAMHS do not only comprise custodial care but also involves a holistic approach. The specialist units were said to offer inpatient and outpatient services and a range of psychotherapeutic interventions. Senior stakeholders reported that CAMHS had evolved a lot since 2014. For 3 years (2014 to 2017) CAMHS consistently had skilled and experienced clinicians. The specialists were described as passionate about what they do, striving to provide effective CAMH services despite the challenges. These CAMH specialists were described as having a vision of how services should be, and this vision was reportedly shared and implemented very effectively in various forums that meet on a regular basis. These meetings include highly qualified multidisciplinary team members from all levels of care. Participants described that information about CAMHS, and referral care pathways were shared across the districts and across disciplines, thus raising awareness about CAMHS and referral pathways. The goodwill from the district level was recognised as a facilitator to sharing of best practices and increased awareness of CAMHS.

Participants commented that the Western Cape was advantaged compared to other provinces in the country with three strong and well-structured tertiary CAMH units: Lentegeur Child and Family Unit (linked to Stellenbosch University), the Tygerberg Child and Adolescent Psychiatry Unit (linked to Stellenbosch University), and the Division of Child and Adolescent Psychiatry

(DCAP) at Red Cross War Memorial Children's Hospital (linked to the University of Cape Town). The three specialist CAMH units were described as the strengths and pillars of CAMHS in the province. They were also perceived by the participants as the strongest CAMH units in the country with a reputation for providing excellent tertiary CAMHS that are comprehensive across ages.

CAMHS were receiving some support from the Western Cape Government DoH which included interactions and discussions with CAMH specialists about CAMHS. There were also interactions between CAMH specialists and district managers about CAMHS, and in some districts multidisciplinary health teams that included a CAMH specialist had been formed. CAMHS also received support from the academic systems (University of Cape Town and Stellenbosch University) through training, clinical supervision, and research.

Tertiary CAMH specialists offered support to mental health providers and non-specialists at primary and secondary care levels through supervision and training. As a result of these interactions, referral care pathways had been improved in recent years.

4.3.2 Weaknesses

Five main weaknesses emerged from the analysis: limited capacity, workload demands, inadequate and inequitable resource allocation, poor implementation of early detection and preventive policies, and overall neglect of CAMHS. **Table 4.2** provides a summary of the identified themes and subthemes, illustrated with representative quotes from participant transcripts.

Table 4.2 A summary of themes illustrating the weaknesses in child and adolescent mental health services

Overarching theme	Subthemes	Illustrative examples/quotes
Limited capacity	Insufficient training in CAMH services	*"…there's insufficient focused training on child and adolescent psychiatry…"* **[Nursing manager]**
Workload demands	Statistics not correlating to child psychiatry	*"Stats is a problem…if my output is about 25 patients per month*…that doesn't speak to my workload…doesn't speak to how many crises I've had for in between..."* **[Advanced senior psychiatric nurse]**
Inadequate and inequitable resource allocation	Unequal distribution of CAMH services	*"…we're dealing with a large gap of socioeconomic status…so there's a large variation of accessibility for services and knowledge about the services etc. …"* **[Child & adolescent psychiatrist]**
	Dependency on NGOs	*"I think that too many things are left to NGOs..."* **[Advanced senior psychiatric nurse]** *"Too much is now left to NGOs where they are now seeing these children..."* **[Advanced senior psychiatric nurse]**
Poor implementation of early detection and preventive policies	Preventative approaches not implemented	*"…preventative approaches...that's not being implemented…"* **[Advanced senior psychiatric nurse]** *"There's no early detection and prevention for CAMH services…we only get them once it's a train smash and there's a lot of services that we need…"* **[Child & adolescent psychiatrist]**
Overall neglect of CAMH services	Lack of knowledge of the needs of CAMH services	*"There's lack of understanding of child and adolescent mental health, it's still termed naughtiness even with educational services…"* **[Advanced senior psychiatric nurse]** *"…it's very difficult to put a voice to those people who don't know what we do, versus what they do...they don't understand what the need is this side…"* **[Nursing manager]**

Overarching theme	Subthemes	Illustrative examples/quotes
	Lack of priority for CAMH services	*…a psychiatric emergency versus medical emergency...there's not so much recognition...like a patient in ICU..."* **[Advanced senior psychiatric nurse]** *"They don't see a psychiatric emergency like a medical emergency…less urgent…"* **[Advanced senior psychiatric nurse]** *"A psychiatry emergency is always less important than a medical emergency…"* **[Advanced senior psychiatric nurse]**
	Low levels of advocacy for CAMH services	*"…we haven't got the bodies to do the advocacy…"* **[Child & adolescent psychiatrist]** *"In the actual fact there's lots of advocacy but it's been busy with Esidimeni…"* ** **[Child & adolescent psychiatrist]**
	Lack of insight about CAMH services	*"…from my side…from the management side...it's very difficult to put in voice...it's like people don't understand what we do this side...it's also sensitive…"* **[Nursing manager]**

***A local term used to refer to the workload expectation in services i.e. the requirement to see a certain number of patients per day in a service;**

****Referring to the Life Esidimeni Crisis (2018) when 118 adults with mental health disorders and/or intellectual disabilities died after being transferred from specialist facilities to non-registered NGOs**

1. Limited Capacity

Participants described a general lack of capacity in the Western Cape within the DoH, the Department of Education (WCED), and the Department of Social Development (DSD). The WCED and DSD were described as having high workloads and a shortage of resources to meet the demand. DoH staff felt that the WCED and DSD referred a lot of inappropriate cases to CAMHS, adding to the workload of the DoH. Participants referred to insufficient training on CAMH within all three departments and expressed concern about lack of standardised best practices across CAMHS. Limited human resources within the DoH for CAMHS were described, particularly at primary and secondary levels of care. Non-specialists were described as overwhelmed by the CAMH workload, despite their goodwill.

2. Workload Demands

There were complaints about the 'stats' requirements for staff in CAMHS. In this context, 'stats' is a local term used to refer to the workload expectation in services, in other words, the requirement to see a certain number of patients per day in a service. Service providers felt that these 'stats' requirements did not correlate with the work that they do. The pressure on service providers to meet the 'stats' quotas set by senior managers was seen to be at the expense of the quality of service that was needed by users. As a result, clinical staff felt as if they were not doing enough when low numbers were reflected. Service providers felt strongly that the type of 'stats' quotas for CAMHS should reflect and capture all the qualitative therapeutic work done and not just be about numbers. Participants reported that generalists in primary healthcare settings and secondary level were also unable to manage their 'stats' demands, given the high workload associated with CAMH cases.

3. Inadequate and Inequitable Resource Allocation

Participants reported that there were no outpatient, inpatient, or inpatient emergency facilities for CAMHS at secondary level (i.e. at district/regional hospital level). Children were still mixed with adults at primary and secondary levels of care. CAMH resources were still unequally distributed in the Western Cape thus limiting access to CAMHS for those who do not live in Cape Town close to specialist facilities. Participants further commented that there were

fewer resources and access to CAMHS for areas with the lowest socioeconomic status, including rural areas.

Non-governmental/non-profit organisations (NGOs/NPOs) and academic institutions were providing good support to the overburdened Department of Health CAMHS. Academic institutions were recognised not only as conducting research and teaching, but also as providers of clinical services to children and their families. NGOs and NPOs were recognised as providing services for a lot of cases that could not be seen in the DoH CAMHS. However, participants expressed the view that the NGO/NPO sector was 'overused' as a way of compensating for the lack of government funded CAMHS.

4. Poor Implementation of Early Detection and Preventive Policies

Despite the reported strength of the presence of preventive service plans, concern was expressed that these policies and plans had not been implemented. Early detection of CAMH problems was lacking, cases were often described as being referred only when there is a crisis or when the problem had worsened and became complicated – by which time complex, long-term, and multiple resources are typically required for intervention. Participants reported that the preventive work becomes the burden of the parents and families who are expected to take initiative to ensure care for their children.

5. Overall Neglect of Child and Adolescent Mental Health Services

Participants reported that the needs for CAMHS were not prioritised and often not met, in comparison to other medical disciplines, particularly for emergencies. Given that CAMHS are dependent on budget allocation within facilities, CAMHS in those facilities must often advocate for the needs of CAMHS. However, these attempts were described as 'often in vain' due to limited insight of those in managerial positions, non-specialists, and those who allocate budgets. Participants expressed concern about a lack of insight and understanding about what CAMHS entail and about the exact needs of CAMHS, in spite of ongoing information, advocacy, and education within facilities and institutions. Participants acknowledged that advocacy for CAMHS at a provincial and national level was actually lacking and that existing

advocacy in mental health had mainly focused on the "Life Esidimeni" crisis (Ferlito, 2018) which solely focused on the mental health needs of adults with and without intellectual disabilities. The "Life Esidimeni" crisis involved the death of 118 adults with mental health problems and/or intellectual disabilities in 2018, when they were forcibly removed from "Life Esidimeni" psychiatric homes and placed in ill-equipped, unprepared, and unlicensed NGOs. The court ruled a) that the Gauteng DoH was negligent, and b) that financial compensation should be provided to the families of the deceased (Ferlito, 2018).

4.3.4 Opportunities

The following were identified by participants as opportunities for development and strengthening of CAMHS in the Western Cape: collaborative working between CAMH and paediatric services and increased Provincial Government (DoH) involvement. **Table 4.3** provides a summary of the identified themes and subthemes, illustrated with representative quotes from participant transcripts.

Table 4.3 A summary of themes illustrating the opportunities to improve child and adolescent mental health services

Overarching theme	Subthemes	Illustrative examples/quotes
Collaborative working between CAMH services and paediatric services	Early identification of CAMH problems	*"There was a proposed merger of paediatricians and child psychiatrists. The first 1,000 days... the paediatricians are reporting on the first 1,000 days…actually the first 1,000 days is a facilitator…"* **[Child & adolescent psychiatrist]**
Increased Provincial Government (Department of Health) involvement		*"There's now some support from the Department [Department of Health] for the last three years…"* **[Child & adolescent psychiatrist]**

1. Collaborative Working Between Child and Adolescent Mental Health and Paediatric Services

The ‘First 1,000 days of life project’, a collaborative cross-agency programme involving the DoH, WCED, and DSD (Schwarzenberg & Georgieff, 2018), was created as a systematic preventative programme to identify and reduce risk factors for maternal and infant mental health problems during the first 1,000 days of life. The programme was given as example of an approach that helped to establish and build relationships across agencies (DoH, WCED, and DSD) and between different disciplines, and led to reporting on health indicators in the first 1,000 days of life. It was instrumental in creating awareness among paediatricians about maternal and infant mental health, which improved interaction and cross-referrals between CAMH and paediatric services. The project was therefore identified as a model to improve integrated services across agencies and disciplines working with children and adolescents at risk of mental health problems.

2. Increased Provincial Government (Department of Health) Involvement

Participants described that there had been increased interaction between the Provincial DoH and CAMH specialists over a 3-year period (2014–2017) with an interest from the Provincial DoH to understand CAMH services and service needs. This was seen as an opportunity for CAMH specialists to advocate for the needs of CAMHS.

4.3.5 Threats

The following threats for CAMHS in the province were identified: silo working of agencies, societal stressors, inadequate infrastructure and other resources, and lack of dedicated funding for CAMHS. **Table 4.4** provides a summary of the identified themes and subthemes, illustrated with representative quotes from participant transcripts.

Table 4.4 A summary of themes illustrating the threats for child and adolescent mental health services

Overarching theme	Subthemes	Illustrative examples/quotes
Silo working of agencies	Lack of multisectoral collaboration	*"The Department of Social Development and the Western Cape Education are the two biggest headaches...if they don't know which way [to refer patients] it becomes health's problem, and inevitably because it's not physical health it ends up in mental health…they are overburdened...they are flooded..."* **[Advanced senior psychiatric nurse]**
	Lack of multi-agency work	*"…lack of multi-agency joint working. We're very much dependent on…social workers and the Department of Education and when those aren't functioning, that impacts on our work…"* **[Senior clinical psychologist]**
Societal stressors	Societal decay	*"Societal decay is affecting us [CAMH services] …"* **[Advanced senior psychiatric nurse]** *"Lack of structure… fractured families…lack of stability…"* **[Advanced senior psychiatric nurse]**
	Fractured families	*"…We come from a system which has been traumatised over generations with both systematic violence like group segregation…migrant labour… the political situation in the country has facilitated the breakup of families… so the parenting has been done by grandparents…which were under-resourced…it was just the system that was trying to produce the generation with difficulties… we're sitting with a generational legacy which has not been addressed…trying to address the child's problem in the context of weak parenthood…"* **[Child & adolescent psychiatrist]**
	Stigma	*"With children there's always stigma. They cannot defend themselves. That can be a barrier…"* **[Child & adolescent psychiatrist]**

Overarching theme	Subthemes	Illustrative examples/quotes
Inadequate infrastructure and other resources	Limited dedicated CAMH therapeutic facilities	*"The children now are being lost...there are a lot of children with psychosis...we've lost therapeutic services for children…"* **[Policymaker]** *"There are no emergency psychiatric beds for children in this province, when TLC* is full..."* **[Advanced senior psychiatric nurse]** *"There's no inpatient facilities for non-psychotic children…"* **[Child & adolescent psychiatrist]**
Lack of dedicated funding for CAMH services	No separate funding for CAMH services	*"…we have a competition with more sexy…you know once we lost out to the penis transplant**…it's always about ICU*** and the neurosurgeries and the… and the penis transplants and all the other stuff…"* **[Child & adolescent psychiatrist]** *"CAMH services always have to compete with other departments for funding…"* **[Child & adolescent psychiatrist]** *"There is no separate funding for CAMH services…"* **[Policymaker]**

***Therapeutic Learning Centre, a small inpatient unit for children with complex mental health problems; **Innovative surgery performed for the first time in South Africa; *** Intensive Care Unit for physically ill children**

1. Silo Working of Agencies

Participants described a lack of 'joined-up' or coordinated multi-agency work between the DoH, WCED, and DSD. All these departments were described as working in 'silos' which made it difficult to manage cases that required intervention or input from all three agencies. There was a strong feeling that the challenges and service pressures within WCED and DSD impacted directly on the DoH, leading to inappropriate referrals to the DoH and struggles to do joint working across agencies.

2. Societal Stressors

Participants cited the high rates of poverty, crime, substance abuse, and violence in communities as resulting in psychiatric morbidity in children and adolescents. This was perceived to lead to a 'revolving door' system for children and adolescents affected by mental health problems. Stakeholders described that treating mental health problems effectively when children live in maladaptive contexts and unsupportive communities becomes difficult to sustain. Many children were described as coming from traumatised backgrounds and fractured family structures. Parents often have mental health problems and intervention is needed for both the parent and the child. Senior stakeholders also reported significant stigma attached to child and adolescent mental illness and an associated lack of insight into CAMH problems. Psychiatric problems in children were often viewed as a child just 'being naughty' or as parents not being able to discipline their child. Families who seek help from CAMH services were often stigmatised within their extended families, their communities, and within the healthcare system.

3. Inadequate Infrastructure and Other Resources

Participants reported that in the whole of the Western Cape there were only three CAMH specialist units providing inpatient and outpatient services exclusively for children and adolescents. These units provide tertiary services and are therefore based only at the two tertiary teaching hospitals in Cape Town. The limited services and infrastructure were described not only as a weakness (as described above), but also as a threat to future services and service delivery.

Participants expressed concern that there are no dedicated CAMHS at primary level (public health services at community level). Children and adolescents are seen together with adult psychiatric patients in outpatient psychiatric services that are not child/adolescent-friendly. Children and adolescents may therefore be traumatised by the aggressive or high-risk behaviours of adult patients with serious mental illnesses. At day hospitals psychotropic medications are inconsistently available (e.g., available for a few weeks, and then not available for the next month). This may risk the worsening of the mental states of children and adolescents and/or development of treatment resistance. As outlined earlier, resources were most limited in the most needy and vulnerable communities such as in very low socioeconomic or rural settings.

At secondary (district/regional) level, there are no dedicated facilities for CAMH problems – neither for outpatient care nor for psychiatric emergencies. Acute cases of children under the age of 12 years therefore have to be admitted to general paediatric wards, and adolescents over 13 years of age have to be admitted to adult psychiatric emergency inpatient units. These inpatient units are not child/adolescent-friendly and do not have the appropriate resources to assess children and adolescents. Often there are no therapeutic resources, such as developmentally appropriate reading material or self-help guides, or play materials to engage children and adolescents while in the unit. Units are also not designed to provide safety and privacy to a child/adolescent with an acute psychiatric problem. Service providers are not trained to manage the challenging behaviour of the acutely mentally ill child or adolescent. Even more pronounced than in outpatient settings, adolescents are frequency exposed to aggressive and high-risk behaviours of adults with acute severe mental illnesses.

4. Lack of Dedicated Funding for Child and Adolescent Mental Health Services

There were no dedicated budgets for CAMHS at national or provincial level. Participants reported that, at some stage in the past, provincial budgets were divided into mental health and general health, and that the mental health budget was dedicated and ring-fenced. The ring-fenced mental health budget was, however, discontinued and only mental hospitals now have dedicated

budgets. CAMH is a predominantly outpatient-based service and there are no dedicated CAMH hospitals. The budget for CAMHS is therefore integrated in the general health budget, within the facilities where CAMH teams are based, for instance at Tygerberg, Lentegeur, or Red Cross War Memorial Children's Hospital. Participants expressed the view that there was high competition with other departments and their emergencies for budget in these facilities, and that CAMHS were often the least valued and prioritised, making it difficult to maintain essential resources or to improve the existing resources.

4.4 Discussion

Noting the lack of improvement in CAMHS in South Africa over the years since the last situational analysis in 2005 (Kleintjes et al., 2010), and the lack of progress in policy development and implementation (Kleintjes et al., 2010; Mokitimi, Schneider & de Vries, 2018), we sought to obtain senior stakeholder perspectives on the current state of CAMHS to provide key local knowledge that could inform policy and service strengthening for CAMH in a South African context. The study therefore collected multistakeholder data from CAMH policymakers, senior service managers, and senior service providers on the SWOT of CAMHS in the Western Cape Province of South Africa.

Stakeholders identified a number of positive aspects of CAMHS. These included recent improvements in services, strong specialist services at tertiary level, improved collaborative working with the provincial DoH, and enhanced interaction between the specialist multidisciplinary teams and non-specialist colleagues at district and community level. These findings suggest potential strategies for CAMH service strengthening through ongoing collaboration with policymakers and funders, and ongoing training and capacity-building with district and community level colleagues. Results may suggest that particular benefits may come from the identification of appropriate task-sharing activities in keeping with the WHO recommendations (World Health Organization, 2007).

The stakeholder findings also identified a significant number of negative aspects of CAMHS, many of which were similar to observations made more than 10 years earlier (Kleintjes et al., 2010). Poor intersectoral working, limited and inappropriate resources, unreasonable expectations of CAMH staff, and the absence of dedicated budgets for CAMH, all within the context of societal stressors, were seen as major barriers to CAMHS. Current proposals on budget allocation, the structuring of CAMHS and allocation of resources for CAMHS are therefore likely to threaten the development of comprehensive CAMHS and compromise the efficacy of CAMH providers at all levels of care very significantly over the next decade. This, in turn, may result in greater costs to treat complicated CAMH problems in adulthood (Juengsiragulwit, 2015; Weiss et al., 2012; World Health Organization, 2005).

In an attempt to generate a synthesis of the findings from this SWOT analysis, we sought a visual model that could help to integrate the otherwise potentially unrelated positive aspects outlined (strengths and opportunities) in relation to the negative aspects outlined (weaknesses and threats). Using the concept of 'tipping points' in the context of our study, we propose that the strengths and opportunities versus the weaknesses and threats may contribute to a scale of potential for strengthening (or weakening) of CAMHS. **Figure 4.3** provides a graphic representation of this concept, incorporating the findings from this study. Data generated in this study suggests that, even though a number of positive elements were identified, a much larger number of negative elements of CAMHS may be present, threatening a tipping point towards disruption and weakening of services.

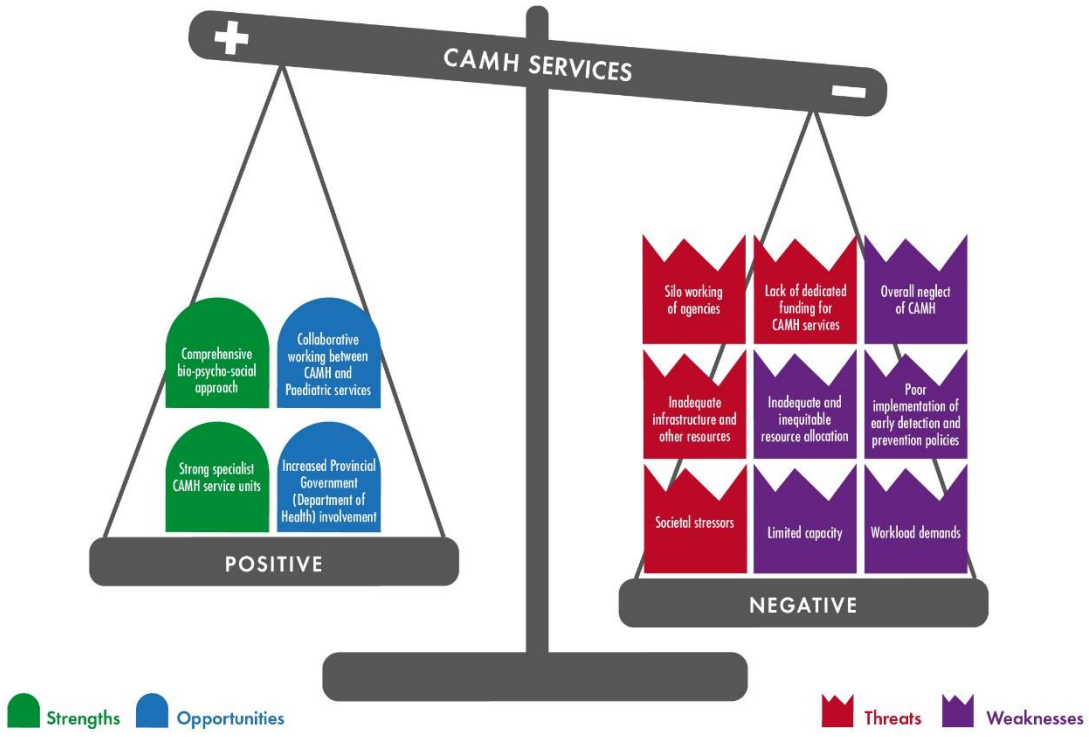

Figure 4.3 The tipping point model of child and adolescent mental health services

While these findings are of significant concern, particularly in a country which is often thought of as well-developed in terms of mental health and health services, the 'tipping point model' of CAMHS strengthening may also allow us to identify small events, actions, and activities that could lead to significant positive change. From the data presented here, it seems that, for instance, the First 1,000 days of life project (which was a multisectorial project to identify and manage risks to mothers and their infants), and recent collaborative work between CAMH teams and provincial DoH (to identify and strengthen some elements of CAMHS) may represent examples of positive tipping events. These can facilitate recognition of CAMH as a health priority and provide an opportunity for changing budget allocations to create parity with other medical problem. Such interactions may also influence policies that could formally define interactions, roles, and responsibilities between the four government

departments directly involved in children and adolescents (DoH, WCED, DSD, and Justice).

It is clear that there are many unanswered questions about CAMH in the Western Cape and in South Africa that could shed light on potential positive tipping events for CAMH strengthening. For instance, the perspectives and lived experience of clinicians at the very grassroots of district and community service delivery, and those of families and children who access CAMHS may identify additional positive or negative tipping factors. It would be of particular importance to seek broad representation across socioeconomic, cultural, linguistic, rural/urban, religious, and age-based variables.

4.4.1 Limitations of the study

We acknowledge that the data generated in this multistakeholder analysis were derived from one small group of high-level clinical, managerial, and policymaking stakeholders in one South African province. Great care should therefore be taken in generalisation of findings. However, given that this was a qualitative study, the data were sufficient to generate saturated themes, supporting the robustness of findings. At least some of the themes and subthemes that emerged may therefore resonate with the needs of other provinces and LMIC. It is important to consider potential bias in a sample where about 50% of invited participants did not join. However, we set out to provide equal and fair chances to all participants (across levels of care, professional groups, health districts, rural/urban) to participate. For instance, all participants were sent the same number of reminders and all participants were invited to submit written comments if they were unable to participate in person due to conflicting demands. We acknowledge that there was lack of rural representation in the workshop, other important demographic groups were well-represented. We further acknowledge that the study performed qualitative analysis of data which may be open to bias. However, to increase trustworthiness and robustness of findings, we used two independent raters (one a CAMH specialist, the other a non-clinician) to generate themes and subthemes. Member-checking during the workshop further added to the

trustworthiness of results. It will be important to perform triangulation of data with subsequent studies (e.g., provider or user perspectives) to generate the most comprehensive findings. All discussions were held in English, even though not all participants were primary English speakers. However, as outlined in the methods section, English is very much the 'lingua franca' in professional settings, and all participants indicated that they were fluent in English. We were therefore confident that the quality of data was not compromised as a result of conducting the workshop in English. It would be important for grassroots level analysis to interview participants in their primary language, such as isiXhosa or Afrikaans. The absence of other service providers and of children and families in this manuscript may appear to be a limitation. However, given the importance of the user/carer perspective and the provider perspective (as shown in **Figure 4.3**), we have opted to dedicate two separate sub-studies and separate manuscripts to the voices of families and children who use CAMHS, and to those who provide services at the grassroots level.

4.4.2 Relevance of findings to other low- and middle-income countries

As outlined under limitations, we acknowledge that themes and subthemes identified may not all be of direct relevance to other LMIC. In fact, it is important to consider that different countries, communities, and settings may have very different CAMH service models and healthcare systems. It would therefore be of the utmost importance to perform similar SWOT analysis in different settings that may identify similar or different 'tipping' events or factors that could be used for CAMH strengthening activities in those settings. We predict that there may be some universal themes, subthemes, and 'tipping points' across LMIC such as lack of policy development, inadequate CAMH resources, poor intersectoral collaboration, unclear financing for CAMHS, and the potential integration of CAMHS into general health services (Bruckner et al., 2011; Juengsiragulwit, 2015). However, these should all be subject to empirical investigation.

4.5 Conclusions

The findings of this SWOT analysis provided insight into senior stakeholder perceptions about the current state of CAMHS in the Western Cape Province of South Africa. The weaknesses and threats to CAMHS identified here were clearly of concern. As a next step, we propose that further exploration of clinician and user perspectives from the grassroots of CAMHS should be investigated in order to identify positive 'tipping' events, activities, or behaviours that could be incorporated into a comprehensive strategy to strengthen CAMHS in South Africa, and that may be of potential value in other LMIC.

4.6. Chapter Summary

There is general consensus that CAMHS in LMIC have an urgent need to be strengthened. However, this requires not only a universal understanding of services and service needs, but also an in-depth local knowledge to inform relevant service strengthening. This study sought to explore the perspectives of senior child and adolescent mental health service providers and policymakers in one South African province to identify strengths, weaknesses, opportunities, and threats to child and adolescent mental health services. A qualitative study was conducted with thirteen purposively sampled senior child and adolescent mental health service providers, senior managers, and policymakers from the Western Cape Province, using a half-day multistakeholder workshop format. Verbal and written data were recorded and coded for analysis. Two independent raters performed thematic analysis. The comprehensive bio-psycho-social approach and strong specialist child and adolescent mental health service units were identified as strengths. Limited capacity, workload demands, inadequate and inequitable resource allocation, poor implementation of early detection and preventative policies, and overall neglect of child and adolescent mental health services, were identified as weaknesses. Collaborative working between child and adolescent mental health and paediatric services and increased provincial government (DoH) involvement, were identified as potential opportunities to develop and

strengthen CAMHS. Silo working of agencies, societal stressors, inadequate infrastructure and other resources, and lack of dedicated funding for CAMH, were identified as threats to the development of services. This analysis of strengths, weaknesses, opportunities, and threats reinforced the widespread neglect of CAMHS in South Africa and highlighted areas for further research and advocacy. There is a clear need to explore the perspectives and experiences of service users and providers to generate comprehensive multistakeholder evidence that may identify positive ‘tipping points’ for improvements and strengthening of CAMH service delivery, training, and research.

Chapter 5: Child and adolescent mental health services in the Western Cape Province of South Africa – the perspectives of service providers

5.1 Introduction

To strengthen health systems, all the elements (hardware and software) of a particular health system should be evaluated (Gilson, 2012; World Health Organization, 2007). This requires an in-depth exploration of CAMHS including policy, resources, and perspectives of stakeholders at all levels (senior service providers, grassroots level service providers, and users). In Chapter 2, our policy analysis at national and provincial level in South Africa showed a clear neglect of CAMHS at policy level in the Western Cape. These findings were concerning, given that good service provision should start with good policies. A fine-grained situational analysis of CAMHS in the Western Cape (Chapter 3) identified significant gaps across hardware elements (policies, funding, clinical services, primary healthcare, human resources, intersectoral collaboration, and information systems) suggesting a weak foundation for the provision of CAMH services in the province. In Chapter 4 we proceeded to do a SWOT analysis of CAMHS in the Western Cape, performed by a range of senior stakeholders (funders, policymakers, senior service managers, and senior clinicians). This approach allowed us to collect information not only about hardware elements, but also about some of the software elements, such as belief systems, attitudes, relationships and value systems (Gilson, 2012). The findings of the SWOT analysis, performed completely independently from the situational analysis in Chapter 3, identified many weaknesses and threats to CAMH in the province, complementing the observations made in the situational analysis. The SWOT analysis also identified some areas of strengths and opportunities that could be used to support service strengthening in CAMHS. We proposed a 'tipping point' model (Mokitimi, Schneider & de Vries, 2019) suggesting that a number of positive and negative forces interact on the scale of services. The scale, as presented in Chapter 4,

was predominantly skewed towards negative tipping points. In a tipping point model, service strengthening could be achieved not only through major restructuring, but also through the collective effects of small positive tipping events.

This chapter set out to explore the perceptions of service providers about CAMHS in the Western Cape and to seek their recommendations for future strategies to strengthen services. We selected to focus on service providers for two reasons: Firstly, grassroots level service provider perspectives are important to help gain insight into the real-world context in which services are provided. In the Western Cape there has been very limited exploration of the views of CAMHS providers at grassroots level who have direct day-to-day clinical interactions with children, adolescents and their families. Secondly, these perspectives may be able to provide valuable practical observations that could suggest further tipping points to be used for the strengthening of CAMHS. We therefore set out to collect qualitative data from a broad range of service providers across the urban and rural geographical service areas in the province, and across all levels of care (primary, secondary and tertiary). We were interested to see if we would be able to identify a) themes that may be similar to those identified in the SWOT analysis with senior stakeholders, and b) themes that may be novel, different or elaborations of those identified in the SWOT analysis.

5.2 Methods

5.2.1 Study design

A qualitative exploratory study was conducted using focus group discussions (FGDs) and semi-structured individual interviews (SSIIs). FGDs and SSIIs are useful in generating a rich understanding of participant experiences and beliefs (Gill, Stewart, Treasure & Chadwick, 2008).

5.2.2 Study participants and setting

Purposive sampling was used to select CAMH professionals who were providing a direct service to children and adolescents with mental health problems and their families. Participants were selected from the health sector in the Western Cape. The Western Cape is divided into a number of urban (metropolitan) and rural districts (see **Figure 4.2** in Chapter 4). We aimed to include a wide range of service providers from all the urban health districts (Southern/Western substructure, Mitchell's Plain/Klipfontein substructure, Tygerberg/Northern substructure, Khayelitsha/Eastern substructure), and rural districts (Cape Winelands, West Coast, Overberg, Eden and Central Karoo), and from all levels of care (primary, secondary and tertiary).

The Provincial Mental Health Directory (Western Cape Department of Health, 2015), a list of all mental health professionals and their contact details, was used to identify the mental health service providers. Those who were not listed in the provincial directory were identified at facilities through facility managers. Participants were recruited both telephonically and via email.

5.2.3 Research ethics

The study was done in compliance with Declaration of Helsinki (2013). Ethics approval was obtained from the University of Cape Town Faculty of Health Sciences Human Research Ethics Committee (HREC 188/2016). Permission to conduct the study was also obtained from the Western Cape Department of Health (HREC:2016RP39_567) and from Red Cross War Memorial Children's Hospital (RXH:RCC73).

5.2.4 Data collection

Information sheets containing details about the study as well as consent forms were provided to invited staff, signed by the participants prior to the study, and were collected on the day of face-to-face interviews and/or focus group discussions. Data were collected between May and July 2017. SSIIs and FGDs were conducted by the primary researcher and two research assistants in a quiet, private space in a convenient location selected by each participant

or group. The research assistants were mental health professionals with experience in conducting FGDs and SSIIs. All SSIIs and FGDs were audio recorded and field notes were taken during and after the interviews. The duration of each FGD and SSII ranged from 30–90 minutes.

The discussions covered various topics exploring the lived experiences of providing child and adolescent mental health services, care pathways, intersectoral collaboration, barriers and facilitators to care, and recommendations on how to improve CAMHS. The interview guides are presented in appendices K and L of this thesis.

Member checking was done during the interview process and at the end of each SSII and FGD to optimise the trustworthiness of the findings. The interviewer summarised the key points that were made by the participants to validate the key issues that require attention in CAMHS and then asked the participant(s) to confirm whether the information that they had given had been captured and interpreted accurately.

5.2.5 Data analysis

Audio recordings were analysed using thematic analysis (Maguire & Delahunt, 2017; Nowell et al., 2017) using the NVivo 11(QSR) qualitative data software package (Catarina, 2015). Relevant sections were transcribed verbatim in NVivo. Data were coded, and codes were subsequently grouped into themes. The coded transcripts were analysed by running query reports, and primary document tables of the codes and themes were produced in order to explore the key issues.

To strengthen the trustworthiness of analysis, data triangulation was performed. Written notes and observations were made by the research team during FGDs and SSIIs and were compared with the data from FGDs and SSIIs to corroborate the findings of this study. Furthermore, to ensure objectivity of the data, two researchers (the author and a colleague experienced in qualitative analysis) coded all the data independently. The two researchers met regularly to compare and discuss their findings until consensus was reached. No quantitative measure of agreement was calculated.

5.3 Results

A total of forty-six (n=46) mental health service providers across all districts in the Western Cape participated in this study. Participants included child & adolescent psychiatrists, general psychiatrists, medical officers (medically qualified professionals without formal qualifications in psychiatry), psychiatric registrars (generalists who are training in psychiatry), and mental health nurses. In total, eleven SSIIs and four FGDs were conducted. **Table 5.1** provides a summary of the study participants.

Table 5.1 Participants in the study of service providers

Participants	**Total: n=46**	Child & adolescent psychiatrists = 4 Psychiatric registrars = 1 Medical officers = 1 General psychiatrists = 2 Mental health nurses = 38
Number of focus group discussions (FGDs)	4	
Number of semi-structured individual interviews (SSIIs)	11	
Level of care	Primary	SSIIs = 3 FGDs = 4 (n= 35)
	Secondary	SSIIs = 4
	Tertiary	SSIIs = 4
Geographical representation	City of Cape Town (urban)	SSIIs = 8 FGDs = 3 (n=15)
	Rural districts	SSIIs = 3 FGDs = 1 (n=20)

The results of the FGDs and SSIIs based on identified themes are presented below. The themes identified that were similar to those from the SWOT analysis (Chapter 4) are presented in **Table 5.2**.

Table 5.2 Themes identified in this study of grassroots service providers that overlapped with the SWOT analysis of senior stakeholders in Chapter 4

Overarching theme	Service provider themes (this study)	SWOT analysis themes (Chapter 4)	Illustrative examples/quotes
Lack of resources	Lack of CAMH infrastructure	Inadequate infrastructure and other resources	*"… I mean there's no specific psychiatry ward; so many adolescent patients have to be admitted to normal ward with our other sick patients, which raise a lot more other issues. Even for the children, they also have to be admitted to the paeds (paediatric) ward with other sick children, and then you have this very disruptive kid amongst other sick children which is a challenge…"* **Child & adolescent psychiatrist (secondary level, urban district)**
	Heavy workload	Workload demands	*"… all the different clinics have their different challenges ... and I'm gonna say that ... to expect clinic sister to see children is ... it's not ... it's not realistic. They barely get to see their 50–60 adults, sometimes they're 70 adults in the clinic per day ... they barely get to see those patients the way they should be seen …"* **District child & adolescent psychiatrist (secondary level, urban district)**
	Lack of financing	Lack of dedicated funding for CAMH services	*"… mental health patients don't get the same quality of care as general patients do ... even if you look at the departmental budgets ... even psychiatry tends to get a smaller portion of budgets ... so ... you know ... we are not able to provide services to exactly the standard that we would want …"* **Medical officer (secondary level, urban district)**
	Inequitable distribution of available resources	Inadequate and inequitable resource allocation	*"… there is inequity of service ... which is very obvious … for example if I look at the size of my team here, the [tertiary CAMHS unit in one substructure] team is three times the size than is of [the other tertiary CAMHS unit in another substructure] ... separate*

Overarching theme	Service provider themes (this study)	SWOT analysis themes (Chapter 4)	Illustrative examples/quotes
			psychologist for each thing at outpatients, nurses separate for each thing ... it is really an imbalance in terms of distribution of resources ... which is really challenging ..." **Child & adolescent psychiatrist (tertiary level, urban district)**
Lack of intersectoral collaboration	Silo working of the Departments of Health, Education and Social Development	Silo working of agencies	*"… big challenge is education; the department does not pick up these disorders soon enough. Social development is overloaded too …"* **Child & adolescent psychiatrist (secondary level, urban district)** *"... the social development system is overloaded and dysfunctional so that when a child has had a psychiatric experience, it becomes incredibly difficult to place them ..."* **Child & adolescent psychiatrist (tertiary level, urban district)**
Limited training	Limited training	Limited training	*"The challenge is … the staff (in non-mental emergency inpatient units) is not trained to work with mentally ill patients and with adolescents … I feel for them because now they must deal with psychiatric patients …"* **Mental health nurse (secondary level, urban district)**
External contributing factors	Stigma	Societal stressors	*"... sometimes stigma is an issue, no parent wants their children to be labelled as a psychiatric patient..."* **Child & adolescent psychiatrist (secondary level, urban district)**

Additional themes identified

Additional themes not identified in the SWOT analysis (Chapter 4) are summarised and described with illustrative quotes in **Table 5.3**.

Table 5.3 Additional themes from service providers on child and adolescent mental health services in the Western Cape

Overarching Theme	Examples
Lack of uniformity and consistency	Three specialist CAMH units work differently
Lack of support for staff	Lack of professional support Lack of emotional and moral support
Lack of acknowledgement of staff	Lack of acknowledgement for initiatives introduced by staff in CAMH services
Negative staff attitudes	Negative staff attitudes about seeing children and adolescents prevent them from providing good CAMH services
Health service innovations	Examples of innovative service provision by mental health nurses in primary healthcare clinics
External contributing factors	Stigma Poor socioeconomic circumstances Substance use

Lack of uniformity and consistency

Participants described that there was a lack of uniformity and consistency among the three specialist CAMH units in terms of the services offered, skills provided, structuring and in organisation of CAMHS. One specialised in autism, the other in neuropsychiatric conditions and the third in substance abuse and rehabilitation. Participants perceived specialist units to be implementing the national CAMH policy in their own way, including how they structured and organised CAMHS in their areas. Respondents further felt that there was no uniformity among the specialist CAMH units with regards to referral care pathways. The perception was that the one would accept referrals only from medical professionals, while the others accepted referrals from any professionals. Service providers felt that this perceived lack of uniformity

created confusion not only to them, but also to service users when they move between the catchment areas for these units.

> *"The units are running very inefficiently. For example, very few people know about what's happening where. Thus, too many things in parallel and in isolation. Service offerings are not consistent in terms of processes, and resource allocation is imbalanced, which leads to certain services can only be offered at certain places."*
>
> **Child & adolescent psychiatrist (tertiary level, urban district)**

Lack of support for staff

Participants felt that there was a lack of professional and emotional support for staff. For instance, they described having to pay for their own private supervision and emotional/therapeutic support. Community mental health providers felt that they did not receive support from the specialists in the specialist CAMH units, especially with difficult cases that they manage at primary level. Mental health providers in rural areas felt that there was very limited interaction between them and specialist CAMH team members.

> *"… very little liaison with tertiary levels so we don't really have much support from the tertiary [services] …"*
>
> **Child & adolescent psychiatrist (secondary level, rural district)**
>
> *"It's an incredible stressful discipline, which makes you want to cry, kill people, and therefore … needs to be a support system for containment and there's no budget for that … so we occasionally end up having to support ourselves in the group meetings. I myself run group support but I myself need one of those so I have to pay for it, but not everyone can afford that ..."*
>
> **Child & adolescent psychiatrist (tertiary level, urban district)**

Lack of acknowledgement of staff

A number of mental health nurses at primary healthcare facilities felt that they had developed potential CAMH service models that were working well in their facilities, and that these service models could be rolled out to other facilities.

The challenge was that they felt facility managers and DoH provincial planners did not notice and did not acknowledge them. Instead, the DoH provincial planners continued to invent models that were not working, according to the providers.

> *"... we don't really get incentives for services ... at least that is what would make what we do worth it ... it would be very nice and very grateful and appreciated if management comes and say ... Mr ... now you started the Tuesday [clinic] ... and I can see you went through all this lengths to get it established and running ... patients are happy and we can see the kids are getting back to school early ... thank you for what you put in ..."*
>
> **Mental health nurse (primary level, urban district)**
>
> *"... we sit in mental health forums ... and we present in the forums that [is what] we do because ... these people in the forums are talking stuff that we are already busy doing ... and they're still trying to figure out how they're going to get us right ... but it is there and it's already been done ..."*
>
> **Mental health nurse (primary level, urban district)**

Negative staff attitudes towards seeing children and adolescents

Mental health nurses at primary healthcare facilities felt that the negative attitudes of their fellow mental healthcare providers towards CAMHS was a problem. A number of staff said that they worked hard to provide the best possible services for their patients under difficult and resource-constrained conditions. They took initiative to create structures within their facilities, within their specialist services and with other non-specialists, and managed to provide CAMHS that at least met the needs of their users. The majority of mental health nurses at primary level, however, felt overwhelmed and unable to provide CAMHS in their settings. The few mental health nurses who felt that they could provide good CAMHS said that their colleagues need to change their negative attitudes towards CAMHS and be open to restructuring their services in order to accommodate children and adolescents. They

acknowledged that they also experienced challenges but still felt strongly that it was possible to provide good CAMHS if negative attitudes can change.

> *"I think the services is great ... because we as clinicians we tend to complain that we can't take this on board ... we have too much of adult psychiatric patients ... and whatever ... but I think if we have proper systems in place ... like putting the children on a specific day it will actually make your work routine and work life much more easier ... I think other clinicians are not realising that, and that's why they ... they're actually ... I feel like kind of negative to take this type of systems on board and dismissing it as 'I don't have time' ... but not really seeing that it will actually spare time … I would recommend you know ... other mental health clinicians to also think positively about the outcome of having a child clinic at the day hospital clinic setting ..."*
> **Mental health nurse (primary level, urban district)**

Health service innovations

A few mental health nurses at PHC facilities shared their innovations for providing ideal effective CAMHS despite all their challenges with resources. For example, there were facilities that provided stand-alone CAMHS. In some facilities, a specific day of the week was set aside as a CAMH clinic, or specific afternoons were set aside for children and adolescents only. Children and adolescent were not mixed with adult psychiatric patients. Mental health nurses coordinated CAMHS within the facilities in such a way that they were prioritised in all departments (administration, pharmacy and general assessments) so that they did not miss out at school. Their files were kept in a mental health section.

"… otherwise I did do the talks at schools, so even the teachers know what type of children to refer to me … I do ADHD outreaches … I am working in a multidisciplinary team with the MOs … I have a child-friendly services … I don't want them to wait among adults in a day hospital setting … so I take the folders straight to the doctor and the doctor will do the work-up …"

Mental health nurse (primary level, urban district)

*" … the facility managers can now see that they need to have a child-friendly services … but that was only now in the *Desmond Tutu youth-friendly initiative … they launched the youth-friendly services last week Friday, and we started already in January … we were like ahead of them … we were almost like the main leaders …"*

Mental health nurse (primary level, urban district)

* Desmond Tutu youth-friendly initiative: The initiative was launched in the Western Cape by the Department of Health in partnership with the Desmond Tutu HIV Foundation, aimed at rolling out the services to the youth between 10 and 24 years of age, to make healthcare services more accessible to the needs of the youth, to keep young girls in school, and to decrease the rates of teenage pregnancy, Tuberculosis (TB), and HIV/AIDS.

External factors contributing to poor child and adolescent mental health

HIV/AIDS, substance use and stigma were identified by providers as external factors contributing to poor child and adolescent mental health. Unresolved social circumstances create a vicious cycle as children keep going back to the same circumstances. Stigma impacts on help-seeking behaviour for CAMH, and drug use is a problem for children and adolescents who are susceptible to mental illness.

"... because we're treating the same people … they go back to the same social circumstances … nothing has changed … it becomes a vicious cycle …"

Mental health nurse (primary level, urban district)

*"… substances is a big problem, and substances can't be dealt with at the *Cape Flats, it needs to be dealt with a higher level …"*

Child & adolescent psychiatrist (secondary level, urban district)

***** geographical part of the City of Cape Town

5.3.2 Recommendations to improve child and adolescent mental health services

Participants made eight recommendations to improve CAMHS in the Western Cape, as outlined in **Table 5.4**. These included increasing CAMH staffing, providing dedicated CAMH services at secondary care and creation of child-friendly infrastructure at primary care, review of current requirements for high volume output rather than quality service delivery, formalisation of intersectoral collaboration, increased learning opportunities for trainees, employment of a 'lead' professional for CAMH in the province, providing more support for staff, and acknowledging staff initiatives in CAMHS.

Table 5.4 Service provider recommendations to strengthen child and adolescent mental health services

1. Increase CAMH staffing
2. Provide dedicated child and adolescent mental health services at level 2 (secondary care) and child-friendly infrastructure at level 1 (primary care)
3. Review current service focus on number of patients seen versus quality of care provided to children
4. Formalise intersectoral collaborations
5. Increase learning opportunities for trainees
6. Employ a lead professional for CAMH in the province
7. Increase support for staff
8. Acknowledgement of staff initiatives

Increase child adolescent mental health staffing

CAMH providers recommended that each primary healthcare facility should be staffed with at least two mental health nurses, an intern psychologist or clinical psychologist, an occupational therapist, a psychiatric registrar and a social worker. At secondary level there should be specialist CAMH providers and mental health multidisciplinary professional for CAMHS.

Providers emphasised that there should also be equitable distribution of human resources across the three specialist CAMH units and across the three sub-structures.

> *"… specialist CAMH professionals should be allocated at level 1 [primary healthcare level] who will engage with children on their level. There should be clinical psychologists at every CHC [community health centre]. There should be a tertiary CAMHS outreach team that goes to see children and adolescents at level 1."*
>
> **Mental health nurse (primary level, urban district)**

Provide dedicated child and adolescent mental health services at secondary care level (level 2) and child-friendly infrastructure at level 1

Providers recommended that there should be inpatient and outpatient mental health units exclusively for children and adolescents at secondary care level. These units should have their own multidisciplinary teams and child-friendly assessment and intervention tools. At primary level all services should be provided with child-friendly assessment tools in order to engage therapeutically with children and adolescents.

> *"I think there should be something between us and tertiary, for children specifically ... Like I said maybe beds in the district level where there could be a team, a psychiatric team that are seeing children there, then if the cases are complicated and need tertiary level then, they come from there to this level, because now there is nothing between us and tertiary, for children ..."*
>
> **Mental health nurse (primary level, urban district)**

> *"… the environment at clinic levels should be I feel like … colourful … not this grey, cream or whatever … but colourful ... attracting this child to say I'm feeling like I'm in a space where I can express myself and say anything … that will be ideal…"*
>
> **Mental health nurse (primary level, urban district)**

> *"I can just agree with others with the environment itself … when I started there I sort of asked for these things ... chairs for the little ones … pictures … then I decided to buy my own just to have it there ...*

they [children] run to these chairs … it makes it so much nicer … that is actually important for a child to feel comfortable in that area …"

Mental health nurse (primary level, urban district)

Review current service focus on number of patients seen versus quality of care provided to children

Providers felt that they need to be relieved from the current requirements of having to see a set number of patients per day and capturing these statistics. They said that the administrative duties add to their workload, and yet it does not reflect on the amount of work done in a day. They felt that the focus should be shifted to quality of service to children and adolescents rather than just the quantity.

"… because now we must fight to keep those stats … basically it's just totals based … I won't be able to give that quality of therapy … what is the point of seeing the child for five minutes because you wanna build stats, then you're not really doing anything … not providing therapy …"

Mental health nurse (primary level, urban district)

Formalise intersectoral collaborations

Providers recommended that collaborations between the DoH, WCED, WCDSD and the Department of Justice should be formalised at top management level in the province. Each department should be clear on their roles and responsibilities for CAMHS and referral care pathways.

"I feel that mental healthcare services can't stand on its own … Department of Health, it needs the Department of Social Services intimately linked with it ... because it is a struggle when you find a child who is being abused … it needs … it's not a simple process to ... you know … access those services …"

Psychiatric registrar (tertiary level, urban district)

Increase learning opportunities for trainees

Mental health providers felt that trainees should not be counted as part of the workforce during their academic placement in the facilities, because the

workload deprives them of the opportunity to learn. Trainees should be afforded the opportunity to learn in the field.

> *"… but what I'm saying is that perhaps six months is not enough … perhaps there needs to be a structural change in the Department [of Psychiatry] so that they don't see registrars as gap fillers but as students, as people who need skills rather than human resource gap fillers … so there's also to be mindful that these people are actually here to learn and not to fill the gap of lack of human resources …"*
>
> **Psychiatric registrar (tertiary level, urban district)**

Employ a lead professional for child and adolescent mental health in the province

Participants recommended that a senior lead professional post for CAMHS should be created as part of the senior management structure in the province. The 'CAMHS lead' could coordinate services in the three substructures, in rural districts and across sectors. Such a post should ensure that all three specialist CAMH units are uniform and consistent in service delivery, for instance through a line management function to the heads of the CAMHS units. In addition, the CAMHS lead professional will oversee all levels of care in the province to ensure equitable distribution of services and resources across the province.

> *"My ideal is, there must be someone higher up in charge of child and adolescent psychiatry. I really feel that's what's lacking, to kind of draw people together, to draw the three big units together and see it from the top. I think at the moment they all do a good job but they're doing it from their own aspects ... and then they meet regularly …"*
>
> **Child & adolescent psychiatrist (tertiary level, urban district)**

Increase support for staff

Participants felt that CAMH specialists should be more visible in rural areas and in primary healthcare facilities to support staff. For instance, they could offer outreach services to primary healthcare by doing consultations with

patients and providing supervision to primary healthcare staff. Staff also felt that they need to be supported by the provincial Department of Health to access clinical supervision, mentoring and emotional support.

> *"Tertiary institutions need to support us. They should have something like outpatient clinic for our difficult cases."*
>
> **Mental health nurse (primary level, urban district)**

Acknowledgement of staff initiatives

Providers felt that their efforts and initiatives should be acknowledged. They said that the Department of Health should consult with them to learn about their grassroots initiatives and innovations in CAMH. They felt that some of these initiatives may have potential for implementation in other parts of the provincial CAMHS.

> *"… I do think with the little that we have and that we do … we do a difference in one or two … and I must add on there's not just the numbers that go up, but the successful cases that go up … You're running your own clinic … but basically everything is your own … I feel that community mental health nursing is gonna grow to such a level that if they [management] don't receive that [acknowledgement of staff initiatives], they're [community mental health nurses] gonna look for something that is gonna satisfy them …"*
>
> **Mental health nurse (primary level, urban district)**

5.4 Discussion

Given the limited data on the views of service providers at grassroots level in the Western Cape about CAMHS and service needs, this study sought the perspectives of a range of frontline service providers across all levels of care and across all health districts in the province. We conducted face-to-face semi-structured individual interviews and focus group discussions and asked clinical staff about their experiences on CAMHS, and their recommendations for future strategies that might strengthen CAMHS. The themes that emerged not only

highlighted challenges with both hardware and software elements of the health systems for child and adolescent mental health, but also pointed to a number of potential solutions to strengthen CAMHS in the province.

In terms of hardware elements, participants expressed challenges with the lack and inequitable distribution of CAMH resources, heavy workload and the lack of financing. These challenges highlight the lack of structure and coordination, and of governance and leadership in CAMHS, thereby suggesting that services are currently unresponsive to the needs of children and adolescents with mental health problems, and unresponsive to the requirements of service providers at grassroots level. A particular point was made about the lack of child and adolescent mental health services at secondary care (level 2), where primary care staff perceived there to be nothing in between them and specialist CAMH (level 3/tertiary services), and which they found difficult to access.

The software-related challenges identified included a lack of intersectoral collaboration, inadequate training on CAMHS, lack of support for staff, lack of acknowledgement of staff initiatives, negative attitudes of some staff towards the mental health of children and adolescents, and comments on external contributing factors such as stigma, socioeconomic challenges and substance use in local communities. These issues suggest gaps in relationships between the provincial leadership, managers, planners and policymakers on the one hand, and service providers at grassroots level on the other. It was clear from the qualitative data that this perceived disconnect had a negative impact on the morale of service providers, risking the quality of service provision for users.

We also observed interactions between hardware and software elements, and how they impact on each other. For instance, service providers expressed feeling demoralised and inadequate in rendering effective services because of the structural challenges and lack of good leadership and governance in CAMHS. If these challenges are left unresolved, they will continue to threaten job satisfaction and sustainability for service providers (Barnay, 2016). The capacity for CAMHS may be further reduced if and when service providers

become intolerant of continuing to work under unfavourable conditions and leave the service.

We were, however, encouraged by the recommendations made by the participants to strengthen CAMHS. With the exception of hardware recommendations to increase staffing and develop dedicated CAMHS at secondary care level, all other recommendations appeared to be software elements that could be implemented almost immediately. The example of one facility where staff introduced innovations to provide a responsive service despite their hardware challenges, exemplified the importance of software elements in service strengthening, i.e. leadership, positive attitudes, acknowledgement and recognition of staff initiative. Chunharas and Davies (2016) pointed out that good leadership at different levels can strengthen a health system. This requires having a vision, setting priorities and mobilising stakeholders and resources to achieve the goals. However, without support from the leadership, staff morale can be impacted negatively, and grassroots innovations can fail, instead of being celebrated and rolled out to other settings. Our findings therefore identified a strong message about the potential to use the local expertise and innovation of mental healthcare staff (often mental health nurses) at grassroots level to strengthen CAMHS.

The recommendations call for a review of the current structure and service delivery model for CAMHS. The ideal structure for CAMHS as recommended by service providers should ensure: 1) proper coordination of the services at top provincial level, within the DoH and with other departments, and down to the primary care level; 2) adequate capacity for CAMHS across all levels; 3) collaboration between senior and grassroots level stakeholders; and 4) reasonable and relevant performance requirements for service providers. They also recommended provision of good leadership and governance at provincial level.

Many of the themes identified in this study were very similar to those identified in the situational analysis (Chapter 3) and SWOT analysis (Chapter 4). The similarities between three completely independent investigations validates and reinforces the significance of the challenges for child and adolescent mental

health services in the Western Cape. Our findings also concur with broader South African and international literature. For instance, a qualitative study that explored multistakeholders' perceptions of CAMHS in another South African province (KwaZulu-Natal) found that there was a shortage of CAMH resources (human and infrastructure) resulting in service providers being overwhelmed with workload, inadequate CAMH training for non-specialists, lack of a coordinated system of CAMH, and stigmatisation of mental illness in children and adolescents (Babatunde, van Rensburg, Bhana & Petersen, 2020). In an international systematic review that explored primary care practitioners' perceptions of the barriers to the effective management of CAMH problems, the authors found lack of staff training, lack of prioritisation of mental health problems, lack of resources, and family issues as key barriers (O'Brien et al., 2016). Our findings are therefore likely not only to be applicable in the Western Cape and in South Africa, but also in other settings, particularly in LMIC.

Study Limitations

We acknowledge a number of potential limitations of the findings in this chapter. First, data were collected in 2017, and therefore there may have been some hardware or software changes in CAMHS after the study. However, as practitioners within the system under investigation we have not observed any significant changes that would invalidate the observations made here. Our findings are also the most comprehensive exploration of service provider perspectives in the province to date. Second, given the qualitative nature of the work, we acknowledge the possibility that we may have missed important themes in this study. However, to mitigate against that, data analysis was performed by two independent raters (one of whom had never worked in the CAMH system), and findings were triangulated to ensure robustness. Third, participants did not include all professional groups, e.g. occupational therapists, speech and language therapists or psychologists. We acknowledge that the full range of allied health professionals are crucial to comprehensive CAMHS and that additional themes may have emerged through their participation. It would therefore be important to include these groups in future studies. Finally, the voices of children and families were not included.

However, given the importance of their voices, we have opted to perform a separate investigation dedicated to the perspectives of families and CAMH service users. This will be the focus of Chapter 6.

5.5 Conclusions

These findings provided insight into the perceptions of service providers at grassroots level about the current state of CAMHS in the Western Cape Province of South Africa. The challenges identified here highlighted the hardware and software weaknesses in CAMHS in the province and converged with results from the situational and SWOT analyses performed. The observations and recommendations made are directly relevant to system strengthening in the Western Cape. We propose that the themes identified may be equally relevant to other provinces and other LMIC. We sincerely hope that our findings will provide service developers, funders and policymakers with an evidence-base that can be used to strengthen CAMHS, ultimately to ensure that we meet the needs of all our service users.

5.6 Chapter Summary

CAMHS need to be strengthened globally, and especially in low-resourced environments. Policy development, planning and service provision should be relevant to the needs of stakeholders at grassroots level. In order to provide and strengthen such services, the perspective of all stakeholders is required. Community-based service providers represent one such stakeholder group. This study therefore set out to explore their lived experiences and perceptions of the services, and to ask for their recommendations to strengthen child and adolescent mental health services in South Africa.

Using focus group discussions and semi-structured individual interviews, qualitative data were collected from purposefully selected multidisciplinary health service providers across the Western Cape, one of the nine South African provinces. Verbal, written and audio recorded data were entered into

NVivo 11 (QSR), and a thematic analysis was performed by two independent raters.

Results highlighted a significant lack of CAMH resources, poor intersectoral collaboration, limited access to training, absence of consistency and uniformity in service delivery, weak support for staff, and high rates of negative attitudes of staff. External factors contributing to poor child and adolescent mental health services identified by service providers included poor socioeconomic circumstances, high rates of HIV/AIDS, substance use and stigma. The eight recommendations to strengthen child and adolescent mental health services included a need to 1) increase CAMH staffing; 2) provide dedicated CAMH services at secondary care and child-friendly infrastructure at primary care; 3) review current service focus on number of patients seen versus quality of care provided to children; 4) formalise intersectoral collaborations; 5) increase learning opportunities for trainees; 6) employ a lead professional for CAMH in the province; 7) increase support for staff and 8) acknowledge staff initiatives. Findings underlined the need for quality improvement, standardisation and scale-up of mental health services for children and adolescents in South Africa. Whilst we used the Western Cape as a 'case study', we propose that our findings may also be relevant to other low-resource settings. We recommend that the complementary perspectives of service users, including children and adolescents, be sought to inform service transformation in child and adolescent mental health.

Chapter 6: Child and adolescent mental health services in the Western Cape – the perspectives of service users

6.1 Introduction

There is a clear need to strengthen child and adolescent mental health services (CAMHS) in the Western Cape as reflected in perspectives collected in the thesis from policy analysis (Chapter 2), situational analysis (Chapter 3), SWOT analysis of senior stakeholders (Chapter 4), and from grassroots clinical service providers in the province (Chapter 5). For services to be effective, they should be person-centered and responsive to the needs of the users (Berntsen et al., 2019). Incorporating the voices of users into planning is therefore an essential step to ensure the relevance of the services to users. This can help to identify barriers to the access and service utilisation, to identify strategies to strengthen the services, and to ensure ongoing collaboration between planners and service users.

In some high-income countries, users are routinely and actively included in the consultative process for the development of CAMHS (Graham et al., 2013; McGorry, Bates & Birchwood, 2013). However, this process is lacking in many parts of the world (Worrall-Davies & Marino-Francis, 2008), including South Africa, as shown in Chapter 2, where we found no evidence that service users were involved in policy development for CAMHS.

In 1997 the South African Government launched the *Batho Pele* initiative (meaning “People First” in Setswana, one of the 11 official languages of the country), with the stated goal to transform and improve services (including health services) in a way that would put the public at the centre of service delivery and decision-making for policy development and implementation (Khoza, Du Toit & Roos, 2010). The eight *Batho Pele* principles are shown in **Table 6.1** and include consultation, service standards, redress, access, courtesy, information, transparency, and value for money. The principles were proposed to promote accountability of service providers and reinforced the

importance of the user voice in compelling the government to find better ways to deliver an effective service. ‘Consultation’, one of the *Batho Pele* principles, stated that citizens should be consulted about the level and quality of the public services they receive, and that they should be given a choice about the services that are offered. This principle underlines the importance of hearing directly from service users about their needs and to ask how they would like services to be delivered to them.

The South African Bill of Rights, the Mental Healthcare Act no. 17 of 2002 (Department of Health, Republic of South Africa, 2004) and the Children’s Act 38 of 2005 further support the *Batho Pele* principles by putting an emphasis on the rights of users, and on collaboration between providers and users, including children and adolescents with mental health disorders and their families.

Table 6.1 The eight Batho Pele principles

Principle 1: Consultation. An interaction between service providers and users, and engaging about services and service-related issues. Engaging the higher authorities about the issues and working collaboratively on strategies to improve the service
Principle 2: Service standards. Setting out what services are offered, how and when, and what the service standards are
Principle 3: Redress. Allowing the community to express how they feel about the service and bring their complaints, and be engaged in how the challenges in the service will be addressed. Allowing the citizens to be decision-makers in the process
Principle 4: Access. Provision of relevant, responsive, accessible and equitable services to all citizens
Principle 5: Courtesy. Public servants should always be courteous and helpful when providing the service
Principle 6: Information. Providing relevant information about the service to the public
Principle 7: Transparency. Being transparent and provide information to the public about the services, decision-making, departments and the relevant people to contact in those departments
Principle 8: Value for money. Delivering cost-effective services efficiently and without any waste of resources

With the *Batho Pele* principles in mind, this study sought to determine the perspectives of CAMH service users (parents/caregivers and adolescents) regarding their experiences of mental health services received, and to seek their recommendations on how to strengthen services in the province for children and adolescents (and their families) with mental health problems.

6.2 Methodology

6.2.1 Study design

A qualitative, exploratory study was conducted to explore the perspective of services users. Focus group discussions (FGDs) and semi-structured in-depth interviews (SSIIs) were used to generate participant experiences and perspectives (Gill, Stewart, Treasure & Chadwick, 2008).

6.2.2 Study participants and setting

Purposive sampling was used to select participants who were users of CAMHS in the Western Cape Province. Mental health service providers were asked to identify suitable potential participants (adolescents between 12 and 18 years, and their parents/caregivers) who had been users of their services. Staff were requested to ensure that potential participants would a) be able to engage in conversation with researchers, b) had a stable mental health state, and c) that there were no other perceived clinical risks to participation in the study. We aimed to include service users from all health districts and across all levels of care (primary, secondary and tertiary). The recruitment target was twenty-four users.

6.2.3 Research ethics

The study was done in compliance with Declaration of Helsinki (World Medical Association, 2013) and with human research ethics approval from the University of Cape Town Faculty of Health Sciences Human Research Ethics Committee (HREC 188/2016). Permission to conduct the study was also obtained from the Western Cape Department of Health

(HREC:2016RP39_567) and from Red Cross War Memorial Children's Hospital (RXH:RCC73). For ethical reasons, only young people over the age of twelve were included in the study.

6.2.4 Data collection

Information sheets containing details about the study were given to all potential participants via their primary clinical contacts. The study was explained to the participants in their language of choice (English, Afrikaans or isiXhosa). Those who agreed to participate, were provided with consent and assent forms. Caregivers provided written consent for their own participation and for their child's participation, and adolescents under the age of 18 signed assent forms.

SSIIs and FGDs were held from May to July 2017 and were conducted by trained researchers and two research assistants in a quiet, private space at the health facilities where users received their services. The research assistants were mental health professionals with experience in conducting FGDs and individual interviews, but they were not staff at any of the health facilities. Interviews were conducted in one of three languages (isiXhosa, English or Afrikaans) based on participants' preferences. All SSIIs and FGDs were audio recorded and field notes were taken during and after interviews. The duration of FGDs and SSIIs was 30–90 minutes. For individual interviews, the children and adolescents were interviewed with their parents present in the same room, but for focus group discussions, parents were not in the same room with the children.

The interview schedule covered various topics exploring a) the lived experiences of children or parents/caregivers in CAMHS and b) eliciting recommendations on how to improve mental health services for children and adolescents.

Member checking was done during the interview process and at the end of each SSII and FGD to optimise the trustworthiness of the findings. Key points made by the participants were summarised and checked with interviewees to ensure that these were captured accurately by researchers. This was done with particular caution with adolescents to ensure that the interviewer did not

influence the spontaneous thoughts, reflections and recommendations provided during interviews.

6.2.5 Data analysis

Audio recordings were analysed using thematic analysis (Maguire & Delahunt, 2017; Nowell et al., 2017) using the NVivo11 (QSR) qualitative data software package (Catarina, 2015). Relevant sections were translated into English and then transcribed verbatim in NVivo. Data were coded, and codes were subsequently grouped into themes. The coded transcripts were analysed by running query reports, and primary document tables of the codes and themes were produced in order to explore the key issues.

To strengthen the trustworthiness of data analysis, triangulation was performed (Carter, Bryant-Lukosius, DiCenso, Blythe & Neville, 2014). Written notes and observations during FGDs and SSIIs were made by the research team and were compared with the data from FGDs and SSIIs audio recordings to corroborate the findings of this study. Furthermore, to ensure objectivity of the data, two researchers (the author and a colleague with significant experience in qualitative data analysis) coded all the data independently. The two researchers met regularly to compare and discuss their findings until consensus was reached. No quantitative measure of agreement was calculated.

6.3 Results

A total of twenty-two mental health users (ten caregivers and twelve adolescents) participated in this study. After initial consent, two (2) participants (caregivers) dropped out of the study. Participants were all from primary and secondary levels of care, and from the City of Cape Town metropolitan region. No participants from tertiary level clinics were available at the time of the study. A subset of participants in primary care had previously received services from specialist CAMH (tertiary level) services, and were therefore able to comment on their experiences of a tertiary level service. We were unfortunately not able to recruit any participants from the rural districts of the province. In total, twelve

(12) SSIIs and three (3) FGDs were conducted. **Table 6.2** provides a summary of participants in the study. **Table 6.3** provides the demographic characteristics of participants in the study.

Table 6.2 Participants in the service user perspective study

Interviews	Participants	Drop-outs
Number of focus group discussions = 3 (adolescents = 2; caregivers = 1)	Adolescents = 4 Caregivers = 4 Total = 8	Caregivers = 2
Number of semi-structured individual interviews = 12	Adolescents = 8 Caregivers = 6 Total = 14	
Total participants	**n = 22**	

Table 6.3 The demographic characteristics of participants in the service user perspective study

Chronological Age	Gender (M/F)	Self-declared Race/Ethnicity (B/C/W/O)	Presenting complaint (as reported by participants)	Facility	Sub-structure
Adult	M	C	ADHD	PHC	Western
Adult	M	C	ADHD	PHC	Western
Adult	F	C	ADHD	PHC	Western
Adult	F	B	ADHD	PHC	Western
Adult	F	B	ADHD	PHC	Eastern
Adult	F	C	PTSD symptoms	PHC	Mitchell's Plain
Adult	F	C	PTSD	PHC	Northern
Adult	F	C	Behavioural problems &	PHC	Northern

Chronological Age	Gender (M/F)	Self-declared Race/Ethnicity (B/C/W/O)	Presenting complaint (as reported by participants)	Facility	Sub-structure
			Aggression		
Adult	F	C	Aggression	PHC	Northern
Adult	F	C	Aggression	PHC	Northern
14 yrs	M	C	ADHD	PHC	Western
15 yrs	F	C	ADHD	PHC	Western
15 yrs	F	C	ADHD	PHC	Western
10 yrs	M	B	ADHD	PHC	Eastern
14 yrs	M	C	Epilepsy +ADHD	PHC	Mitchell's Plain
14 yrs	M	B	Depression	PHC	Eastern
17 yrs	F	C	Aggression + Conduct D	PHC	Northern
17 yrs	F	C	Aggression + Conduct D	PHC	Northern
15 yrs	F	C	Aggression + Conduct D	PHC	Northern
17 yrs	F	C	Aggression + Conduct D	PHC	Northern
13 yrs	F	C	PTSD	PHC	Mitchell's Plain
15 yrs	M	C	ADHD	PHC	Northern

M = male; F = Female; B = Black; C = Coloured; W = White; O = Other racial/ethnicity group; ADHD = Attention deficit/hyperactivity disorder; PTSD = Post-traumatic stress disorder; PHC = Primary Healthcare Clinic

6.3.1 Service user perspectives about child and adolescent mental health services

The results of the SSIIs and FGDs presented below are based on themes identified in thematic analysis. **Table 6.3** provides a summary of the themes.

Table 6.4 Themes from service user experiences of child and adolescent mental health services in the Western Cape

Main theme	Subthemes
Slow, inappropriate and unacceptable CAMH services at primary care level	Long processes and waiting times
	Missing patient folders
	Appointments too frequent
	Wrong dates for appointments
	Lack of priority for children and adolescents
Lack of dedicated CAMH resources at primary and secondary care levels	Lack of dedicated CAMH infrastructure
	Exposure to contagious medical conditions
	Traumatic exposure to adult psychotic patients
	Lack of equipment (beds, child-friendly equipment)
	Lack of privacy and confidentiality
Staff rudeness and negative attitude	Staff shouting and screaming at CAMH patients and refusing to offer them a service
A positive new service structure well-organised at a primary outpatient clinic	Separate CAMHS service model at primary care level
Well-organised tertiary outpatient clinics	A faster, better organised and well-coordinated separate CAMH clinic

Slow, inappropriate and unacceptable CAMH services at primary care level

Children, adolescents and caregivers perceived the administration system at primary healthcare facilities to be disorganised. They felt that the services were slow and caused their children to miss out on schoolwork, and parents to be absent from work, putting them under financial constraints as they lose a day's income.

Adolescents and caregivers reported that they would arrive very early in the morning for their appointments, and then had to wait to get their folders at reception. Sometimes they were told that their folders were missing, and administrators had to create a new folder, which required families to join another long queue, or worse, be sent home to come back the next day.

> *"… when the new sister came in, then there was no folder for my son, and looked like my son has not been here for a long time, and then they found another folder, but yeah it's really not nice here …"*
> **Caregiver at a primary healthcare facility**

> *"… sometimes they tell us to go home and come back the next day, then they will help first the next day. But it's not fair, why don't they help everyone before they go home ..."*
> **Caregiver at a primary healthcare facility**

Children and adolescents with mental health problems were described as not prioritised, while administrative staff prioritised elderly people. Caregivers and their children also had to wait in long queues at the pharmacy section to collect medication.

> *"… sometimes we have to ... sit there by the pharmacy. Sjoe! [exclamation] ... and all the time if we're five in a row, then they take a pension person … they don't even care that some of the children must still go to school ..."*
> **Caregiver at a primary healthcare facility**

The administrative staff and service providers were described as not concerned that the children had to go to school or that caregivers had to go to work. In some facilities, mental health professionals sometimes gave families wrong dates for appointments, which caused families to have to attend the clinic again, costing time, money, and time off school and work.

> *"…the last time that I was here… they [mental health nurses] told my mom that I must be here on Friday, but we only see the psychiatrists like on Tuesday… and that's…I miss the school day on the day I had to do a project … I could have done a project … it's a waste of money…"*
>
> **Adolescent user at a primary healthcare facility**

Children and caregivers also felt that monthly appointments at primary care level were too frequent as they cause children to miss out on school.

> *"… the other thing is they used to see the child once, and the parents collect the tablets every month and the child comes every 3 months. But now the new sister wants the children to come every month now, and it's difficult, especially now that the children are in high school. It's challenging …"*
>
> **Caregiver at a primary healthcare facility**

Lack of dedicated child and adolescent mental health resources at primary and secondary care levels

Caregivers and adolescents expressed concerns about the lack of dedicated CAMH infrastructure at primary and secondary care levels, resulting in psychological trauma for children and adolescents. Adolescents and caregivers complained that in primary and secondary healthcare facilities, children and adolescents were mixed with adult patients who may have psychotic illnesses. The exposure to adult psychotic patients caused some children to refuse to attend their appointments because they feared that they might end up like those adults. They complained that other services, such as

paediatric services, had their own dedicated infrastructure within the facility, and asked why this was not the case with CAMHS as well.

> *"… why would Dr ... send me to a hospital where [people] are tied up… I hate it here ..."*
>
> **Adolescent user at a secondary level emergency psychiatric unit**

At secondary care level, children and caregivers complained that there were no emergency inpatient facilities dedicated for children and adolescents with mental health problems. Children in need of psychiatric emergency services were admitted to general paediatric wards or adult psychiatric wards with psychotic patients, trauma units, general medical wards, or even to general overnight wards. There was a significant issue with adolescents who were seen as 'in between', because they were neither children nor adults. Adolescents were told that they were too old for paediatric wards which admit only up to 12-years of age, and too young for adult units. For example, a 13-year-old participant who needed emergency mental healthcare services reported (with her caregiver) that she could not be admitted to a paediatric unit because service providers said that she is not a child, and also could not be admitted to an adult psychiatric emergency unit because she is not yet an adult. She said that she was made to feel that she did not belong anywhere.

> *"… so, they took her to trauma unit, but when she woke up, they had to take her out of the trauma unit but there was not facility for her, because they couldn't take her in paediatric ward, and they couldn't take her into adult ward because she is not an adult yet … I was furious, but eventually she went to the paediatric ward …"*
>
> **Caregiver at a secondary level emergency psychiatric unit**

Caregivers expressed their fears and concerns that their children would become contaminated with germs or contract infections and other diseases in paediatric or general medical wards as a consequence of the lack of dedicated space for their children.

"… so, we had to stay here with all other sick patients, germs and all from HIV, heart attack, TB, meningitis, and all …"

Caregiver at a secondary level emergency psychiatric unit

"Why are the children mixed with adults?"

Caregivers (at both primary and secondary care levels)

Children and adolescents mentioned that there was a shortage of beds in psychiatric emergency units, and that patients had to sleep on the floor.

"… why would Dr ... send me to a hospital where people sleep on the floor … I hate it here ..."

Adolescent user at a secondary level emergency psychiatric unit

Caregivers and adolescents described feeling bored in the emergency psychiatric units, some medical wards and overnight emergency units, because there were no toys or child/adolescent-friendly equipment to keep them occupied.

"… there are no activities that they can occupy themselves with ... in the overnight ward there's nothing ..."

Caregiver at secondary care level

There was also concern about a lack of privacy and confidentiality, particularly in primary healthcare facilities. Caregivers and adolescents complained that staff and other patients would enter the consultation room at any time without permission and interrupt the consultation.

"…sometimes people just walk in the door while busy in the consultation, sometimes they don't even knock and that is just not on…"

Caregiver at a primary healthcare facility

Staff rudeness and negative attitude at primary and secondary care levels

Users at primary and secondary care levels complained about negative staff attitudes. Users in one primary healthcare facility complained that general healthcare service providers – especially the general nurses – refused to monitor their vital signs (pulse, blood pressure, etc.) as expected, and instead sent them back to the mental health section for the mental health staff to perform these tasks. An adolescent and their caregiver in another facility related their experience when staff in the paediatric ward, emergency unit and in medical wards were very rude, shouted and screamed at them and refused to accept the adolescent, claiming that they could not manage children and adolescents with mental health problems in their units.

> *"… as we walked in there [adult emergency psychiatric inpatient unit at a secondary care psychiatric hospital] the sister was so angry and she started screaming at us and the ambulance guy like we were to be blamed … because the sister was shouting and saying they don't have beds for her [the daughter] and the other hospital [general district hospital] did not contact them, so there's no space for her … the sister was so rude, no manners whatsoever. I think they should not employ someone like that in these services ..."*
>
> **Caregiver at a secondary level emergency psychiatric unit**

Families felt that the rude and negative attitude reinforced a sense of not belonging in the system for children and adolescents in need of emergency mental health services. Only one participant reported that a few service providers in one paediatric unit were friendly towards them and showed concern and engaged with them positively.

A positive, well-organised new service model at a primary outpatient clinic

Users in one primary healthcare facility expressed that the service used to be very slow and disorganised and that young people were not prioritised at that facility. Since the new staff (mental health nurses) at the mental health section

started, the service had changed for the better. The mental health nurses at that facility coordinated the CAMHS in such a way that patients received all their care (interventions, medication and observations) in the same section. They mentioned that they collected their folders and their medication from the mental health section and not from the general reception anymore. In this way they received a very quick service which at least made it easy for them to attend school and to get to work early. They expressed their satisfaction with such a service, which accommodates their needs. Families were receiving a faster service where everything was organised, including their medication at the mental health section. This service ensured that children and adolescents were not missing time out from school or work.

> *"… like here [whole facility] the service is too long … like if we came here at 6:30 o'clock, we'd get out at five o'clock … but since they started putting the medication there where we see the doctor first [mental health section], we come out now earlier … that's a good thing"*
>
> **An adolescent at a primary healthcare facility**

Well-organised tertiary outpatient clinics

Adolescents and caregivers at primary level, who had previously received specialist CAMHS at tertiary level, were able to compare the primary and tertiary healthcare services. They felt that the outpatient services at a tertiary level clinic were very quick, well-organised, and with short waiting times at the pharmacy. When they attended this facility, they were still able to get to school and work without missing out on classes or losing pay for the day. They expressed a wish that they could get a similar service at primary level.

> *"… at [previous tertiary service facility] there was a pharmacy there, you don't come out so late, at [primary healthcare] you sit there … like the latest, I've sat there … like an hour ... sit there for hours …"*
>
> **An adolescent comparing a tertiary and primary healthcare facilities**

6.3.2 Recommendations from service users to improve child and adolescent mental health services

Four themes emerged from CAMH users as recommendations to improve services, as shown in **Table 6.4**. These included restructuring processes and procedures to become more child- and family-friendly, creating separate CAMHS, prioritising CAMHS to provide equitable services to children and adolescents with mental health problems, and providing information and psychoeducation to caregivers.

Table 6.5 User recommendations to improve child and adolescent mental health services in the Western Cape

Themes
• Restructure processes and procedures to become more child- and family-friendly • Create separate CAMH services • Prioritise CAMHS, and provide equitable services to children and adolescents with mental health problems • Provide clear communication and information, including formal psychoeducation to caregivers

Restructure processes and procedures to become more child- and family-friendly

Users recommended that the filing system should be reviewed as a matter of urgency to ensure that files don't go missing. The pharmacy section should have a separate window for children and adolescents that would prioritise them so that they can still go to school on time. The frequency of follow-up appointments should also be reduced by allowing caregivers to collect medication on a monthly basis while seeing children and adolescents for consultation only every to 3–6 months at primary healthcare facilities.

> *"... you know mos [what], all the children don't have patience to sit so long ... why didn't they take the medication and bring it in the room ... it's better for the people, it's quick in and out and patients don't have to wait for so long by the chemist ..."*
>
> **Caregiver at primary healthcare facility**

Create separate services for child and adolescent mental health

Users recommended that children and adolescents should be seen separately from adults in primary healthcare facilities. CAMH specialists who are trained to work with children should be allocated at primary healthcare facilities to engage with children. Child and adolescent emergency inpatient services should be separated from other general health services, from general paediatric and adult psychiatric services. Families emphasised that there should be a child and adolescent mental health facility that accommodates the 'in between' children, such as the 13-year-olds.

The mental health section within primary healthcare facilities should have its own equipment for doing basic observations (vital signs, such as blood pressure; pulse; height; weight) so that users do not have to go to the general section, receive bad service and experience rudeness and negative attitudes from non-mental health staff.

> *"…they should get a separate side for kids ... they should have a separate room that is just for kids, and a section for adults as well ... that is as important as me that has depression or schizophrenia or something like that ..."*
>
> **Caregiver at a primary healthcare facility**

> *"... so I asked Sister [professional nurse] ... why didn't they put away the blood pressure [keep the blood pressure equipment] ... there for the children … there in the room [mental health section] ... apart from there [general health section] ... they're supposed to have that ..."*
>
> **Caregiver at primary healthcare facility**

Prioritise CAMHS and provide equitable services to children and adolescents with mental health problems

Users asked for CAMHS to be prioritised and that they should be given the same value as, for instance, to adult psychiatric services.

> *"… the mental health for the children … even if it's once … they give us the same appointment … the psychologist can go that side*

[separated] … to attend us may be from 12h00 to 14h00, then adults from 14h00 ..."

Caregiver at a primary healthcare

Provide clear communication and information, including formal psychoeducation to caregivers

Caregivers expressed the need for clear communication and information, including formal psychoeducation about their children's mental health conditions so that they know what to do and how they can support their children.

"… if now they are changing treatment, they need to tell you … I need to know … the treatment alone cannot work … the most important thing is for us parents to know … like we need to know everything … I think that's the major problem now, most of the people don't know where to go …"

A caregiver at a primary healthcare facility

6.4 Discussion

Given the principles of *Batho Pele* (People First), this study set out to explore the perspectives of CAMH service users (parents/caregivers and adolescents) in order to inform service strengthening and policy development in the Western Cape. Twenty-two individuals from across health districts in the City of Cape Town participated in focus group discussions and semi-structured individual interviews. Our findings identified several concerns: user perspectives presented a sobering experience of service delivery by primary and secondary care services who, apart from one exceptional team, clearly did not put 'people first'. The themes identified here suggested potential violation of many of the *Batho Pele* principles including service standards perceived as poor, lack of clear and transparent information, lack of courtesy towards service users, and major challenges in access to appropriate services. The current service standards were perceived to be very poor and unacceptable, with lack of provision and lack of respect for users. Qualitative findings not only identified

poor services, but also that the experience of poor services acted as additional barriers to future care (e.g. young people who didn't want to go back to clinics), thus creating a potential vicious circle. We were encouraged to hear consistently positive feedback about specialist CAMH services (tertiary level of care).

While South Africa has legislative provisions in place to ensure adequate service provision for users, there is still no dedicated provision for children and adolescents with mental health problems. Despite the evidence on the burden of CAMH problems in the Western Cape (Kleintjes et al., 2006), CAMHS remain neglected. It is also of concern that, while there is acknowledgement in the Western Cape's strategic plan (Western Cape Department of Health, 2014) of the need to have dedicated CAMHS, there is still no such provision.

On the one hand, proposals to integrate CAMHS into general health and paediatric services seem ideal (Flisher et al., 2012; Kleintjes et al., 2010; World Health Organization, 2008) and this may be a common practice in other parts of the world (Hazell, Sprague & Sharpe, 2015). However, in the Western Cape (and potentially in many other low-resource settings), this system may not be without challenges. As was illustrated in this study, young people and their families felt unsafe and psychologically traumatised in the presence of adults with serious mental health problems and felt unsafe in the presence of those with serious physical illnesses. Patients and staff can experience severe trauma in settings where staff are not adequately trained to manage and contain the dysregulated behaviours of the mentally ill patients (Belfer, 2008; Royal College of Psychiatrists, 2015; Shatkin & Belfer, 2004), or where the physical environment cannot contain an acutely disturbed patient. Of equal concern is the potential harm to children and their families from negative attitudes towards them when they seek services, as was highlighted clearly in the findings of our study. Unless, and until general health and paediatric services can be made to be safe, and not only child- and adolescent-friendly, but also 'child and adolescent *mental health*-friendly', policymakers, funders and health professionals are potentially violating not only the *Batho Pele*

principles, but also the ethical principle of ‘first do no harm’ (*primum non nocere*).

One positive theme that emerged from the study was an example of innovation by one group of passionate staff which resulted in clear service improvements. The experiences of responsive and person-centred care were recognised and appreciated by the users. In Chapter 5, service providers shared some of their innovations to provide acceptable CAMHS in facilities despite the challenges mentioned. Here, the success of service innovations was reflected in the voices of the users. Such positive efforts should be acknowledged by those in authority and be rolled out to other facilities.

The recommendations by service users on how to strengthen CAMHS in the Western Cape called for the restructuring of the processes and procedures to become child- and family-friendly, creation of separate CAMHS, prioritisation of CAMHS to provide equitable services to children and adolescents with mental health problems, and the provision of appropriate communication of information, including providing clear information to caregivers. Implementation of such service strengthening approaches can result in a responsive CAMHS that recognises the vulnerability and unique needs of its population.

We were very disappointed not to have been able to include voices of service users from rural districts in the Western Cape. Interestingly, the themes that emerged from our study in the City of Cape Town, showed many similarities with findings in the Amajuba rural district of KwaZulu-Natal (KZN), where Babatunde and colleagues recently performed a situational analysis (Babatunde, van Rensburg, Bhana & Petersen, 2020) and collected stakeholder perspectives. In their investigation of health, education, non-profit organisations and service users, emerging themes included lack of services, poor coordination, lack of intersectoral work and low prioritisation of CAMH work. The stakeholder study combined findings for providers and service users, so it was not possible to do a direct comparison between the two studies, but illustrative quotes from the KZN study included comments about the need for information and parent education, and some positive examples of

good care and support to families (Babatunde et al., 2020). One very interesting theme that emerged from the KZN-study was the important role of schools and the Department of Education as partner in the early identification and treatment of child and adolescent mental health problems. Even though themes around schools and education did not emerge in our data other than the need for health services to be mindful of the need for young people to attend school, we completely agree with this observation. Future studies in the Western Cape should include the role of school mental health and educational services as key partners for the provision of CAMHS.

Limitations of the study

We set out to recruit participants from all levels of care from both the City of Cape Town and rural districts. Most unfortunately, we were not able to recruit any families from rural districts in the timeline available for data collection for this study. This is a clear limitation of the study and underlines how hard it can be to reach the 'voices' we most want to hear. Given the many concerning themes identified from within the City of Cape Town, there is a clear imperative to prioritise families and young people from rural communities in future CAMH research. However, it was interesting to hear the rural voices of families from another South African province, which complemented our findings.

6.5 Conclusion

In this chapter, we found little evidence from users of positive, user-centred *Batho Pele* practice in CAMHS. It is important that these voices of users of CAMHS be incorporated into policy development, policy implementation and service strengthening for CAMHS. Putting people first, CAMHS should be age- and developmentally appropriate, safe, confidential, respectful, accessible, and acceptable to all service users and their families. Even though there are limited data on user perspectives in the Western Cape, the rest of South Africa and in other low- and middle-income countries, our results appear to be similar

to those faced by users in many other countries (Royal College of Psychiatrists, 2015), thus highlighting the universality of needs and challenges in CAMHS.

6.6 Chapter Summary

The mental health disorders of children and adolescents represent a key area of concern, yet CAMHS are neglected – especially in low- and middle-income countries. There is a clear need to provide CAMHS that are relevant to the needs of service users, but little research has been done to explore their needs, experiences of services, and recommendations for service strengthening. In 1997 the South African Government introduced the *Batho Pele* (People First) principles as a yardstick for all government services. In this study we sought to explore user perspectives about CAMHS in the Western Cape, one of the nine provinces of South Africa. Using focus group discussions and semi-structured interviews, qualitative data were collected from purposively selected CAMH users (parents/caregivers and adolescents). Data were entered into NVivo 11 (QSR), and thematic analysis was performed by two independent raters. Results highlighted slow, inappropriate and unacceptable CAMHS at primary care level, lack of dedicated CAMH resources at primary and secondary care levels, and staff rudeness and negative attitude. Only one positive theme was identified about a new service initiative at primary care. Only specialist CAMHS (tertiary level) were regarded as well-organised. To improve CAMHS, users recommended that the processes and procedures should be restructured to become child- and family-friendly, that separate CAMHS should be created at primary and secondary care levels, that CAMHS should be prioritised to provide equitable services to children and adolescents with mental health problems, and that communication and information, including formal psychoeducation, should be provided to caregivers. The data from this study provided very little support for the *Batho Pele* principles and highlighted a clear need for CAMH service strengthening in the Western Cape specifically, and in South Africa as a whole. We propose that these findings may be similar in other low-resource settings. Our findings highlight the importance of putting ‘people first’ by listening to their

voices on an ongoing basis, and at all levels of CAMH policy development and implementation.

Chapter 7: Synthesis of multilevel findings, and future directions for policy development and health systems strengthening

7.1 Introduction

In spite of the clear need for CAMHS across the globe, very little has been done to develop and strengthen CAMHS in LMIC. South Africa is an example of an LMIC where CAMHS have been very limited as a result of various probable factors, including the legacy of apartheid, stigma associated with mental health, and lack of priority of CAMH. In this thesis, we set out to generate an evidence-base about CAMH and CAMH services in one South African province as a basis to inform potential service strengthening of CAMHS across the full healthcare system through policy development and implementation.

We proposed that a comprehensive understanding of specific services requires a multilevel exploration of so-called 'hardware' and 'software' elements in the health systems that support these services. In Chapter 1 we discussed the six building blocks required for an effective CAMH system, and the aims and objectives of the study. In Chapter 2 we reviewed the CAMH policy landscape with an analysis of the current state of policy development and implementation at national and provincial levels in all nine provinces of South Africa. Using the Walt and Gilson policy analysis triangle (1994), we examined the content, context, processes and actors involved in mental health or CAMH-specific policies. In Chapter 3 we evaluated the hardware and software elements of CAMHS in the Western Cape Province by performing a situational analysis using the WHO-AIMS version 2.2 of 2005 (Brief version) adapted for the South African context and to CAMHS. After exploration of the policy landscape (Chapter 2) and resource landscape (Chapter 3), we proceeded to seek the perspectives of stakeholders within the province – first, providers at senior provincial (Chapter 4) and grassroots levels (Chapter 5),

and next, parents/caregivers and adolescent service users (Chapter 6). We collected information from these stakeholder groups through a stakeholder engagement workshop, focus group discussions and semi-structured individual interviews.

In this chapter we will present a brief overview of the thesis and key findings, before synthesising these and presenting a set of recommendations for policy development and service strengthening based on the evidence generated here.

7.2 Key Findings

The key findings across all chapters are presented as a visual summary in **Table 7.1.** Here findings are presented as forty-eight sequential observations as reported throughout the thesis. The table indicates the observations and the chapters where the observations were made.

Next, we reviewed findings using the WHO (2010) framework for health system as outlined in Chapter 1: 1) service delivery, 2) health workforce, 3) information systems, 4) access to essential medicines and technologies, 5) financing, and 6) leadership and governance. In addition, findings were separated into positive and negative hardware and software elements, as described by Gilson (2012). These are presented in **Table 7.2**.

Table 7.1 Visual summary of findings in the thesis

Findings	Policy analysis	Situational analysis	SWOT analysis	Grassroots service provider perspectives	Service user perspectives
1. A national CAMH policy was in place	✔	✔			
2. None of the nine provinces had their own CAMH policy	✔	✔			
3. None of the nine provinces had implementation plans to support the national CAMH policy	✔	✔			
4. Provincial general health policies varied but did not refer to CAMH	✔	✔			
5. No documented evidence that any CAMH experts, service users (parents or children) or CAMH-related non-profit organisations were consulted or included in the process of developing the provincial general policies in any of the nine provinces	✔				
6. To ensure that the rights of children and adolescents were met, a human rights review body (Mental Health Review Board) existed		✔			
7. No separate budget for CAMHS		✔	✔	✔	
8. No provincial authority exclusively for CAMHS and no Provincial Director for CAMH		✔	✔	✔	
9. CAMHS were provided based on the geographical service areas/catchment areas		✔	✔	✔	

10. CAMH outpatient services were available at facilities spanning primary to tertiary level of care		✔	✔	✔	
11. Child and adolescent inpatient services were provided at secondary (level 2) and tertiary level (level 3)		✔	✔	✔	
12. Adolescents with mental health problems were admitted in adult inpatient units at secondary level and (occasionally) at tertiary level		✔	✔	✔	✔
13. Adolescents with intellectual disabilities and co-occurring psychiatric disorders were seen in two specialist units for people with intellectual disability		✔		✔	
14. Children and adolescents were seen in clinics alongside adults at primary and secondary levels of care		✔	✔	✔	✔
15. Only three tertiary units, all based in the City of Cape Town, were providing dedicated specialist mental health services to children and adolescents		✔	✔	✔	✔
16. No specialist CAMHS were provided at secondary care level		✔	✔	✔	✔
17. The majority of children and adolescents were treated in the City of Cape Town as outpatients, but a greater proportion of children and adolescents from rural districts were admitted to secondary hospitals		✔			
18. No dedicated or specialist CAMHS existed in any rural districts		✔	✔	✔	
19. No disaggregated data for children and adolescents at any level of care		✔			
20. No Department of Health residential facilities existed exclusively for children and adolescents with mental health problems		✔			

21. Child and adolescent forensic mental health services were provided from one adult mental hospital in the City of Cape Town		✔	✔		
22. There were no dedicated CAMH hospitals in the province		✔			
23. All mental health facilities (outpatient and inpatient) at primary, secondary and tertiary levels of care had at least one psychotropic medicine of each therapeutic class available		✔		✔	
24. Limited access to psychosocial interventions for children and adolescents at primary and secondary levels of care		✔		✔	✔
25. Limited training in CAMHS across all levels of care		✔	✔	✔	✔
26. Limited public education in CAMH		✔			
27. Limited human resources for CAMHS		✔	✔	✔	
28. No formal data were available on human resources specifically for CAMH		✔			
29. Limited research in CAMHS		✔			
30. Comprehensive multidisciplinary, bio-psycho-social intervention only available in specialist CAMH (tertiary) services		✔	✔		
31. Strong specialist CAMH service units			✔		
32. Limited workforce capacity at tertiary level of care		✔	✔	✔	
33. Workload demands on existing staff were very high			✔	✔	
34. Inadequate and inequitable resource allocation within the City of Cape Town, and, in particular, in rural districts		✔	✔	✔	✔

35. Poor implementation of early detection and preventive policies			✔		
36. Overall neglect of CAMHS		✔	✔	✔	
37. Some evidence of collaborative working between CAMH and pediatric services			✔		
38. Increased Provincial Government (Department of Health) involvement			✔		
39. Silo working of agencies		✔	✔	✔	
40. Societal stressors and other external contributing factors on the mental health of children and adolescents			✔	✔	
41. Lack of ring-fenced funding for CAMHS		✔	✔		
42. Lack of intersectoral collaboration		✔	✔	✔	
43. Lack of uniformity and consistency across services at all levels of care		✔		✔	
44. Lack of support for staff			✔	✔	
45. Lack of acknowledgement of staff			✔	✔	
46. Negative staff attitudes, including rudeness towards patients				✔	✔
47. Evidence of health service innovations			✔	✔	✔
48. Slow, inappropriate and unacceptable CAMHS					✔

Table 7.2 Key findings of the study, grouped according to the World Health Organization (2010) building blocks for health systems and Gilson (2012) software and hardware elements

SERVICE DELIVERY	
Hardware	**Software**
Positive elements • Services provided based on geographical service areas/catchment areas • Outpatient services provided at all levels of care (primary, secondary, tertiary) • Inpatient services provided at secondary and tertiary levels of care • Adolescent ID services in two specialist units • All outpatient and inpatient services across levels of care have access to essential psychotropic medications for children and adolescents • Comprehensive multidisciplinary care available in the three tertiary CAMH units, including access to psychosocial interventions • Some collaboration between CAMHS and paediatrics services	**Positive elements** • Passionate multidisciplinary teams in specialist CAMHS • Positive support for and appreciation of specialist CAMHS • Increased collaboration with provincial Department of Health
Negative elements • Children and adolescents seen alongside adults at primary care level • Adolescents admitted to adult inpatient units at secondary level of care • Specialist outpatient and inpatient CAMHS only in City of Cape Town, none in rural districts • Only three specialist CAMH teams in province, with limited outpatient and inpatient capacity • No specialist outpatient or inpatient CAMHS at secondary level • Limited access to child- and adolescent-friendly tools and equipment suitable for CAMH work at primary and secondary levels of care • No CAMH hospitals, no CAMH residential units, limited CAMH forensic services • Variable and inconsistent provision of psychotropic medications to services • Limited access to psychosocial interventions at primary and secondary care levels	**Negative elements** • Low priority of CAMH in comparison to adult mental health and general healthcare • Services perceived as inconsistent and inequitable across the province • Services perceived as slow, inappropriate, and inaccessible • Limited intersectoral collaboration

HEALTH WORKFORCE	
Positive elements • Some highly skilled staff in specialist CAMH units • Some examples of service innovations at primary care level • Some evidence of CAMH training at primary, secondary and tertiary care levels	**Positive elements** • Passionate and committed staff at specialist CAMHS
Negative elements • Lack of human resources for CAMHS • Inequitable distribution • Limited capacity in existing services • Workload demands • Limited and poorly documented training in CAMH to staff in primary and secondary care levels	**Negative elements** • Lack of support for staff at primary and secondary care levels • Lack of acknowledgement of staff at primary and secondary care levels who develop service innovations to improve CAMH service delivery • Negative staff attitudes towards CAMH at primary and secondary levels of care • Sectors perceived to work in 'silos' thus reinforcing 'us and them' thinking • Limited public education about CAMH, thus leaving CAMH to be perceived as a low priority
INFORMATION SYSTEMS	
Positive elements • Some high quality CAMH research	**Positive elements** • N/A
Negative elements • Inadequate and inaccessible information systems • No disaggregated data for children and adolescents versus adult data i.e. under-18-year-olds • Limited research on CAMH	**Negative elements** • N/A
ACCESS TO ESSENTIAL MEDICINES AND TECHNOLOGIES	
Positive elements • Availability of psychotropic medicines across all levels of care	**Positive elements** • N/A

Negative elements • Inconsistent availability of psychotropic medications across all levels of care (e.g. types, dosages) • No technologies to support e.g. data collection across levels of care	**Negative elements** • Lack of understanding of the needs for consistency and predictability of medications in CAMH
FINANCING	
Positive elements • Some funding provided for specialist CAMHS and for specialist training at tertiary level	**Positive elements** N/A
Negative elements • No separate, ring-fenced, or disaggregated budget for CAMH	**Negative elements** • Low priority of CAMH in relation to adult mental health and general healthcare • Child and adolescent psychiatry classified as a 'subspecialty' and therefore perceived as the domain of only tertiary level services
LEADERSHIP AND GOVERNANCE	
Positive elements • National CAMH policy in place • Mental Health Review Boards in place • Strong leadership in specialist CAMH teams	**Positive elements** • Increased awareness about CAMH • Increased collaborative work between policymakers and service providers
Negative elements • No provincial CAMH policies or implementation plans • No reference to CAMH in general health policies • No involvement of CAMH experts/users in policy development or review • No dedicated provincial leadership for CAMH	**Negative elements** • CAMH not perceived as a priority area of health that requires strengthening

7.2.1 Service delivery

Findings showed that CAMHS in the Western Cape were provided at all levels of care (primary, secondary and tertiary) and at least at inpatient and outpatient level, were based on catchment areas/geographical service areas. This is a positive finding in the Western Cape compared to other provinces in South Africa where there is some evidence of a lack of even primary level care in some areas, especially rural districts (Babatunde et al., 2020; Docrat et al., 2019). However, CAMHS in the Western Cape were still limited and were provided under very resource-constrained conditions by inadequately trained service providers. This was exemplified by the poor infrastructure, absence of separate clinics for children and adolescents with mental health problems, and lack of appropriate tools and equipment to engage with children and adolescents at primary and secondary levels of care. Service delivery was also not uniform or consistent between the three specialist tertiary units, or at primary and secondary levels of care. There was a notable gap in CAMHS in the rural districts of the Western Cape, similar to that noted by Babatunde and colleagues (2020) in KwaZulu-Natal Province (KZN).

In terms of service provision across levels of care, mental health nurses seemed to be the main service providers in primary care and acted as gatekeepers to other levels of care. This was a positive aspect of the Western Cape compared to, for example, KZN where mental health nurses often did not see children and adolescents at all (Babatunde et al., 2020). However, service providers at primary care felt unsupported and unacknowledged by senior management and policymakers, overwhelmed and overburdened with a huge caseload as they also provide services for adult psychiatric patients. This was associated with low staff morale, negative staff attitudes and a negative impact on service delivery. This was mirrored in the perspectives of users describing inappropriate, slow and unacceptable services at primary level.

At secondary level of care, we observed a lower proportion of children and adolescents seen in outpatient clinics, but a higher proportion admitted to secondary hospitals in rural districts. We also observed an absence of any

specialist CAMHS at secondary care level in the province, and only limited access to psychosocial interventions. Given the absence of dedicated inpatient services for young people at secondary care, adolescents were admitted to adult inpatient units, which were experienced as frightening and traumatising. A total of 795 under-18-year-olds were admitted to inpatient units in secondary care (representing 4.35% of all secondary care mental health admissions) in 2016. This proportion is a reflection of a lack of CAMHS at secondary level of care.

Of all outpatient services providing mental healthcare at all levels of care, we identified that only three units (0.9%) were providing dedicated mental health services to children and adolescents. All other facilities were open to all ages. This matches with the provider and user perspectives of lack of CAMH-friendly services. No formal data were available to document the total number of children and adolescents seen in specialist CAMHS at tertiary level in 2016, but a total of 346 under-18-year-olds were admitted to inpatient specialist CAMH units. This is, however, not a surprise given a) the lack of inpatient infrastructure for CAMHS (Chapter 3) and b) that across all nine provinces, the rates of CAMH inpatient admissions were very low compared to adult services (Docrat et al., 2019). Overall feedback about the three specialist CAMH units was very positive from service providers and users. It seemed that only at tertiary levels of care multidisciplinary CAMHS and a range of psychopharmacological and psychosocial interventions were available. The specialist CAMHS provided teaching and training, performed some research and provided some consultation and outreach to secondary and primary levels of care. However, service pressures prevented consistent and predictable outreach and training to secondary and primary care facilities. This was particularly limited in rural districts.

One of the striking findings from the situational analysis in Chapter 3 was our estimation that fewer than 10% of children and adolescents predicted to require outpatient or inpatient CAMHS actually received such services in 2016, the year of our situational analysis. In a study of mental health service use in the same year as our situational analysis, Docrat and colleagues reported that

94.2% of mental health outpatient services were for adults versus 5.8% for children and adolescents, and that 89.9% of mental health inpatient admissions in the Western Cape were for adults vs 10.1% for under-18-year-olds (Docrat et al., 2019).

Taking together all service delivery elements from the thesis, we therefore have to conclude that the health system in the province (Western Cape) was unable to meet the mental healthcare needs of children and adolescents in the province with a disproportionate impact in rural districts.

7.2.2 Health workforce

In our study, services to children and adolescents with mental health problems were provided by a range of professionals including child & adolescent psychiatrists, general psychiatrists, medical officers, clinical psychologists, social workers, mental health nurses, occupational therapists, and speech and language therapists. However, multidisciplinary expertise was only available in specialist CAMHS at tertiary level of care. In addition, the specialist services were all based in the City of Cape Town, with no direct access to specialist CAMH at secondary levels of care or in any of the rural districts of the province. Docrat and colleagues (2019) identified the Western Cape as one of only three South African provinces with access to child & adolescent psychiatrists in the government sector, with the highest proportion per population (0.08 per 100,000 in the Western Cape, 0.04 per 100,000 in the Free State, and 0.02 per 100,000 in Gauteng) but still being inadequate, and even lower than the estimated required norm of about 43.7 per 100,000 population for CAMH services as estimated by Lund and colleagues (2010). It is therefore clear that significant additional human resources are required.

CAMH service specialists at tertiary level have links with primary level providers and other generalist, and they provide training on CAMHS through supervision and in-service training. However, our findings suggest that the training was still limited and poorly documented. Therefore, providers at primary and secondary levels of care felt that they lacked the necessary skills

to provide a responsive service for CAMH. Lack of human resources also placed an added workload on the available service providers and compromised the quality of care rendered to the users. This situation is also similar to other South African provinces (Babatunde et al., 2020; Docrat et al., 2019). Docrat and colleagues (2019) identified lack of human resources as a key barrier to the realisation of mental health legislation.

7.2.3 Information systems

As summarised in **Table 7.2**, information systems on CAMH were inadequate in the Western Cape. While the province used reliable health information systems to capture detailed patient data and provider activities, its implementation was limited or inadequate, and the data were not compiled in a way that allowed for disaggregation of data. For example, patient data were not disaggregated by age and/or diagnosis. Data on human resources for CAMHS was also not comprehensive, which made it difficult to determine resource gaps. There seems to be consensus from other sources that the health information systems in South Africa are generally flawed (Wright, O'Mahony & Cilliers, 2017), and it appeared that this pattern had not changed in child and adolescent mental health since 2004 (Dawes et al., 2005; Flisher et al., 2012). One of the challenges identified by these authors was insufficient capacity for staff to capture and analyse the data for decision-making. The combination of information system and human resource challenges therefore may have combined to provide very limited data to develop an accurate profile of need. Good information systems are important for determining the problem, the need, and planning programmes and policy development (World Health Organization, 2007).

7.2.4 Access to essential medication and technology

Our study found that psychotropic medication was widely available in all facilities at all levels of care. However, there were inconsistencies in the availability of the required strengths of medication, forcing users to switch

between dosages and between long-acting and short-acting medications, thus creating a problem both in treatment outcomes and in compliance to pharmacological treatment. In addition, there were challenges with internet access and basic telephone services in some facilities. Challenges with technology and medication continue to be a common problem in South African provinces.

7.2.5 Financing

We identified no separate budget for CAMHS. Financing for CAMHS was integrated with general health service budgets. We acknowledge that this is a challenge not limited to the Western Cape. The recent study by Docrat and colleagues (2019) found that at national level in South Africa in 2016, 5% of the total health expenditure was dedicated to mental health, and that 86% of the mental health budget was used on inpatient care mainly in psychiatric hospitals. Given that no disaggregated budgets were available, no conclusions could be drawn on the proportion of budget allocated to CAMHS either provincially or nationally. This is clearly a major limitation to understanding and strengthening CAMHS in the country.

7.2.6 Leadership and governance (stewardship)

It was encouraging that a national CAMH policy existed, but very disappointing that no implementation plans had been developed since the publication of the CAMH policy in 2003. Our findings highlighted a lack of dedicated CAMH leadership and governance in the province. We argue that the absence of a clear CAMH leadership structure also explains why provincial plans and strategies have not been developed and implemented. Core tasks of such a leadership role or team would include coordination of existing services, liaison with other sectors, development of a blueprint for service strengthening and acting as champion for the mental health needs of children and adolescents (Department of Health, Republic of South Africa, 2013; Semrau et al., 2019). In terms of software elements, we acknowledge that there has been some

increased awareness of CAMH and greater collaboration between the provincial Department of Health and local services as reflected in the SWOT analysis by the senior stakeholders. However, to date, CAMH is still not perceived as a priority area of health that requires strengthening.

7.3 Recommendations for policy development and child and adolescent mental health service strengthening

In this section we first present a summary of participant recommendations to strengthen CAMHS in the province, before concluding with our own set of recommendations based on all the evidence provided in this thesis.

7.3.1 Participant recommendations

Table 7.3 provides a summary of the themes and recommendations to strengthen CAMHS from the study, organised into the WHO (2010) health systems components and Gilson's (2012) hardware and software elements.

Table 7.3 Participant recommendations for child and adolescent mental health service strengthening and policy development (see Chapters 4 and 5)

SERVICE DELIVERY	
Hardware recommendations	**Software recommendations**
• Provide child-friendly infrastructure at level 1 (primary care) • Provide dedicated CAMHS at level 2 (secondary care) • Create separate CAMHS at primary and secondary levels of care • Restructure processes and procedures to become child- and family-friendly • Reduce waiting times for CAMHS • Provide psychoeducation and information to caregivers	• Reduce stigma about mental health
HEALTH WORKFORCE	
Hardware recommendations	**Software recommendations**
• Increase CAMH staffing • Review current service focus on number of patients seen vs quality of care provided to children and adolescents • Increase learning opportunities for trainees	• Increase support for staff • Acknowledgement of staff initiatives
INFORMATION SYSTEMS	
No participant recommendations	
ACCESS TO ESSENTIAL MEDICINES AND TECHNOLOGIES	
No participant recommendations	
FINANCING	
Hardware recommendations	**Software recommendations**
• Provide a separate budget for CAMHS	• No participant recommendations
LEADERSHIP AND GOVERNANCE (STEWARDSHIP)	
Hardware recommendations	**Software recommendations**
• Employ a lead professional for CAMH in the province • Formalise intersectoral collaborations	• No participant recommendations

Below we outline our key recommendations based on all the evidence generated in this thesis. **Table 7.4 – Table 7.7** provide a summary of evidence-based recommendations for policy development, service development, training and research.

7.3.2 Recommendations for policy development

Given that the focus of all policy recommendations are likely to link to the national CAMH policy, it may be important to start with a review of the current policy, given that it was drafted almost two decades ago. Review by a multistakeholder panel could determine whether it is still fit for purpose, before proceeding to the development of implementation plans. However, once concluded, it would be essential for all provinces to develop implementation plans and associated monitoring and evaluation strategies to check on implementation. Apart from policy development goals, some of the actions recommended here will clearly require advocacy and lobbying of government agencies. In order to secure the appointment of provincial CAMH 'leads' it may be necessary to lobby national and provincial government to acknowledge child and adolescent mental health as a health priority. The appointment of a CAMH provincial lead may improve the likelihood of implementation of the other recommendations made here.

A provincial CAMH 'lead' could be the 'point person' to ensure that many of the other recommendations made here, including ensuring availability of policy documents, access to disaggregated data, communicating and participating with research teams, and facilitating the creation of communication mechanisms (e.g. think tanks or 'indabas') of all relevant user and provider stakeholders, are implemented.

Table 7.4 Recommendations for policy development

• Review of the national CAMH policy (2003) to determine whether it is still fit for purpose • Development of provincial implementation plans of the national CAMH policy and associated monitoring and evaluation procedures • High-level lobbying to encourage the South African government to include CAMH as a health priority in the country • National and provincial mandating for the appointment of a CAMH lead in each province • Provincial CAMH leads should be empowered to oversee CAMH policies, implementation plans, and monitoring and evaluation • National policies and provincial plans should be readily and electronically available in the spirit of transparency, and to facilitate communication and implementation of policies • National and provincial government should commit to incorporating research findings into planning and policy development • National and provincial government should ensure that there are clear and accessible information systems that show disaggregated data for CAMH in the province • National and provincial government should create suitable communication mechanisms for interaction with service providers and service users in order to strengthen CAMHS in a participatory manner

7.3.3 Recommendations for service development

Based on the evidence generated here, there is a clear need to revisit and redesign CAMHS in order to develop and implement a clear 'stepped-care' pathway from first concern and assessment at primary level of care, to next-step diagnosis and treatment in secondary care, and final progression to specialist CAMHS in tertiary care (Orygen,The National Centre of Excellence in Youth Mental Health, 2019; World Health Organization, 2018). Given that the majority of children and adolescents will present in primary care, there is a need to design PHC services for CAMH to be more child- and adolescent-friendly, and to provide primary care staff with appropriate training, tools and supervisory support to manage children and adolescents using 'shared-care' protocols (Doull, 2012). Many of these services will be in rural districts, and

particular care will be required to consider how best to develop and support such services.

At secondary level of care, there was a strong recommendation to develop specialist CAMHS. At present, child and adolescent psychiatry is categorised as a ‘subspecialist’ service by the national DoH, and therefore provided only at tertiary level of care in the South African healthcare framework. In order to develop specialist CAMH service provision at secondary level of care, either child and adolescent psychiatry has to become categorised as a ‘specialist’ (rather than ‘subspecialist’ service), or CAMH teams should be developed at secondary level of care with multidisciplinary mental healthcare staff with appropriate training and expertise in CAMH, but without requiring ‘subspecialist’ skills. However, feedback from service providers and users was clear that child- and adolescent-friendly services, clinics and inpatient facilities should be established as a matter of urgency. The latter model could work well with supervision mechanisms from subspecialist tertiary services.

The three specialist CAMH teams were providing evidence-informed multidisciplinary services in line with national and international guidelines. However, there were significant service pressures on these services, which reduced their opportunities to provide high-level supervision, training and outreach to other levels of care. In addition, specialist CAMHS were only available in the City of Cape Town. We therefore recommend that a) specialist CAMHS should be empowered and mandated to provide scheduled and documented training, supervision and support to primary and secondary level services, and b) that the provincial government should consider setting up additional specialist CAMHS in regional hospitals in rural districts.

For all levels of care, we also recommend considering the use of technology (e.g. video consultation, training, apps, etc.) to support identification, diagnosis and intervention, as well as training and supervision. This may be of particular value in rural and remote communities and clinics. The required strengths of psychotropic medication should also be made available consistently at all facilities.

Table 7.5 Recommendations for service development

• CAMHS should be redesigned in order to provide a clear 'stepped-care' pathway across all levels of care in urban and rural districts • Primary care should develop child- and adolescent-friendly services to meet the basic mental health needs of children and adolescents with access to pharmacological and basic psychosocial support • Primary care staff should receive appropriate training and supervision from secondary and tertiary care staff to deliver high-quality 'shared-care' • Secondary care should develop child- and adolescent-friendly services and should include specialist CAMH staff, as well as appropriate pharmacological and psychosocial interventions • Secondary care staff should receive appropriate training and supervision from tertiary care staff to deliver high quality 'shared-care' • Specialist CAMH teams should be supported to maintain and develop their multidisciplinary expertise in outpatient and inpatient services • Due consideration should be given to establishing additional specialist CAMH teams in the Leadi provincial rural teaching centres • In addition, specialist CAMH teams should be supported to provide training, supervision and outreach to primary and secondary care teams in order to do clinical capacity-building across the provincial platform • Specialist CAMH teams should be supported to act as highly expert centres for clinical service delivery, training, research and policy development • The role of technology to provide remote support for clinical services, training and research should be considered • The required strengths of psychotropic medication should be made available consistently at all facilities

7.3.4 Recommendations for training

Training has a fundamental role both as a hardware and software element in services. Given that the Western Cape is one of only two South African provinces currently providing subspecialist training in the country, universities should be supported and sustainably funded to provide specialist training in child and adolescent psychiatry. In addition, specialist training should be supported in clinical child and adolescent psychology, nursing and other allied professions. Given the urban-rural-divide observed, it would be important for training to take place not only in tertiary settings, but also in regional and district hospitals and community clinics. Apart from the specialist CAMH workforce, training should be provided to colleagues in secondary and primary care in

order to ensure development of a highly skilled workforce across all levels of care.

Apart from the health workforce, collaborative training should also be developed and provided to other sectors of care including education and social development. One of the foundations of CAMH and CAMHS is seeing the child and adolescent in the context of their family and community. Intersectoral working and training is therefore of fundamental importance. In many countries school mental health services and teams provide the core of care in CAMH (Babatunde et al., 2020). This is therefore an exciting and important area for joint training and research (see **Table 7.6**) in South Africa.

As a whole population-approach, training to the general population on mental health and mental health literacy will be an important mechanism to reduce mental health stigma and increase community knowledge about mental health, mental illness and treatment.

Table 7.6 Recommendations for training

• Universities should be supported to provide specialist training in child and adolescent psychiatry through the sustainable funding of training posts • Training should be provided in clinical psychology, child and adolescent psychiatric nursing and other allied professions to ensure a highly skilled workforce for the future • Training posts should be provided in urban and rural districts • Training should also be provided across all levels of care and across professional groups to develop knowledge and ensure up-to-date evidence-based practice in CAMH • Training should be developed jointly with other sectors including education and social development to ensure a broad and multisectoral workforce in CAMH • Public awareness work on CAMH, stigma and all environmental factors related to CAMH should be supported

7.3.5 Recommendations for research

It was encouraging to see some CAMH research in the province. However, significantly more research on CAMH is required both provincially and nationally, particularly in the domains of clinical services research,

implementation science and policy-related research. In order to increase the potential impact and implementation of relevant research, we would also encourage researchers to seek mechanisms to join up with national and provincial governments and policymakers to ensure synergies, joint priority-setting and joint learning. Universities and other relevant bodies should emphasise research capacity-building to ensure the training of a highly skilled next generation of CAMH researchers. Particular areas of clinical research should focus on 'task-sharing' from tertiary to secondary and primary levels of care (Hoeft, Fortney, Patel & Unutzer, 2018). Task-sharing refers to strategies to adapt a highly complex approach so that it can be delivered through training by a lower level of healthcare worker at a lower level of service and has been implemented with good intervention, implementation and fidelity outcomes in low- and middle-income settings of adult mental health services (Hoeft, Fortney, Patel & Unützer, 2018; Juengsiragulwit, 2015; O'Brien, Harvey, Howse, Reardon & Creswell, 2016; Semrau et al., 2019). There is also an increasing body of research using task-sharing in autism in Africa (Schlebusch et al., 2020).

The COVID-19 pandemic that hit the globe in 2020 has led to a rapid shift of many clinical and research activities to remote technology platforms. However, in low-resource settings like South Africa, the drive towards technology introduced a significant risk of increasing the pre-existing health disparities in these settings (Amaral & de Vries, 2020). Nevertheless, COVID-19 demonstrated that, even in low-resource settings, technology may become a very powerful tool to aid the identification, diagnosis and treatment of people with mental health problems, and to support training and supervision of all involved in mental healthcare. The use of technology to support CAMH and CAMHS should therefore be encouraged in research in the coming years.

Table 7.7 Recommendations for child and adolescent mental health research

• Clinical service research, implementation science research, and policy-related research should be conducted in the Western Cape and other South African provinces • Researchers should develop a mechanism to develop research priorities in partnership with government policymakers, and all other stakeholder groups to ensure alignment of research priorities • Researchers should be supported to develop clinical and applied research capacity in CAMH to ensure a highly skilled next generation of researchers in CAMH • Research should explore task-sharing opportunities to move clinical tasks from tertiary to secondary and primary levels of care in urban and rural districts • Research should explore the feasibility of technology for identification, diagnosis, and treatment of CAMH disorders, and for training and supervision of staff

In Chapter 4 we presented a 'tipping point' model of positive and negative potential tipping events or activities that may strengthen or weaken CAMHS. Taking together all the findings from this thesis, we believe that there are many potential positive tipping events or actions (particularly 'software' elements) that could contribute to positive change and strengthening of CAMHS in the Western Cape and beyond.

7.4 Next Steps: From Identification to Implementation

In the same way that there is a well-acknowledged gap between research evidence and implementation of such evidence in clinical practice, the same gap exists between evidence-generation and policy implementation. An exploration of factors that prevent transformation of policy and practice (i.e. that act as potential barriers and facilitators of policy implementation) would be a very helpful next step. There are many potential reasons for this evidence-to-policy gap but one key barrier is the lack of appropriate communication mechanisms between researchers and policymakers, which often limits the opportunities for joint priority setting and solution generation. Shroff and colleagues (2015) identified that one of the facilitators for incorporating

evidence into decision-making is personal contact between researchers and policymakers. A second important process is that of participatory research (De Silva et al., 2014). In this project, we set out to share the development of project goals with various stakeholders (including policymakers, funders, senior managers), and we included various of these stakeholders and stakeholder groups throughout the studies presented in the thesis. For instance, the SWOT analysis performed in Chapter 4 very strategically included key senior stakeholders.

The next step for the data generated in this thesis is therefore to 'close the loop' by sharing findings from the thesis with a broad group of CAMH stakeholders. The goal is to use a stakeholder engagement workshop as a participatory opportunity for joint priority setting and planning of next steps.

One methodology that can be used during stakeholder engagement is 'Theory of Change' (ToC), a theory-driven participatory approach to programme design and evaluation (Breuer et al., 2014; De Silva et al., 2014). Various stakeholders share knowledge, discuss and plan service delivery strategies and reach consensus on indicators to be used to monitor the outcomes of the plan. 'Theory of Change' workshops have been used in the development and evaluation of mental health systems of care for children and adolescents in the United States (Weiss et al., 2012) and in programmes for improving mental healthcare (PRIME project) in LMIC such as Ethiopia, India, Nepal, South Africa and Uganda, for planning, contextualization of plans and to obtain stakeholder buy-in (Breuer et al., 2014; De Silva et al., 2014). Our goal would be that a participatory workshop would lead to a joint action plan for CAMH service strengthening.

Apart from stakeholder engagement, we will also aim for the findings of the thesis to have an impact through other dissemination routes. Apart from submission of studies for peer-reviewed publication in (preferably) open-access journals, we will also seek and create impact activities through local, provincial, national and international conferences, workshops and other communication opportunities. We strongly feel that the conclusion of the research presented in this thesis should not be the end of the process, but

rather the start of the important dissemination and implementation phase of research. We trust that the striking and, at times, sobering findings of this thesis will then be able to have a broad impact a) to highlight the needs of CAMHS and b) to provide some evidence-informed options to strengthen those services. The WHO-AIMS as designed, was not fit-for-purpose as framework for a situational analysis of CAMH resources. Given the recognition of CAMH as a major global service gap, it may be valuable for the WHO to consider developing a CAMH-specific framework for situational analysis and potential systems strengthening activities. We suggest that the adaptations made in Chapter 3 may provide a helpful starting point for such a process.

7.4.1 Practical tips for the strengthening of existing services

All the next step actions listed above are necessary to ensure that the evidence-base generated in this thesis may have an impact in real life. However, engagement with key stakeholders' discussion of policies, plans and implementation thereof, will require time, negotiations and potentially extended procedures. The author of this thesis is a nurse practitioner. Apart from the medium- to longer-term next steps for impact, the findings from this thesis also provided a number of practical suggestions that could be implemented by staff in existing services without delay. Taking together all the findings from this thesis in **Table 7.8** we therefore decided to distil a table of positive practice tips for existing services and service providers. Table 7.9 gives an example of local innovation in one primary healthcare team where various practical strategies were introduced at no cost to the service in order to provide a more responsive CAMH services to young people attending the specific clinic.

Table 7.8 Practical tips to strengthen existing services that support children and adolescents with mental health disorders

PRIMARY LEVEL
1. Create dedicated CAMH spaces within the existing mental health services a) set up a dedicated room for children and adolescents (in facilities where there are two or more separate rooms allocated to mental health services) b) create a 'children's corner' within the interview room, and demarcate it with a divider/screen in order to create privacy to engage with the child or adolescent (in facilities where there is only one room allocated for mental health services) **2. Make the space child- and adolescent-friendly within the service** a) place a small table, chairs and child-friendly toys to engage with the child or adolescent b) keep a small box or cabinet for toys and other materials/tools for young people c) place child- and adolescent-friendly educational images/posters on the wall **3. Separate the time of child and adolescent clinic from adult mental health patients** a) allocate different times to see children and adolescents, as opposed to adult patients (e.g. morning sessions for children and adolescents, and afternoon sessions for adult patients) b) allocate separate days to see children and adolescents only (e.g. one or two days in a week depending on the case load of children and adolescents) **4. Create links with other departments within the facility in order to generate support for child- and adolescent-friendly services that you have created** a) raise awareness and provide information about the CAMH service that you are providing, to other heads of the departments b) discuss service provision for children and adolescents with those departments

c) advocate and negotiate for the prioritisation of children and adolescents in service delivery in those departments, and especially the departments where they are likely to wait long (i.e. administration/reception and pharmacy)
d) ensure that CAMH services are included in the facility meetings discussions by adding them on the agenda for every meeting
e) ensure that lines of communication are continuously open with all departments
f) provide support for other departments that are also rendering a service for children and adolescents
g) work jointly with the school nurse and the social worker (where those categories exist in a facility) in order to facilitate support for children and adolescents with educational and social problems. These categories are the main links to your external educational and social services.

5. Organise your child and adolescent clinic to deliver a more effective service
a) organise for the collection of all CAMH files/folders from the administration preferably a day before the CAMH clinic. This will ensure that children and adolescents do not have to wait for their folders at reception but can come straight to their section and receive a quick service and still be able to attend school
b) arrange with the pharmacy department to allocate staff to service children and adolescents with mental health problems on the day of CAMH clinic (this will ensure that they receive their medication faster, are able to return to school, and not miss unnecessary days off school)

6. Training in CAMHS
a) create a weekly schedule that will allow time to attend joint training on CAMHS
b) encourage facility managers to allocate time for weekly face-to-face or remote training

7. Encourage staff to propose innovations to strengthen CAMH service delivery and acknowledge their innovations
a) encourage staff to share service strengthening innovations to children and adolescents and implement
b) create a system to acknowledge and celebrate positive service strengthening initiatives in clinics

8. Set up a clear plan for communication with and training of parents/caregivers
a) agree on a clear plan with all staff on how to share information with parents/caregivers and families
b) set up parent education & training sessions in local clinics in liaison with or under the guidance of specialist CAMH units

SECONDARY LEVEL
The same as for primary level, PLUS: **1. Create dedicated inpatient CAMH space within a facility to be available wherever a young person requires admission** a) allocating a separate ward in or near the mental health section b) create and demarcate a separate section for children and adolescents within the paediatric or mental health section/unit (ideally a separate room or section of the ward where young people and their families/caregivers can be supported safely and privately, and away from adult patients) **2. Make the space child- and adolescent-friendly within the inpatient unit** a) provide child- and adolescent-friendly toys, materials and equipment in the child and adolescent section/ward (including relevant health equipment such as smaller blood pressure cuffs) b) provide developmentally appropriate set of table and chairs in the room for engagement with the young person, and child- and adolescent-friendly posters/pictures on the wall c) keep a small box or cabinet in the room to store toys, materials and dedicated equipment d) place a sleeper couch in the room for a parent/carer as required **3. Allocate staff for the dedicated CAMH ward** a) the separated CAMH and adult sections can be managed by the same operational manager b) ask staff who have a particular interest in working with children and adolescents to volunteer **4. Create a support and supervision system for CAMH staff in the inpatient unit** a) set up a support and supervision system for the dedicated CAMH staff through links with specialist CAMH units.
TERTIARY LEVEL
1. Create a support and supervision system for CAMH staff in other levels of care and for rural areas a) set up a consistent and sustainable system for supervision of staff at primary and secondary levels who provide services to children and adolescents with mental health disorders

b) create a system for regular contact with rural CAMH service providers e.g. through remote technology or outreach services in order to provide supervision and support for rural services
c) set up joint academic case presentations and seminars with rural service providers e.g. through remote technology and/or face-to-face meetings
d) include rural service providers in all virtual training opportunities and activities on CAMH

2. Increase public awareness on CAMHS
a) increase public education on CAMH through targeted mental health awareness campaigns in local, provincial and national media, and in partnership with other sectors, including the non-profit sector

3. Focused research and research training
a) engage in health systems and implementation science research relevant to CAMH
b) provide research capacity-building training and opportunities for emerging researchers in CAMH. This should include opportunities for medical, non-medical and the full range of interdisciplinary staff involved in CAMH

Table 7. 9 A success story of responsive CAMHS in primary care

A primary healthcare clinic in Cape Town had two mental health nurses providing mental health services for adults and children. One of the mental health nurses had previously worked in another primary healthcare clinic where she was mentored and trained in CAMH by an advanced mental health nurse (the researcher) who provided CAMH outreach services at that facility, As a result the PHC nurse developed a passion for CAMH services. She was transferred to the new PHC where there were no CAMH service pathways. The two PHC mental health nurses decided to restructure CAMH services in their clinic. They set aside a specific day in a week as a CAMH clinic. The morning session of the day was specifically for children with ADHD, and it was called an 'ADHD clinic'. Children and adolescents with other mental health problems were seen in the afternoon. Adult mental health patients were seen on other days of the week, separately from the children and adolescents. The mental health nurses negotiated with the facility manager and other departments to create a more streamlined administrative and clinical pathway for their CAMH service: 1. For files of children and adolescents with mental health problems to be collected and stored securely in the mental health section of the clinic, away from all physical healthcare files; 2. For the mental health nurses to collect all the medication for children and adolescents and dispense them in the mental health section, to prevent families having to wait for too long in long ques, and children from panicking in the ques 3. The nurses divided the mental health section into two – an adult space, and a separate child- and adolescent-friendly space with toys, materials and resources suitable to the needs of the young people; 4. The nurse with particular interest in CAMH prioritised seeing children, adolescents and their families; the other nurse prioritised working with adult mental health patients, and they worked as a team; 5. The nurses received training and supervision form the specialist CAMH team at least once a month, and they also had access to the specialist CAMH team at any time telephonically for emergency advice. CAMHS users in this particular facility voiced their satisfaction about the service they received and commented on the difference in their experience after the mental health nurse arrived at the clinic.

7.5 Limitations of the thesis

Over and above specific limitations highlighted in individual chapters, we need to acknowledge a few overarching limitations of the work presented here. Firstly, we acknowledge that the work included in this thesis focused on public sector services in the province and did not consider the potential role of private sector CAMH. However, given that 80% of families in South Africa are dependent on public sector health services, we felt it was appropriate to examine this sector only. It would be of interest to consider the potential role

of private psychiatric care in relation to CAMHS in the province and the country.

Secondly, we also acknowledge that, within the public sector, we focused our research on the Department of Health, rather than on any other sector, for example the Departments of Education, Social Development or Justice. It is therefore important to emphasise that this was a pragmatic decision in the context of the thesis, rather than to suggest in any way that these other sectors may not play vitally important roles in the delivery of CAMHS. There are many examples of outstanding partnerships between the Departments of Health and Education, for instance. This may be a very important area for future CAMH research in the South African context.

Thirdly, even though we commented on this in Chapter 6, we have to acknowledge the relative and absolute lack of rural representation in our work. In part this was attributable to practical challenges in identifying and reaching participants in rural districts. However, it also underlined the broader challenge of making sure that the voices of rural districts are heard in CAMH research. We were reassured to see work by Babatunde and colleagues (2020) that specifically focused on CAMH research in a rural part of KwaZulu-Natal, and much greater effort needs to be made in future also to include participants from other rural communities in research.

Finally, we acknowledge that data collection for the thesis was based on a situational analysis of 2016 data and qualitative data collected in 2017. It is therefore possible that there may have been some CAMH service strengthening that had occurred since these data were collected. However, given that the researcher and research team were based in the Western Cape Province over the full duration of the study, we are not aware of any major policy or implementation changes that occurred and as such may have reduced the value of our observations and recommendations.

7.6 Reflexivity

My accumulated work experience is a big reason for this and study and must be acknowledged. I am a mental health nurse by profession, and I work in a specialist CAMH unit. I previously worked in various settings as well as various facilities in adult and child and adolescent mental health services. I have twenty-one years of experience in psychiatry. My experience and my exposure therefore make me very familiar with most mental health service providers across the Western Cape as I have worked closely with a number of them. I am therefore also very familiar with some of the issues in both adult and child and adolescent mental health services. I am part of one of the provincial specialists CAMH teams that provide supervision and support for the service providers at secondary and tertiary level. Given that I was the primary data collector for the work in this thesis, I have to acknowledge that, unconsciously, I may have been biased in my exploration of the themes and issues in this thesis. However, I consciously aimed to collect data in an objective manner, sought independent supervision throughout the thesis, and ensured inclusion of second coders for all qualitative data analysis. However, my experience and understanding of CAMHS also allowed me to provide a more nuanced and deep analysis of the data.

I trust that the combination of my conscious and unconscious contributions in this thesis will provide a contemporary evidence-base that could help to strengthen CAMHS in the Western Cape Province of South Africa and beyond.

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APPENDICES

Appendix A: Human Research Ethics (HREC) Approval. 2016

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 404 7682 • **Facsimile** [021] 406 6411
Email: nosi.tsama@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

08 June 2016

HREC REF: 188/2016

Prof P de Vries
Child and Adolescent Psychiatry
46 Sawkins Road
Rondebosch

Dear Prof P de Vries

PROJECT TITLE: CHILD AND ADOLESCENT MENTAL HEALTH SERVICES IN THE WESTERN CAPE OF SOUTH AFRICA: SITUATIONAL ANALYSIS, STAKEHOLDER PERSPECTIVES, AND IMPLICATIONS FOR HEALTH POLICY IMPLEMENTATION (PhD-candidate- Ms S Mokitimi).

Thank you for your response letter to the Faculty of Health Sciences Human Research Ethics Committee dated 01 June 2016.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30th June 2017.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

We acknowledge that the following student will be involved in this study: Ms Stella Mokitimi.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval before the research may occur.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Yours sincerely

Signature Removed

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

HREC 188/2016

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH 2006), based on the Association of the British Pharmaceutical Industry Guidelines (ABPI),and Declaration of Helsinki (2013) guidelines.
The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

HREC 188/2016

Appendix B: Human Research Ethics (HREC) Approval. 2020

UNIVERSITY OF CAPE TOWN

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

12 JUN 2020

HEALTH SCIENCES FACULTY
UNIVERSITY OF CAPE TOWN

FHS016: Annual Progress Report / Renewal

HREC office use only (FWA00001637; IRB00001938) This serves as notification of annual approval, including any documentation described below.			
☑ Approved	Annual progress report	Approved until/next renewal date	30.06.2021
☐ Not approved	See attached comments		
Signature Chairperson of the HREC/ Designee	signature removed	Date Signed	16/6/20

Note: Please note that incomplete submissions will not be reviewed.
Please email this form and supporting documents (if applicable) in a combined pdf-file to hrec-enquiries@uct.ac.za.
Please clarify your plan for research-related activities during COVID-19 lockdown

Comments to PI from the HREC

Principal Investigator to complete the following:

1. Protocol information

Date (when submitting this form)	12 June 2020		
HREC REF Number	188/2016	Current Ethics Approval was granted until	30/06/2020
Protocol title	Child and adolescent mental health services in the Western Cape of South Africa: situational analysis, policy evaluation, stakeholder perspectives, and implications for health policy implementation		
Protocol number (if applicable)	HREC188/2016 protocol version 2.0		
Are there any sub-studies linked to this study?		✓ Yes No ☐	
If yes, could you please provide the HREC Ref's for all sub-studies? Note: A separate FHS016 must be submitted for each sub-study.		HREC 754/2019	
Principal Investigator	Professor Petrus J de Vries		

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

Department / Office Internal Mail Address	Sue Struengmann Professor of Child & Adolescent Psychiatry Division of Child & Adolescent Psychiatry Department of Psychiatry and Mental Health University of Cape Town Room 25, Building B, 46 Sawkins Road, Rondebosch, Cape Town, 7700, South Africa Tel: +27 (0) 21 685-4103 Fax: +27 (0) 21 689-1343 E-mail: petrus.devries@uct.ac.za

1.1 Does this protocol receive US Federal funding?	☐ Yes	No✓
1.2 If the study receives US Federal Funding, does the annual report require full committee approval? **Note: Any annual approvals for Full Committee review MUST be submitted on the monthly HREC submission dates.** **(Please send electronic copy for full committee review to** hrec-enquiries@uct.ac.za)	☐ Yes	☐ No

If yes in 1.2 please complete section 1.3 below for invoicing purposes	
1.3 Annual Approval for full committee review	**- R 3450 (inclusive of vat)**
For invoicing purposes, please provide:	
Sponsor's name	
Contact person	
Address	
Telephone number	
Email Address	

2. List of documentation for approval

No new documents for approval.

3. Protocol status (tick ✓)

☐	Open to enrolment
✓	Closed to enrolment (tick ✓)
☐	Research-related activities are ongoing
☐	Research-related activities are complete, long-term follow-up only
✓	Research-related activities are complete, data analysis only
☐	Main study is complete but sub-study research-related activities are ongoing
☐	Study is closed → Please submit a Study Closure Form (FHS010)

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

4. Enrolment

Number of participants enrolled to date	110
Number of participants enrolled, since last HREC Progress report (continuing review)	15
Additional number of participants still required	15

5. Refusals

Total number of refusals (participants invited to join the study, but refused to take part)	34

6. Cumulative summary of participants

Total number of participants who provided consent	110
Number of participants determined to be ineligible (i.e. after screening)	1
Number of participants currently active on the study	15
Number of participants completed study (without events leading to withdrawal)	95
Number of participants withdrawn at participants' request (i.e. changed their mind)	36
Number of participants withdrawn by PI due to toxicity or adverse events	0
Number of participants withdrawn by PI for other reasons (e.g. pregnancy, poor compliance)	0
Number of participants lost to follow-up. Please comment below on reasons for loss of follow-up.	0
Number of participants no longer taking part for reasons not listed above. Please provide reasons below:	0

7. Progress of study

Please provide a brief summary of the research to date including the overall progress and the progress since the last annual report as well as any relevant comments/issues you would like to report to the HREC:
All data were collected in 2016 and 2017. Since then we have been working on analysis, and write-up of publications and a PhD dissertation. We also added a small substudy to the main study (HREC 754/2019), which focuses on educational aspects. This study is currently in the analysis and write-up phase. To date 2 peer-reviewed articles have been published from the study. Four further manuscripts are in preparation.

8. Protocol violations and exceptions (tick ✓ all that apply)

✓	No prior violations or exceptions have occurred since the original approval
☐	Prior violations or exceptions have been reported since the last review and have already been acknowledged or approved
☐	Unreported minor violations that have occurred since the last review, as well as significant deviations not yet reported, are attached for review

9. Amendments (tick ✓ all that apply)

☐	No prior amendments have been made since the original approval
✓	Prior amendments have been reported since the last review and have already been approved
☐	New protocol changes/ amendments are requested as part of this continuing review (See note below)

Note: If new protocol changes are being requested in this review, please complete an amendment form (FHS006).
Specific changes in the amended protocol and consent/assent forms must be **bolded**, *italicised* or tracked and all changes must include a rationale.

10. Adverse events

10.1 Please provide below or attach a narrative summary of serious adverse events and/ or unanticipated problems since the last progress report. Please indicate changes made to the protocol and informed consent document(s) as a result (if not already reported to the HREC). Please comment on whether causality to any study procedure or intervention could be established.
N/A

10.2 Have participants received appropriate treatment/ follow-up/ referral when indicated (e.g. in the case of abnormal or incidental clinical findings, distress or anxiety)?		
☐ Yes	☐ No	✓ Not applicable
If yes, please describe:		

11. Summary of Monitoring and Audit Activities (tick ✓)

11.1 Was this study monitored or audited by an external agency (e.g. SAHPRA, FDA)?		
☐ Yes	☐ No	✓ Not applicable

11.2 Did a Data and Safety Monitoring Board publish a report?		
☐ Yes	☐ No	✓ Not applicable

11.3 If yes, please identify the agency and attach a summary of the findings.

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

Agency Name		Report attached	☐ Yes	☐ No	☐ Not applicable
		DSMB report attached	☐ Yes	☐ No	☐ Not applicable

11.4 Has there been any agency, institutional or other inquiry into non-compliance in this study, or any finding of non-compliance concerning a member of the research team?	
☐ Yes	✓ No
If yes, please explain:	

12. Level of risk (tick ✓)

12.1 In light of your experience of this research, please indicate whether the level of risk to participants has:	
☐	Increased
☐	Decreased
✓	Shown no change
If there has been a change, please explain:	

12.2 Please provide a narrative summary of recent relevant literature that may have a bearing on the level of risk.

13. Statement of conflict of interest

Has there been any change in the conflict of interest status of this protocol since the original approval? (tick ✓)	
☐ Yes	✓ No
If yes, please explain and if necessary, attach a revised conflict of interest statement (Section #7 in the New Protocol Application Form FHS013):	

14. Signature

My signature certifies that the above is complete and correct.			
Signature of PI	Signature Removed	Date	12 June 2020

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

Appendix C: Western Cape Government: Health Ethics Approval. 2016

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 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_2016RP39_567
ENQUIRIES: Ms Charlene Roderick

University of Cape Town

Anzio Road

Observatory

7935

For attention: Mrs Stella Mokitimi

Re: **Child and adolescent mental health services in the Western Cape of South Africa: situational analysis, stakeholder perspectives, and implications for health policy implementation.**

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 following people to assist you with any further enquiries in accessing the following sites:

Crossroads CDC	**Shirley E Abrahams**	**021 385 3003**
Brown's Farm (Imzame Zabantu) CDC	**Boniswa Nunu**	**021 374 6063**

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. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

Signature Removed

DR A HAWKRIDGE

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 7/9/2016.

CC **P OLCKERS** **DIRECTOR: MITCHELLS PLAIN/ KLIPFONTEIN**

Appendix D: Red Cross War Memorial Children's Hospital Ethics Approval. 2016

Dr Jane Kawadza
Manager: Medical Services
Email: Jane.Kawadza@Westerncape.gov.za
Tel: +27 21 658 5788 fax: +27 21 658 5166
RXH: RCC73

Dr Stella Mokitimi
Red Cross War Memorial Children's Hospital

Dear Dr Stella Mokitimi

APPROVAL OF RESEARCH

PROJECT TITLE: CHILD AND ADOLESCENT MENTAL HEALTH SERVICES IN THE WESTERN CAPE OF SOUTH AFRICA: SITUATIONAL ANALYSIS, POLICY EVALUATION, STAKEHOLDER PERSPECTIVES, AND IMPLICATIONS FOR HEALTH POLICY IMPLEMENTATION

It is a pleasure to inform you that approval is hereby granted to conduct the above-mentioned study at Red Cross War Memorial Children's Hospital.

Yours sincerely

Signature Removed

Dr J Kawadza
Manager: Medical Services
Date: 02.08.17

Appendix E: Informed consent form (adult)

Private Bag X3, Rondebosch, 7701, South Africa. (021) 685 4103/5116.

E-mail address: smokitim@pgwc.gov.za

INFORMED CONSENT FORM (for parent/guardian/mental health provider, senior DoH staff)

Project Title: "Child and adolescent mental health services in the Western Cape of South Africa: situational analysis, stakeholder perspectives, and implications for health policy implementation"

Thank you for considering participating in this study

In order to participate in the study, we described, please complete the form below and return it to the researcher who gave you the form.

I……..*(Print own name)*, ***have read and understood the content of the information sheet.***

I AGREE **to take part in the study about** "Child and adolescent mental health services in the Western Cape of South Africa: situational analysis, stakeholder perspectives, and implications for health policy implementation."

I also agree that the interview and/or the focus group discussion can be audio recorded.

I know why they are asking me to participate in this project and all of my questions have been answered.

Signature (participant)……..Date…….

Signature (Witness for a verbal consent)…….Date……..……..

Signature (interviewer)…….……Date……..……

Appendix F: Informed consent form (parental/guardian permission for the child to participate)

Private Bag X3, Rondebosch, 7701, South Africa. (021) 685 4103/5116.

E-mail address: smokitim@pgwc.gov.za

INFORMED CONSENT FORM (for parental/guardian permission for the child to participate)

Project Title: "Child and adolescent mental health services in the Western Cape of South Africa: situational analysis, stakeholder perspectives, and implications for health policy implementation"

Thank you for considering participation of your child in this study

In order for your child to participate in the study we described, please complete the form below and return it to the researcher who gave you the form.

I……..*(Print own name)*, ***have read and understood the content of the information sheet.***

I AGREE that my child can **take part in the study about** "Child and adolescent mental health services in the Western Cape of South Africa: situational

analysis, stakeholder perspectives, and implications for health policy implementation."

I also agree that the focus group discussion can be audio recorded.

I know why they are asking for my child to participate in this project and all of my questions have been answered.

Signature (parent/guardian)……Date……

Signature (Witness for a verbal consent)……..Date……

Signature (interviewer)……..…….Date...……

Appendix G: Informed assent form (for the child)

Private Bag X3, Rondebosch, 7701, South Africa. (021) 685 4103/5116.

E-mail address: smokitim@pgwc.gov.za

INFORMED ASSENT FORM (for a child)

Project Title: "Child and adolescent mental health services in the Western Cape of South Africa: situational analysis, stakeholder perspectives, and implications for health policy implementation"

Thank you for ***thinking carefully about taking part*** in this study

In order to *take part* **in the study we described, *please fill in the form below and then give it back to the researcher who gave it you***

I……..*(Print own name)*, ***have read and understood the information on the information sheet.***

I AGREE ***to take part in the study about*** "Child and adolescent mental health services in the Western Cape of South Africa: situational analysis, stakeholder perspectives, and implications for health policy implementation."

I also agree that the ***group chats*** can be audio recorded.

I know why they are asking me to participate in this project and all of my questions have been answered.

Signature (participant)……...Date……

Signature (Witness for a verbal consent)……..Date…….

Signature (interviewer)……..Date…....……..

Appendix H: Information sheet (mental health care provider)

Private Bag X3, Rondebosch, 7701, South Africa. (021) 685 4103/5116.

E-mail address: smokitim@pgwc.gov.za

INFORMATION SHEET (mental health care provider)

Project Title: "**Child and adolescent mental health services in the Western Cape of South Africa: situational analysis, stakeholder perspectives, and implications for health policy implementation**."

What is this study about?

This is a research project being conducted by Professor de Vries and Stella Mokitimi at the University of Cape Town. I am inviting you to participate in this research project because you are a mental health care provider in the Western Cape Province.

The purpose of this research project is to describe the existing Child and adolescent mental health services, to explore perspectives of users and providers of these services, and to use the information to generate a set of recommendations to inform policy and service implementation.

Where will the interviews and focus groups be conducted?

Focus groups and individual interviews will be conducted at the local venue which is nearest to the place where you live or work, so that it is easier for you to attend. You will be informed telephonically about the exact venue.

How will I travel to the venue for focus group discussions and individual interviews?

The costs for travelling will be fully covered.

What will I be asked to do if I agree to participate?

You will be asked to participate in a focus group discussion with other mental health providers in the same profession as yours. Each focus group will have between six to eight participants and will be around 1 – 2 hours long. The discussion will be audio recorded, and notes will be taken during and after the group, in order to provide a permanent record of what was said. The discussions will be about:

1. Your opinions and views about the services you provide

2. Your experiences and challenges in managing children and adolescents.

3. Your recommendations for Child and Adolescent Mental Health Services

You may also be selected for an individual interview, in order to discuss in more details, the issues that need further clarity. Each interview will be 45-60 minutes long and will explore the same information explored in focus group discussions. The interview will also be audio recorded, and field notes will be taken during and after the interview, in order to provide a permanent record of what was said.

Would my participation in this study be kept confidential?

A code will be attached to all participants, recordings and field notes, so that no participant can be identified by name. All the recordings and field notes will be safely locked away to ensure that no one has access to them except for the

research team. When we write a report or article about this research project, your identity will be hidden.

Confidentiality in FGDs cannot be guaranteed, however all participants will be asked to not to disclose any information about what was discussed in the groups outside the groups, and not to mention any names of the group members.

What are the risks of this research?

There are no known risks associated with participating in this research project.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator, authorities and policy makers to understand more about your experiences in delivering child and adolescent mental health services. Your input will contribute to the body of knowledge about the gaps in needs and services in child and adolescent mental health in the Western Cape. This knowledge may also assist in the generation of recommendations and guidelines for service delivery in child and adolescent mental health services.

Do I have to be in this research, and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time you want. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized.

What if I have questions?

This research is being conducted by Professor de Vries and Stella Mokitimi, of the Faculty of health Sciences, at the University of the Cape Town. If you have any questions about the research study itself, please contact:

Stella Mokitimi at

University of Cape Town

(021) 6854103

smokitim@pgwc.gov.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Chairperson of the UCT HREC –

Prof Marc Blockman

Address: University of Cape Town

Barnard Fuller Building

Anzio Road

Observatory

Cape Town

Tel: (021) 406 6340

Supervisors:

Professor Petrus J de Vries

Address: 46 Sawkins Road

Rondebosch

7700

Tel: (021) 685 4103/5116

E-mail address: petrus.devries@uct.ac.za

Dr Marguerite Schneider

Address: 46 Sawkins Road

Rondebosch

7700

Tel: (021) 406 6308

E-mail address: marguerite.schneider@uct.ac.za

The University of Cape Town Senate Research Committee, the Ethics Committee and the Western Cape Department of Health have approved this research.

Appendix I: Information sheet (mental health care users)

Private Bag X3, Rondebosch, 7701, South Africa. (021) 685 4103/5116.

E-mail address: smokitim@pgwc.gov.za

INFORMATION SHEET (mental health care users: parents)

Project Title: "Child and adolescent mental health services in the Western Cape of South Africa: situational analysis, stakeholder perspectives, and implications for health policy Implementation."

What is this study about?

This is a research project being conducted by Professor de Vries and Stella Mokitimi at the University of Cape Town. I am inviting you to participate in this research project because you are a mental health care user in the Western Cape.

The purpose of the study is to describe the existing Child and Adolescent mental health services, to explore perspectives and issues of users and providers of these services and to use the information to generate a set of recommendations for policy and service implementation.

Where will the focus groups be conducted?

Focus groups will be conducted at the local venue, which is nearest to the place where you live, so that it is easier for you to attend. You will be informed telephonically about the exact venue.

How will I travel to the venue for focus group discussions and individual interviews?

The costs for travelling will be fully covered.

What will I be asked to do if I agree to participate?

You will be asked to participate in a focus group discussion, with other child and adolescent mental health care users. Each focus group will have between six to eight participants and will be sixty (60) minutes long. The discussion will be tape-recorded recorded, and field notes will be taken during and after the group, in order to provide a permanent record of what was said. Group discussions will be conducted at a venue closest to you. The discussions will be about:

1. Your opinions and views about the services you receive`

2. Your lived experiences and challenges in the service you receive.

3. Your recommendations for Child and Adolescent Mental Health Services

Would my participation in this study be kept confidential?

A code will be attached to all participants, recordings and field notes, so that no participant can be identified by name. All the recordings and field noted will be safely locked away to ensure that no one has access to it except for the research team. When we write a report or article about this research project, your identity will be hidden. However, in accordance with legal requirements and/or professional standards, I will disclose to the appropriate individuals and/or authorities, any information that comes to my attention concerning child abuse or neglect or potential harm to you or others.

Confidentiality in FGDs cannot be guaranteed, however all participants will be asked to not to disclose any participants names should they discuss about the groups outside, and not to mention any names of the group members.

What are the risks of this research?

There are no known risks associated with participating in this research project

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator, authorities and policy makers to understand more about your experiences and opinions about in the services you receive. Your input will contribute to the body of knowledge about the gaps in needs and services in child and adolescent mental health in the Western Cape. This knowledge may also assist the generation of recommendations and guidelines for service delivery in Child and adolescent mental health.

Do I have to be in this research, and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time you want. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized.

What if I have questions?

This research is being conducted by Professor de Vries and Stella Mokitimi, of the Faculty of health Sciences, at the University of the Cape Town. If you have any questions about the research study itself, please contact:

Stella Mokitimi at

University of Cape Town

(021) 6854103

smokitim@pgwc.gov.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Chairperson of the UCT HREC

Prof Marc Blockman

Address: University of Cape Town

Barnard Fuller Building

Anzio Road

Observatory

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The University of Cape Town Senate Research Committee, the Ethics Committee and the Western Cape Department of Health have approved this research.

Appendix J: Information sheet (mental health care users: young people)

Private Bag X3, Rondebosch, 7701, South Africa. (021) 685 4103/5116.

E-mail address: smokitim@pgwc.gov.za

INFORMATION SHEET (mental health care users: *young people*)

Project Title: "Child and adolescent mental health services in the Western Cape of South Africa: situational analysis, stakeholder perspectives, and implications for health policy Implementation."

What is this study about?

This is a research project being done by Professor de Vries and Stella Mokitimi at the University of Cape Town. We are inviting you to take part in this research project because you are using the mental health services in the Western Cape.

The main goal of this study is to learn about the child and adolescent mental health services that are being used now, to learn more about what young people, parents and providers think about these services, and then use the information to make the services better in future.

Where will the group chat take place?

Group chats will take place in a place that is nearest to your homes so that it is easier for you to attend. Someone will call you to tell you exactly where the chats will take place.

How will I go to the place where these group chats will take place?

You will be given a bus fare for travelling.

What will I be asked to do if I agree to take part in this study?

You will be asked to take part in a group chat with other young people who also use these services. There will be six to eight people in each group, and the chat will be about sixty (60) minutes long. The discussion will be tape-recorded, and notes will be taken during and after the group, in order to make sure that we have a record of what was said. Group chat will be done at a venue closest to you. The discussions will be about:

1. Your opinions and views about the services you receive

2. What you like and what you dislike about the services you receive

3. Your suggestions on what can be done to make the services better

Will other people who are not taking part know that I also took part in this study, and will they know what I said?

Your name will not be mentioned, and no one will know that you took part in the study. All the recordings and notes will be safely locked away to make sure that no one else sees them but only the research team. However, if we get any information that you are in danger or you are abused, we have to report to the social workers who can take action and help you and protect you. We have to do this to protect you.

Everyone who takes part in the group chats will be asked not to share what was discussed in the group to anyone outside the group, and not to mention any names of those who took part in the study.

Are there any risks of taking part in the study?

There are no risks from helping us with our research. You will still receive the services that you need from the clinic. Nothing bad is going to happen to you because you took part in the group chats. Some people might get upset by talking about frustrations, but we will make sure that you are well supported in the group.

What is the benefit for me in helping with this study?

This research will not directly help you, but we hope that the results will help us to make sure we improve services for young people in future. Your views will help us understand more about which services are not provided and what services should be provided for young people who have mental health problems in the Western Cape.

Do I have to take part, and can I stop participating at any time?

You don't need to take part in the research; it is only if you want to. You may choose not to take part at all. If you decide to take part in this research, you can stop at any time you want. If you decide not to take part in this study or if you stop at any time, you will not be punished for doing that, and it will not affect the help you get from the clinics in any way.

What if I have questions?

Professor de Vries and Stella Mokitimi, of the Faculty of health Sciences, at the University of the Cape Town are doing this research. If you have any questions about the research study itself, you can ask the person interviewing you or contact one of the following people:

Stella Mokitimi at

University of Cape Town

(021) 6854103

smokitim@pgwc.gov.za

Should you have any questions about this study and your rights as a research participant or if you wish to report any problems you have in this study, please contact:

Chairperson of the UCT HREC

Prof Marc Blockman

Address: University of Cape Town

Barnard Fuller Building

Anzio Road

Observatory

Cape Town

Tel: (021) 406 6340

Supervisors:

Professor Petrus de Vries

Address: 46 Sawkins Road

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Dr Marguerite Schneider

Address: 46 Sawkins Road

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7700

Tel: (021) 403 6308

E-mail address: marguerite.schneider@uct.ac.za

The University of Cape Town Senate Research Committee, the Ethics Committee and the Western Cape Department of Health have approved this research.

Appendix K: Information sheet (Senior Department of Health staff)

UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

FACULTY OF HEALTH SCIENCES

Private Bag X3, Rondebosch, 7701, South Africa. (021) 685 4103/5116.

E-mail address: smokitim@pgwc.gov.za

INFORMATION SHEET (Senior DoH staff)

Project Title: "Child and adolescent mental health services in the Western Cape of South Africa: situational analysis, stakeholder perspectives, and implications for health policy implementation."

What is this study about?

This is a research project being conducted by Professor de Vries and Stella Mokitimi at the University of Cape Town. We are inviting you to participate in this research project because you are a Senior DoH staff in the Western Cape.

The purpose of the study is to describe the existing Child and Adolescent mental health services, to explore perspectives and issues of users and providers of these services and to use the information to generate a set of recommendations for policy and service implementation.

Where will the interview be conducted?

The individual interview will be conducted at the local venue which is nearest to the place where you live or work, so that it is easier for you to attend. The exact venue will be discussed and confirmed with you before the interview.

How will I travel to the venue for individual interviews?

We will reimburse you for travel to the interview, if required.

What will I be asked to do if I agree to participate?

You will be asked to participate in an individual interview. Each interview will be 60 minutes long. The interview will also be tape-recorded, and field notes will be taken during and after the interview, in order to provide a permanent record of what was said.

Would my participation in this study be kept confidential?

A code will be attached to all participants, recordings and field notes, so that no participant can be identified by name. All the recordings and field noted will be safely locked away to ensure that no one has access to it except for the research team. When we write a report or article about this research project, your identity will be hidden.

What are the risks of this research?

There are no known risks associated with participating in this research project.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator, to understand your perceptions and opinions on child and adolescent mental health services. Your input will contribute to the body of knowledge about the gaps in needs and services in child and adolescent mental health in the Western Cape. This knowledge may also assist the generation of recommendations and guidelines for service delivery in child and adolescent mental health.

Do I have to be in this research, and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop

participating at any time you want. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized.

What if I have questions?

This research is being conducted by Professor de Vries and Stella Mokitimi, of the Faculty of health Sciences, at the University of the Cape Town. If you have any questions about the research study itself, please contact:

Stella Mokitimi at

University of Cape Town

(021) 6854103

smokitim@pgwc.gov.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Chairperson of the UCT HREC

Prof Marc Blockman

Address: University of Cape Town

Barnard Fuller Building

Anzio Road

Observatory

Cape Town

Tel: (021) 406 6340

Supervisors:

Professor Petrus de Vries

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Dr Marguerite Schneider

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E-mail address: marguerite.schneider@uct.ac.za

The University of Cape Town Senate Research Committee, the Ethics Committee and the Western Cape Department of Health have approved this research

Appendix L: Interview schedule and interview guide for a focus group (Parent and legal guardian)

INTERVIEW GUIDE FOR A FOCUS GROUP (Parent and legal guardian)

Name of the group facilitator:.....

Date:.....

Attendees (CAMH service users)

Good day. My name is _____and this is my colleague_____. Thank you for coming. A focus group is a relaxed discussion.

Present the purpose

We are here today to talk about **your experiences and your perceptions of the service you receive for your child; the challenges which you may be encountering with the service, which may influence your utilisation of the service; and any proposals, you have for future in order to improve the service you receive for your child.** *The purpose is* **to get your views of how child and adolescent mental health services should be provided and to improve the service you receive**. *I'm not here to share information or to give you my opinions. Your perceptions are what matter. There are no right or wrong or desirable or undesirable answers. You can disagree with each other, and you can change your mind. I would like you to feel comfortable saying what you think and how you really feel.*

Discuss the procedure

_____*my colleague will be taking notes and tape recording the discussion so that I do not miss anything you have to say. I explained these procedures to you when we set up this meeting. As you know everything is confidential.* ***Everything we discuss in this room should not to be discussed with others who are not part of this discussion and the names of the group members here should not be shared with anyone outside out this group.*** *When the results of the study are published, no one will know who said what. I want this to be a group discussion, so feel free to respond to me and to other members in the group without waiting to be called on. However, I would appreciate if only one person does talk at a time. The discussion will last approximately one hour. There is a lot I want to discuss, so at times I may move us along a bit.*

Participant introduction

Now let's start by **everyone sharing their name, where they receive mental health treatment for their child/ren and how long they've been receiving the treatment for***.*

Interview (topic and probes)

1. How did you get to be seen here? Please share your journey in the system

2. What are some of the positive experiences you have had in this service?

Can you share with us about your experiences of the services you receive for your child from your facilities?

Please explain more about…….

3. What are some of the difficulties or challenges you have experienced in the service?

4. What do you think can we do to make the service better for families who have children with mental health problems?

Closure

Though there were many different opinions **about your lived experiences, perceptions, challenges and suggestions for the future, it appears unanimous** *that…….. Does anyone see it differently?.....it seems most of you agree……..but some think that ……..does anyone want to add or clarify an opinion on this?*

Is there any other information regarding **your experiences, perceptions, challenges and suggestions for the future, with the services you receive for your children from your facilities** *that you think would be useful for me to know?*

Thank you very much for coming today. Your time is very much appreciated, and your comments have been very helpful.

Appendix M: Interview guide for a focus group (young people)

INTERVIEW GUIDE FOR A FOCUS GROUP (young people)

Name of the group facilitator:……

Date:…….

Attendees (CAMH service users)

*Good day. My name is _____and this is my colleague_____. **Thank you for coming. Let us relax; we'll have a group chat.***

Present the purpose

*We are here today to talk about **the things you like or dislike about the mental health services you receive from your clinics, and to get your ideas about what we can do to make things better for you. Your views are important to us.** There are no right or wrong answers. You can disagree with each other, and you can change your mind. I would like you to feel comfortable saying what you think and how you really feel.*

Discuss the procedure

*_____my colleague will be taking notes and tape recording the discussion so that I do not miss anything you have to say. As I explained **what will happen** to you when we set up this meeting. **Everything we discuss in this room should not to be discussed with others who are not part of this discussion, and the names of group members should not be mentioned to anyone who is not here today. When the results of the***

study are given out to be known by everybody, no one will know who said what. I want this to be a group chat, so feel free to respond to me and to other members in the group without waiting to be called on. However, I would appreciate if only one person does talk at a time. We will chat for one hour.

Participant introduction

Now let's start by ***everyone sharing their name, where they receive mental health treatment and how long they've been receiving the treatment for****.*

Interview (topic and probes)

1. ***Please tell us how did you get to be seen here, what happened and how were you referred here? Please tell us about mental health services that you receive from your clinics***

2. What do you like about these services? **Please explain more about…….**

3. What do you not like about the services?

4. What do you think can we do to make the services better for young people like you?

Closure

Though everyone said a lot about what they like and dislike about the services, and each gave suggestions on what can be done to make things better in future.**, it appears** ***that everyone agrees that…….. Does anyone see it differently?.....it***

seems most of you agree……..but some think that …….does anyone want to add or clarify anything on this?

Is there anything you'd like to add about what you like or dislike about the services, and what you think can be done to make things better that you think would be useful; for me to know?

Thank you very much for coming today. Your time is very much appreciated, and your comments have been very helpful.

Appendix N: Interview guide for a focus group (CAMH care providers)

INTERVIEW GUIDE FOR A FOCUS GROUP (CAMH care provider)

Name of the group facilitator:…….

Date:…….

Attendees (CAMH service providers)

Good day. My name is _____and this is my colleague_____. Thank you for coming. Many of you might have been part of focus group discussions in the past. As you will know, a focus group is meant to be an informal discussion about a specific topic.……

Present the purpose

We are here today to talk about **your experiences and your perceptions of the service you provide; the challenges which you may be encountering with the service, which may influence your provision and utilisation by the users; and any proposals you have for future to improve the service you provide.** *The purpose is to get your views* **of how Child and adolescent mental health services should be provided and to improve the service you provide**. *I'm not here to share information or to give you my opinions. Your perceptions are what matter. There are no right or wrong or desirable or undesirable answers. You can disagree with each other, and you can change your mind. I would like you to feel comfortable saying what you think and how you really feel.*

Discuss the procedure

_____*my colleague will be taking notes and tape recording the discussion so that I do not miss anything you have to say. I explained these procedures to you when we set up this meeting. As you know everything is confidential.* ***Everything we discuss in this room should not to be discussed with others who are not part of this discussion, and the names of group members should not be mentioned to anyone who is not here today*** *When the results of the study are published, no one will know who said what. I want this to be a group discussion, so feel free to respond to me and to other members in the group without waiting to be called on. However, I would appreciate if only one person does talk at a time. The discussion will last approximately one hour. There is a lot I want to discuss, so at times I may move us along a bit.*

Participant introduction

Now let's start by **everyone sharing their name, qualification and training, where they provide mental health services and how long they've been providing the services for.**

Interview (topic and probes)

1. Can you share a little bit about the type of cases you see in your facilities? For example, ADHD, Disruptive disorders and emotional disorders.

Can you share with us about your experiences of the services you provide in your facilities?

Please explain more about……..

- **How do you manage those cases?**
- **What do you do when you get stuck with the case, are you able to get any help from other staff or facilities?**

- **What do you do when you have more complex cases and where do you refer them to?**

2. Do you think do your service(s) do well? What are some of the positive experiences you have had in this service?

3. What do you think are barriers or difficulties in providing services to young people? In your experience of the service so far, what are the challenges that you have encountered so far?

4. Please tell us what do you think can be done to improve the service to young people with mental health problems you provide?

<u>Closure</u>

Though there were many different opinions **about your lived experiences, perceptions, challenges and suggestions for the future, it appears unanimous** *that…….. Does anyone see it differently?.....it seems most of you agree……..but some think that ……..does anyone want to add or clarify an opinion on this?*

Is there any other information regarding your experiences, perceptions, challenges and suggestions for the future, with the services you provide in your facilities that you think would be useful; for me to know?

Thank you very much for coming today. Your time is very much appreciated, and your comments have been very helpful.

Appendix O: Semi-structured individual interview guide (CAMH care providers)

SEMI STRUCTURED INDIVIDUAL INTERVIEW GUIDE (CAMH care providers)

Name of the participant facilitator:……..

Date: …….

Good day. My name is _____ Thank you for coming for an interview. Please feel free and relax, this is going to be a relaxed discussion

Present the purpose

I am here today to talk about **your experiences and your perceptions of the service you provide; the challenges which you may be encountering with the service, which may influence utilisation of the service by the users; and any proposals, you have for future to improve the service you provide.** *The purpose is to* **get your views of how Child and adolescent mental health services should be provided and to improve the service you provide**. *I'm not here to share information or to give you my opinions. Your perceptions are what matter. There are no right or wrong or desirable or undesirable answers. You can disagree with each other, and you can change your mind. I would like you to feel comfortable saying what you think and how you really feel.*

Discuss the procedure

I will be taking notes and tape recording the discussion so that I do not miss anything you have to say. I explained these procedures to you when we set up this meeting. As you know everything is confidential. When the results of the

study are published, no one will know what you said. I want this to be a relaxed discussion, so feel free to respond to me at any time. The discussion will last approximately one hour. There is a lot I want to discuss, so at times I may move us along a bit.

Participant introduction

Sir/Dr/Ms/Mr……...please kindly tell **us your name, your qualification and training, where you provide child and adolescent mental health services and how long you've been providing the services for.**

<u>Interview (topic and probes)</u>

1. Can you share a little bit about the type of cases you see in your facility? For example, ADHD, Disruptive disorders and emotional disorders.

Can you share with us about your experiences of the services you provide in your facility?

Please explain more about……..

- **How do you manage those cases?**
- **What do you do when you get stuck with the case, are you able to get any help from other staff or facilities?**
- **What do you do when you have more complex cases and where do you refer them to?**

2. Do you think do your service(s) do well? What are some of the positive experiences you have had in this service?

3. What do you think are barriers or difficulties in providing services to young people? In your experience of the service so far, what are the challenges that you have encountered so far?

4. Please tell us what do you think can be done to improve the service to young people with mental health problems you provide?

Closure

Though you gave many t opinions **about your lived experiences, perceptions, challenges and suggestions for the future, it appears** *that…….. Do you agree? Do you want to add or clarify an opinion on this?*

Is there any other information regarding **your experiences, perceptions, challenges and suggestions for the future, with the services you provide at your facility** *that you think would be useful; for me to know?*

Thank you very much for coming today. Your time is very much appreciated, and your comments have been very helpful.

Appendix P: Semi-structured individual interview guide (Senior DoH staff)

SEMI-STRUCTURED INDIVIDUAL INTERVIEW GUIDE (Senior DoH staff)

Name of the interviewer:.....

Date: .....

Interviewee:(Policy maker)

Good day. My name is _____ Thank you for allowing me to have this interview with you.

Present the purpose

I am here today to talk about policy development and ***child and adolescent mental health services in the Western Cape. The purpose is to get your perceptions and opinions on policy and child and adolescent mental health services.*** *I'm not here to share information or to give you my opinions. Your perceptions are what matter. There are no right or wrong or desirable or undesirable answers. I would like you to feel comfortable saying what you think and how you really feel.*

Discuss the procedure

I will be taking notes and tape recording the interview so that I do not miss anything you have to say. I explained theses procedure to you when we set up this interview. As you know everything is confidential. When the result of the study is published, no one will know that you are the source of this information.

The interview will last approximately one hour. There is a lot I want to discuss, so at times I may move us along a bit.

Participant introduction

Mr/Ms/Dr……Please tell me your name, in which department do you work and what your portfolio is in the department.

Interview (topic and probes)

Policy development:

- *What are the available policies for child and adolescent mental health in the Western Cape?*
- *What are the strengths and weaknesses of these policies?*
- *Tell us in general about the policy development for child and adolescent mental health in the Western Cape?*
- *What do you think about policy development for child and adolescent mental health in the Western Cape?*

CAMHS:

- *Tell us in general about the current status of child and adolescent mental health service provision in the Western Cape?*
- *What are the gaps in service provision for children and adolescents with mental health problems in the Western Cape?*

- ***What is your understanding of how these services function?***

- ***What are the challenges and barriers to effective service provision for children and adolescents with mental health problems?***

- ***What do you think about the mental health service provision in the Western Cape?***

- ***Would you tell us what are the departmental future plans for mental health services for children and adolescents with mental; health disorders in the Western Cape.***

- ***What do you think needs to be done or can be done to ensure effective service provision for children and adolescents with mental health problems?***

Prioritising:

- *How much is the CAMH policy development and CAMH service provision prioritised in the province.*

- *How much do you think is the CAMH policy development and CAMH service provision prioritised in the province currently?*

- *Do you think CAMH policy development and CAMH service provision should be prioritised in the Western Cape, and Why?*

- ***Please explain more about……..***

Probes:

- **Please explain more about …….**

Closure

Though you gave many opinions **about child and adolescent mental health policy development, service provision and prioritisation of CAMH service in the Western Cape, it appears** t*hat…….. Do you agree? Do you want to add or clarify an opinion on this?*

Is there any other information regarding ***mental health service provision, policy development and prioritisation of CAMH service in the Western Cape*** *that you think would be useful; for me to know?*

Thank you very much for the interview. Your time is very much appreciated, and your comments have been very helpful.