

**MENTAL HEALTH IN THE WORKPLACE:
EXPLORING HOW MENTAL HEALTH IS BEING
ADDRESSED IN THE NAMIBIAN PUBLIC SERVICE**

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ABSTRACT

Introduction: Mental health in the workplace has emerged as an important issue and a number of pieces of legislation at the international and regional level provide a good framework for ensuring that people with mental disorders have equal opportunities for employment and support within the workplace. This issue has not been sufficiently addressed in Namibia. This study therefore explored how mental illness is addressed in human resources policies, processes, procedures, and mental health programmes in the Namibian Public Service workplace.

Methods: This study comprised two components: a review of legal documents and a qualitative study with relevant people addressing mental illness in the workplace. Five existing Laws, Policies and Rules were reviewed. The review looked at any reference to Mental Illness or Mental Health and in instances where both were not used, identified other terms used like, severe psychiatric illness, psychological disorders, MNS disorders (mental, neurological and substance abuse). In cases where none of the terms were used to identify the two concepts or general health or illness in all documents, the review identified other terms or phrases that may have been used to identify physical or mental illness. The review further pinpointed the legal provisions in the laws which have direct reference to mental illness in the workplace. These provisions ranged from recruitment, management, and boarding of people with mental illness in the workplace. In the second component, a qualitative study design was used comprising of three semi-structured interviews and seven focus group discussions. The study had a total of thirty-nine participants selected through a purposeful sampling method. Two representatives, one from each of the unions representing employees in the public service and one participant from the Medical Review Board were interviewed individually. Sixteen Government Ministries were selected and invited to participate in the study, but only nine sent a total of twelve representatives from HR Departments to participate. The Public Service Commission focus group discussion had twelve participants, while members of the Mental Health Association of Namibia representing people with mental illness (MI) and their support persons participated in two focus groups. Four participants who had experienced being medically boarded due to MI, participated in two focus group discussions. All sessions were audio recorded and transcribed verbatim. A Framework Data Analysis approach was used to extract themes to address the aim and objectives.

Results: The findings from the document review show that the legislation framework lacked clear documentation of how to identify and manage mental illness in the workplace, resulting in inconsistencies in how mental illness is managed in the Namibian public sector. The findings of the qualitative study show that participants have limited knowledge of what mental illness is, although people seemed able to describe how to recognize someone with mental illness from the way they act. There is confusion between the concepts of disability and ill-health resulting in many people being boarded prematurely or inappropriately.

Conclusion: The participants appreciated and recognized the importance of the study in all the discussions, suggesting that there is a need for platforms to be created where issues of mental illness and mental health can be discussed. The lack of a coordinating structure for mental illness in the Public Service was seen a stumbling block in addressing mental illness in an appropriate way. The recommendations to have at least one trained health worker who will be dedicated to employee wellness, will be a step in the right direction. There is an urgent need to reform some of the legal instruments to be able to create a positive impact for people with mental illness in the workplace.

LIST OF ABBREVIATIONS

CBT -	Cognitive Behavioural Therapy
CMDs -	Common Mental Disorders
DALYs –	Global Disability Adjusted Life Years
CRPD –	Convention on Right of People with Disability
DSMs - 5	Diagnostic and Statistical Manual of Mental Disorders-5 edition
FGD –	Focus Group Discussion
HICs –	High Income Countries
HR –	Human Resource
ICD -10	International statistical Classification of Diseases -10
ICF -	International statistical Classification of Functions
ILO –	International Labour Organization
LMICs –	Low and Middle Income Countries
MI –	Mental Illness
MH –	Mental Health
MHAN –	Mental Health Association of Namibia
MHSS –	Ministry of Health and Social Services
MLSW –	Ministry of Labour and Social Welfare
MRB –	Medical Review Board
NGO –	Non – Governmental Organization
NIMHAG -	National Inter -sectoral Mental Health Action Group
NMHS -	National Mental Health strategy
OECD –	Organisation of Economic Co – Operation and Development
PHC –	Primary Health Care
PSC –	Public Service Commission
SMDs –	Severe Mental Disorders
SSRI -	Selective Serotin Reuptake Inhibitors
UN -	United Nations
UNCRPD –	United Nation Convention on Persons with Disability
WHO –	World Health Organization
YLLs –	Years of Life Lost
YLDs –	Years Life with Disability

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CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 CASE STUDY

Jack (37years old) is a high ranking official in one of the government ministries in the Republic of Namibia. He suffers from bipolar disorder, for which he has been receiving treatment for some years now. He is doing very well and the management know about his condition. He is very committed to his job, and often he goes the extra mile to ensure that no client leaves the Ministry dissatisfied.*

The peaks and valleys of this illness are severe and the serious mood shifts can last for days or even weeks. There are times, especially when his mood is low, that his illness severely affects his work and the relationship with his colleagues and clients. His co-workers have mixed feelings about his condition; some fear him, some make a mockery of him, some feel that he is a danger to them, a group of them believe he is just rude and has uncontrollable mood swings, while a few are sympathetic towards him. This led to a decision where the head of the directorate laid a complaint against him to the Public Service Commission, with accusations ranging from insubordination, rudeness, and being non-cooperative and 'funny' [i.e. acting oddly]. It was further recommended that he is unfit to work due to his 'madness' and should be laid off.

Although he appeared at the hearing with all his mental illness reports, it was recommended that the Permanent Secretary of his ministry facilitate his exit from the public service. With the intervention of the Minister, the recommendation for dismissal was withheld and only then did the commission decide to engage Jack's psychiatrist to get an informed opinion regarding his condition and his suitability to occupy the position he holds. The psychiatrist's report certified him as fit enough to work, and to date, after nearly four years, he is still contributing greatly towards an effective Ministry and serving his people with dedication.

* Jack is not his real name

1.2 BACKGROUND

Although the symptoms of mental disorders vary, there are also some commonalities. The World Health Organization (2001) describes “mental disorders as conditions which are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others, some examples are schizophrenia, depression, intellectual disabilities and disorders due to psychoactive substance use.”

A study conducted by Whiteford and his colleagues (2010) showed that mental illness is among the leading contributors to the global burden of diseases and disabilities. According to their study, mental, neurological and substance use disorders contribute 10.4%, 2.3% and 28.5% respectively to global disability-adjusted life years (DALYs), years of life lost (YLLs) and years lived with disability (YLDs). The burden of mental disorders on health has long been underestimated. Vigo and his colleagues (2016) argue that this underestimation has been influenced by effects of mental illness that have been wrongly categorized; for example, self-harm and suicide are considered as injuries, while the physical effects of mood, anxiety and stress disorder, like fibromyalgia and low back pain, are considered as musculoskeletal conditions.

Mental illness in the workplace can negatively affect the employee’s performance due to frequent absenteeism, attitude, behaviours and work relationship (Harnois & Gabriel, 2000). For example, a significant number of patients suffering from cognitive symptoms of depression, such as concentration difficulties, indecisiveness and forgetfulness, were reported for performance-related problems at their work place (Wang & Gorenstein, 2014). A further study conducted by Matza and his colleagues (2015) showed that fatigue is a residual symptom that has substantial impact on multiple domains of the life of patients with depression, such as occupational functioning. These conditions further significantly interfere with a person's daily life and may prompt thoughts of suicide. That is why Wada and Nihin (2007) emphasize that depression is not the same as sadness and grief due to a challenging life experience, such as the death of a loved one.

Less than two decades ago, employment was not considered an option for people diagnosed with severe mental illness mainly due to lack of understanding and very little awareness on different mental conditions (Cicchetti, 2016). A study conducted on workplace myths shows that there is misinformation on mental illness; it is perceived as being the same as mental

retardation and that recovery from mental illness is impossible (Gabriel et al., 2000). These myths and attitudes can lead to stigma, which is identified as one of the worst barriers for many individuals who suffer from mental illness (Gabriel et al., 2000).

Discrimination remains the biggest barrier for people with mental illness to be employed and remain in employment, which has led many people to conceal their disorders due to fear of job loss (Wheat et al.2010). Many professional workers, who either resign from a job or take medical leave of absence related to a mental illness episode (e.g. Depression), experience difficulty maintaining a working, stigma-free relationship with their employer (Ajdacic-Gross et al.,2006). The Organisation for Economic Co-operation and Development (OECD, 2014) believes that if people are provided with easy access to adequate mental health treatment, chances of recovery and returning to work for people with mental illness will be higher. While low treatment rates hinder workers' ability to be promoted and reduces a company's productivity, the access to treatment does improve work performance even though it takes time (Thornicroft et al., 2007).

Under the United Nation's Convention on the Rights of Persons with Disability (UNCRPD), mental illness is classified as a disability when any mental condition has long term effects on one's day to day activities (United Nations, 2006). The definition of a disabled person as specified in the International Labour Organization (ILO) Convention 159 (2008:4) on vocational rehabilitation and employment reads as follows: "an individual whose prospects of securing, retaining, and advancing in suitable employment are substantially reduced as a result of a duly recognized physical or mental impairment." Like many United Nations (UN) Conventions this latter convention includes the principle of equal treatment and employment for workers with disabilities.

According to the WHO's Mental Health Atlas (2017), Namibia's response to mental health issues has been rated below average due to there being few mental health workers of various categories for large numbers of patients, 0.08 Psychiatric beds for a population of 10000 people and lack of community facilities. Adding to this, there have been very few studies dedicated to mental illness in Namibia. Namibia, however, has several pieces of legislation that operate within the larger framework of disabilities and human rights. In line with the non-discrimination article in the 1990 Constitution of the Republic of Namibia, augmented by Public Service Act No.13 (1995), the Labour Act No.11 (2007), says; "no one may be

discriminated against on the grounds of sex, race, colour, ethnic origin, religion, creed or social or economic status” (Republic of Namibia, 1990:10). In addition, Namibia is a signatory to international legally binding conventions, including the UNCRPD which addresses the rights of people with mental illness (United Nations, 2006). As a member state to the United Nations, Namibia is required to comply with the United Nations Charter, which requires adherence to resolutions taken (United Nations, 1945). The outdated Namibian Mental Health Act 13 of 1973, currently under review, is the law which ought to address the issues of mental illness in the country.

When one analyses the case study of Jack, as illustrated above, a few questions arise: was he discriminated against due to his condition, was there a lack of understanding of his condition and mental illness in general? Furthermore, did the Psychiatrist’s opinion only become relevant after the intervention of the Minister, were the processes as per the human resource legislation followed, and how many other employees with mental conditions left or lost employment without due consideration of their mental illness?

In conclusion, the above discussion highlights that while discrimination and stigma remain obstacles, there is coherence in the debate that concludes that employment of people with mental disorders is what needs to be promoted. A few human rights and other pieces of legislation at the international and national level provide a good framework for ensuring that people with mental disorders have equal opportunities for employment and support within the workplace (Wheat et al., 2010). There is, however, limited information on how these policies and laws are utilized in Namibia to address the issue of mental illness in the work place.

Being a Deputy Minister in the Ministry of Health and Social Services at the time I started with my studies and being assigned to coordinate issues related to Community Health, Primary Health Care and Mental Health, gave me an opportunity to identify issues which needed immediate interventions. In this position, which I occupied for five years, the aim was to have a positive impact on the health care system, especially when looking to our mandate to formulate policies, propose the review and enactment of laws, set standards for delivery of quality care in the country, provide strategic directions for health, amongst many others. However, in Namibian, like in most developing countries, we are faced with numerous challenges, such as lack of health professionals, low funding for health and the ever

competing priorities that make it difficult live up to these expectations. I however used my time to promote mental health issues and trying to make an impact by bringing changes in many areas in that division. Despite spearheading the discussions on the amendment of the Mental Health Act no 18 of 1973, I saw the need for more research on MH issues. Thus, the first step is to find out and understand how people with MI are treated in the Public Service, as I came across many complaints of people being dismissed from work on account of MI in both the private and public sectors.

There are two reasons why this study was conducted. First, according to the WHO's Mental Health Atlas (2017), Namibia's response to mental health issues has been rated below average due to there being few mental health workers of various categories for large numbers of patients, with 0.08 Psychiatric beds for a population of 10000 people and lack of community facilities. Adding to this, there have been very few studies dedicated to mental illness in Namibia. Namibia, however, has several pieces of legislation that operate within the larger framework of disabilities and human rights. In line with the non-discrimination article in the 1990 Constitution of the Republic of Namibia, augmented by Public Service Act No.13 (1995), the Labour Act No.11 (2007), says; "no one may be discriminated against on the grounds of sex, race, colour, ethnic origin, religion, creed or social or economic status" (Republic of Namibia, 1990:10). In addition, Namibia is a signatory to international legally binding conventions, including the UNCRPD which addresses the rights of people with mental illness (United Nations, 2006). As a member state to the United Nations, Namibia is required to comply with the United Nations Charter, which requires adherence to resolutions taken (United Nations, 1945). The outdated Namibian Mental Health Act 13 of 1973, currently under review, is the law which ought to address the issues of mental illness in the country.

When one analyses the case study of Jack, as illustrated above, there are number of questions one would like this study to answer, the way he was treated, was he discriminated against due to his condition, was there a lack of understanding of his condition and mental illness in general? Furthermore, did the Psychiatrist's opinion only become relevant after the intervention of the Minister, were the processes as per the human resource legislation followed, and how many other employees with mental conditions left or lost employment without due consideration of their mental illness? The above discussion highlights that while discrimination and stigma remain obstacles, there is coherence in the debate that concludes

that employment of people with mental disorders is what needs to be promoted. A few human rights and other pieces of legislation at the international and national level provide a good framework for ensuring that people with mental disorders have equal opportunities for employment and support within the workplace (Wheat et al., 2010). There is, however, limited information on how these policies and laws are utilized to address the issue of mental illness in the work place. It is on this basis that the study would like to investigate the reality on the ground.

The second issue is that there is little academic research or any other kind of research done or published in Namibia on issues of MI and MH, and there is a scarcity of literature in Africa on this very neglected section of health care. Thus, this study will be the baseline, for further studies in the area of MI and MH in Namibia.

This study therefore explores how MI is addressed in human resources policies, processes, procedures, and MI programmes in the Namibian public service workplace. The research question asks how mental health is being address in the in the Namibian Public Service from the perspective of a number of key stakeholders. This will broaden the scope of understanding on how interventions are or could be contributing to prevention of MI, promotion of MH and advancement of a working environment that is conducive for individuals with MI. This research will further aid the process of identifying good practices and possible gaps in addressing the issues of MI in the Namibian workplace. The research findings will be used as baseline information for drafting a model of workplace MH policy for Namibian government ministries, other places of employment and for further research. The recommendations made in this study will be shared with policy makers to advocate for effective implementation or possible law reforms if deemed necessary.

This report is divided in five chapters starting with the introduction which gives an overview of the study, definitions and the information on how MI and Mental health is perceived generally. The literature review sets out our current knowledge and evidence on the management of mental health and mental illness in the workplace. The methodology provides a detailed description of the data collection process, from the number of participants to the way the data were collected. Chapter 4 presents the results of the analysis, while the last chapter, the discussion and conclusions, reflects on these results concluding with a number of recommendations.

1.3 AIM AND OBJECTIVES

1.3.1 Aim

To explore how mental illness is addressed through laws, rules and policies guiding human resource management and processes in the public service in Namibia.

1.3.2 Objectives

The purpose of this chapter is to inform the readers about the method which was used to identify the participants, collect and analyse the data in addressing the objectives of the study as listed below:

1. To review the national policies that govern the human resources management within the public sector, and any policies specifically addressing mental health at a national level
2. To explore the understanding of mental illness and perceptions of how it is managed within the public sector in Namibia from the following stakeholders:
 - Human resources practitioners
 - Public Service commissioners
 - Medical review board members
 - Trade unions
3. To obtain information on the experiences and perspectives on how mental health is addressed from people with mental illness and their support people.

CHAPTER 2: LITERATURE REVIEW

This section will comprise of a review of MI, workplace issues for people with MI, advocating for MH in the workplace, disclosure of MI in the workplace, MI as a cause of occupational disability, policies and programmes to address MI in the workplace. Lastly, it will provide information regarding the status of MH in Namibia and conclude by recommending good practices that have been shown to improve the MH issues in the workplace in a few countries.

2.1 MENTAL DISORDERS AND MENTAL HEALTH

The WHO describes mental and behavioural disorders as disorders that are “characterized by a combination of abnormal presentations of thoughts, emotions, behaviours and relationship difficulty with others” (World Health Organization, 2017). Like that of our physical health our MH is also influenced by a groups of factors such as our biological, psychological, and social (Bebbington, 2001). Germann and Ardiles (2009) also elaborate that: “mental disorders arise from biological, developmental and/or psychosocial factors and can be managed using approaches comparable to those applied to physical diseases.” Moreover, exposure to a variety of modifiable life adversities such as to poor social protection, poor living standards, stressful work and living environment, especially at a young age, is also reported by many studies as risk factors for the development of mental disorders (WHO, 2005).

While understanding MI as disorders which affect people’s minds, bodies and the environment, the concepts used in several papers on MH include both key aspects of the WHO definition, i.e. positive emotions and positive functioning. Keyes (2014) identifies three components of mental health: emotional well-being, psychological well-being and social well-being. Emotional well-being includes happiness, interest in life, and satisfaction; psychological well-being includes liking most parts of one's own personality, being good at managing the responsibilities of daily life, having good relationships with others, and being satisfied with one's own life; social well-being refers to positive functioning and involves having something to contribute to society, feeling part of a community (social integration), believing that society is becoming a better place for all people, and that the way society works makes sense to them (social coherence). The concept of positive functioning is also translated by several definitions and theories about MH into the ability to work productively (Gigi et al., 2015), and may lead to the wrong conclusion that an individual at an age or in a physical condition preventing

her/him from working productively is not by definition in good MH. Working productively and fruitfully is often not possible for contextual reasons, which may prevent people from contributing to their community.

Around 22 groupings of mental disorders are listed in the Diagnostic and Statistical Manual of Mental Disorders-5 edition (DSM-5) and are grouped into two major categories: Severe Mental Disorders (SMDs) and Common mental disorders (CMDs). The SMDs include schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma and stressor-related disorders (American Psychiatric Association, 2013). Schizophrenia is a chronic and severe mental disorder that affects how a person thinks, feels and behaves, that makes him/her seem to lose touch with reality (World Health Organization, 2005). Though schizophrenia is not common, its symptoms can be very disabling and its signs and symptoms presents in three clusters which are: i) psychotic behavioural symptoms, like hallucinations and delusions; ii) disruptive symptoms to normal emotions and behaviours such as reduction in speaking and reduced expression of emotions; and iii) the cognitive symptoms that are subtle for some and more severe for others as they present signs of difficulty with focusing and using of information (National Institute of Mental Health, 2017).

On the other hand, CMDs such as depression and anxiety are highly prevalent worldwide. Globally, around 300 million peoples are said to have been affected by depression in 2015 and a similar number from anxiety disorders (WHO, 2017). A review of five studies assessing the prevalence of mental disorders in Australia found that depression and anxiety are the most commonly reported in relation to other mental disorders (Andrews et al.,2017). Trying to understand the puzzle on why the two disorders are the most commonly reported, a common narrative in the literature identifies a relation between depression and anxiety, though it is clear that they are not the same (Buck, 2008). In one study, it was found that about 90% of patients with anxiety reported depressive symptoms while 85% of patients with depression reported significant anxiety symptoms (Gorman, 1996). This might be the reason why the diagnostic criteria for mixed anxiety and depression is still valid in the 10th revision of the International statistical Classification of Diseases and Related health Problems (ICD-10), (Möller et al., 2016)

Mental disorders are treatable, with a good prognosis and outcome particularly when treatment starts early in the course of the illness (Post & Weiss, 1998). Complex psychiatric comorbidities may follow from a single psychiatric disorder whenever there is a delay in treating the first onset of mental disorders (Kessler and Price, 1993). The National Alliance for Mental Illness (2013) emphasized that despite the fact that there are different causes of mental illness which are affecting people differently, many causes of mental illness are interlinked. The argument is that if people with mental illness are engaged early and given support, outcomes improve and this in turn increases the possibility of recovery (Centre for Public Health Research, 2013). There are three main ways of treating mental illness, these being by provision of pharmacotherapy, or psychotherapy, or ideally a combination of the two. For example, a meta-analysis conducted by Cuijpers and colleagues (2014) reported on findings from 115 studies that met inclusion criteria. The mean effect size (ES) of 94 comparisons from 75 studies of cognitive-behavioural therapy (CBT) versus a control group was reported as being a Hedges $g = 0.71$ (95% CI 0.62 to 0.79), suggesting benefits from CBT interventions. The authors concluded that both pharmacotherapy and psychotherapy are effective in treating patients suffering from major depression, panic disorders and obsessive compulsive disorders. Moreover, the study also showed that combinations of the two treatments are more effective than either treatment alone. Another study also showed that either Cognitive Behavioural Therapy (CBT) or combining CBT with Selective Serotonin Reuptake Inhibitors (SSRI), a common medication for depression, is more effective than SSRI alone for patients suffering from panic disorders with or without agoraphobia (Apeldoorn et al.,2014).

2.2 MENTAL ILLNESS IN THE WORKPLACE

Work related stress has a major impact on both physical and emotional problems (Möller, 2016). Houtman and colleagues (2007) define work related stress as: “a pattern of physiological, emotional, cognitive and behavioural reactions to some extremely taxing aspects of work content, work organization and work environment”. In its survey in 1999, the European Commission on Employment and Social Affairs reported that 40 million people in 15 countries in the European Union were negatively affected by work related stress (Europäische Kommission, 2001). The reasons for these large numbers are attributed to the effects of a fast changing modern working life that places pressing demands in both scientific

and technological advances in the work place (Centre for Public Health Research, 2013). These numbers are known in developed countries because they are able to document an array of research on work related stress, and the fact that employees are increasingly familiar with their conditions and how to manage these (Rantanen et al., 2013).

In low- and middle-income countries (LMICs) there are a number of internal and external factors that increase work-related stress such as job insecurity, cultural aspects defining perceived relationships, low remunerations, long working hours and lack or no coverage of occupational insurance (Houtman, 2007). Despite not having data on the effects of work related stress in developing countries, more than 80% of the workforce in many of these countries consist of informal, small and medium sized enterprises, which often lack knowledge of occupational health in general (World Health Organisation, 1995). For example, among 61 developed and developing countries included in a study conducted by Rantanen and his colleagues (2013), only a fifth of workers (19%) had occupational health care services. Aligning his views to these findings, Chopra in 2009 suggests that this leads to 'job strain' and advocates that the only way to reduce this strain is to adequately address the work-related risk factors such as high demand work, low level of control and an imbalance between reward and effort by employees (Chopra, 2009).

It is reported that loss of appetite, fatigue and tearfulness are symptoms that are similar in both CMDs and stress, though the two can exist independently as people with work related stress can be diagnosed with hypertension without having anxiety and depression (Health and Safety Executives, 2016). In a study conducted to determine the relationship between work related stress and the presence of symptoms of mental disorders among Police Officers in Italy reveal that depression, anxiety and burnout were observed (Garbarino et al., 2013). In the case of depression it was found that the probability of suffering from major depressive disorder increases rapidly with ongoing stress (Sanderson & Andrews, 2006).

Developing chronic fatigue secondary to chronic stress at the workplace is among the main risk factors for developing anxiety, depression, and substance abuse (Chopra, 2009). Many workplace factors which are associated with stress are: fairness in the workplace, lack of ability to resolve work related disputes (Benach et al, 2013). Moreover, factors outside the work environment, such as social stability and network among family members, also have their own contribution to stress at the work place (Sanderson & Andrews, 2006). However,

not all employees with similar mental conditions are affected in the same way. For example, Godin and his colleagues (2009) indicate that for the occurrence of clinical depression, high job-strain and job dissatisfaction were found as independent predictors in males while private life dissatisfaction was found as a relevant independent factor in females.

Occupational disability is highly associated with CMDs (depression and anxiety) which are costing national economies significantly in both loss of productivity and expenditure incurred (Chopra, 2009). It is reported that the National Health Service in the UK pays more in claims for absence due to work stress and other related mental disorders than what they pay for physical illness, in its annual cost of sickness calculations (Chartered Institute of Personnel and Development, 2016). A study conducted by Greenberg and colleagues (1993) in the United States showed that depression alone costs the US economy about 53 billion US\$ annually, with 33 billion US\$ being due to reduced productivity. Another study conducted by Chopra in 2009 also emphasized that a hostile work environment¹ is a risk factor for CMDs, while CMDs themselves have a negative impact on work productivity (Chopra, 2009). Moreover, Vickerstaff and colleagues (2012) identified MI health and Muscular Skeletal Disorders as the two main reasons for incapacity to work, and reported an increasing trend of mental ill health and disability incapacity claims in Britain. In order to reduce this high incidence, it is argued that attention should be paid to the working conditions, organization systems and policies that contribute to the ill health of those with stress, depression and anxiety (Michie, 2003).

Workplace discrimination against people with MI, in particular severe MI, is widely experienced around the world, despite having a number of laws that advocate against any kind of discrimination and stigma. People with MH problems reported being turned down for a job because of their MH problem and many of them decide not to look for work because they anticipate a level of discrimination (Thornicroft et al., 2007). If they get employment, workplace attitudes toward MI make a big difference for their integration and productivity at work (Yoshii, 2014).

¹ A study by Hennekam et al. also emphasized that a work environment where the relationships, whether between employees or between employee and employer, are not good, can be seen as a hostile working environment, which is a risk factor for CMDs.

MH problems in the workplace impact individuals differently and have serious consequences such as reduction in productivity due to poor work performance, absenteeism due to frequent poor psychological and physical health, negative staff attitudes towards work environment with low motivation, commitment and poor relationships with colleagues (Harnois & Gabriel, 2000). A WHO report (2013) showed that MH problems contribute to 35-45% of absenteeism from work in developed countries. For example, in the UK the second most common reason for absence from work was mental health problems resulting in 5 to 6 million lost working days annually (Bezborodovs & Thornicroft, 2013). Even if present at work, a person's productivity can be significantly reduced because of a mental health problem (World Health World, 2013).

Early intervention and treatment of employees is helpful to re-integrate employees back into the work environment after an episode of mental illness (Thornicroft et al., 2007). For example, Chisholm and colleagues (2016) found that benefits of successful treatment of depression and anxiety, include a reduction in overall health-care costs, being employed, pursuing leisure activities, an active engagement in social activities, and the ability to carry out all social and occupational responsibilities.

With the above discussion in mind, the World Health Organization (2005) recommends that workplace mental health policies should be in place. The workplace can be a better place, where employees with mental disorders can be productive members of a team only if mental health and wellbeing in the workplace takes center stage. Access to care needs to be a diverse caring system with support from within the workplace to accelerate the reduction of stigma and discrimination against those with MI. The organizational and personal resilience combined with comprehensive mental health policies and plans have great potential to create a better workplace for people with MI (World Health Organization, 2005).

2.3 MENTAL ILLNESS AS A CAUSE OF OCCUPATIONAL DISABILITY

Defining disability is not an easy task, and no single definition can cover all aspects of disabilities. The UNCRPD (United Nations, 2006) in its preamble defines disability as "result[ing] from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others," and that "Persons with disabilities include those who have long-term

physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (Article 1).

Following the WHO’s International Classification of Functioning, Disability and Health (ICF) (World Health Organization, 2001) the different components of disability can be described as being an impairment at body level, activity limitations in terms of what the person can do, and participation restrictions in terms of what the person does do in their usual environment depending on the barriers and facilitators they experience. Thus, a person with a severe mental illness has an impairment, for example, of mood control or the ability to concentrate. This results in an activity limitation as it is difficult for the person to do their work effectively when they experience these acute symptoms. If the person’s environment is not supportive (e.g. the person experiences stigma and negative attitudes), they are unable to perform their work tasks and they are unable to participate in working. The combination of the person’s impairments and activity limitations and the barriers or facilitators on their environment is what determines if they are disabled or not – not only their impairments and activity limitations.

Psychiatric illness as a cause of occupational disability is under-recognized and under-treated worldwide (Smith, 2009). Aligning with this claim is a study suggesting that this under-recognition may contribute to the doubling of occupational disability due to mental illness in Canada, with an associated high cost to the country of billions of dollars annually (American College of Occupational Medicine, 2006). In South Africa, the applications for medical disability on psychiatric grounds are reported to have increased alarmingly (South African Society of Psychiatrists, 2010). Factors which seem to explain some of these increases are issues of assessment, evaluation, diagnosis and treatment as the accelerator towards medical disability on the ground of psychiatric disorders (Shiels, Gabbay & Ford, 2004).

There are many reasons for the increase. Bauer and colleagues (2006) suggest that the most affected are people with jobs with high social and ethical responsibilities. This claim is supported by studies showing that most people suffering from three leading mental disorders (depression, anxiety and post-traumatic stress disorders) are teachers, police and the military (Mokoka et al., 2012). A study conducted in South Africa reported that most of the people

who are requesting early retirement or paid leave due to work related stress are teachers (Emsley et al., 2009).

The factors that seem to contribute to the increase in occupational disability on grounds of mental illness include (i) the individual with mental illness, (ii) to medical doctors treating them, and (iii) the administrative and procedural aspects. Furthermore, it is reported that many psychiatrists are giving their patients six months sick leave, which in many instances can be extended to 12 months and that is making it difficult for many to return to work. This may lead to the employees with mental illness developing ergophobia (work phobia) as they might not know what they will have to face after this lengthy sick leave (Harris et al., 2005). This is confirmed by a study in the Netherlands whereby people affected by ergophobia are increasing due to how medical professionals are treating them and leading to boarding on grounds of mental illness (Van der Kink et al., 2003). The debate about lengthy sick leave and ultimately boarding of employees on grounds of MI seems to be linked to a lack of understanding of the difference between impairment and disability, especially by attending physician (Henderson et al., 2005).

Thus impairment as the alteration of normal functioning due to a disease, while disability is the alteration of the capability to meet daily personal, social and occupational demands due to impairment and is not assessed only clinically (Saebu, 2010). Given this difference, Kaliski (2006) suggests that impairment must be investigated, diagnosed and treated before determining on medical grounds which functions the person is still able to do and which not.

In addition, the assessment and evaluation approach of people to be boarded on the grounds of either impairment or disability due to mental illness is inconsistent as there are no specific tools designed for this assessment (Bender and Kennedy, 2004). In their guidelines to evaluate the extent of permanent impairment, the American Medical Association suggested three functional areas – physical, social and occupational – that must be assessed to determine the severity of functional impairment in patients with MI (Mcknight and Kashan, 2009). Being declared unfit to work, whether because of the employees request or on recommendation by the medical professionals on the grounds of psychiatric disorders, has a number of repercussions such as inactivity and loss of self-esteem associated with unemployment. Dustan (2009) adds that these people face financial problems, and the situation may

compound their psychiatric difficulties and perpetuate their symptoms rather than facilitating recovery.

To discuss the medical boarding process one has to understand the definition and the complex relation between illness and disability. As summarized by Rovesti and colleagues (2018), three terms provide a comprehensive definition of illness: “illness, which identifies the personal emotional state connected to the loss of health; disease, which refers to the objective, biological and measurable dimension of it strictly linked to the physical activity, and sickness, which refers instead to the public dimension of the disease and highlights the link between illness and society”. On the other hand, disability, as defined earlier in this dissertation, is the outcome of an interaction of the individual with an illness and the context in which they conduct their daily lives (United Nations, 2006, World Health Organization, 2001). The interaction of a person with MI with attitudinal (e.g. stigma and lack of understanding of MI) and environmental barriers (e.g. lack of MH policies in the workplace) hinders their full and effective participation in the society on an equal basis with others (United Nations, 2006).

When managing MI in the workplace, it is important to consider the person’s functioning in the workplace context (disability) and the person’s ability to fulfil their work tasks, and not focus on the illness alone. To illustrate this, **Figure 1** below, shows that disability is multidimensional and interactive and that all components of disability are important and all can react with each other (World Health Organization, 2001).

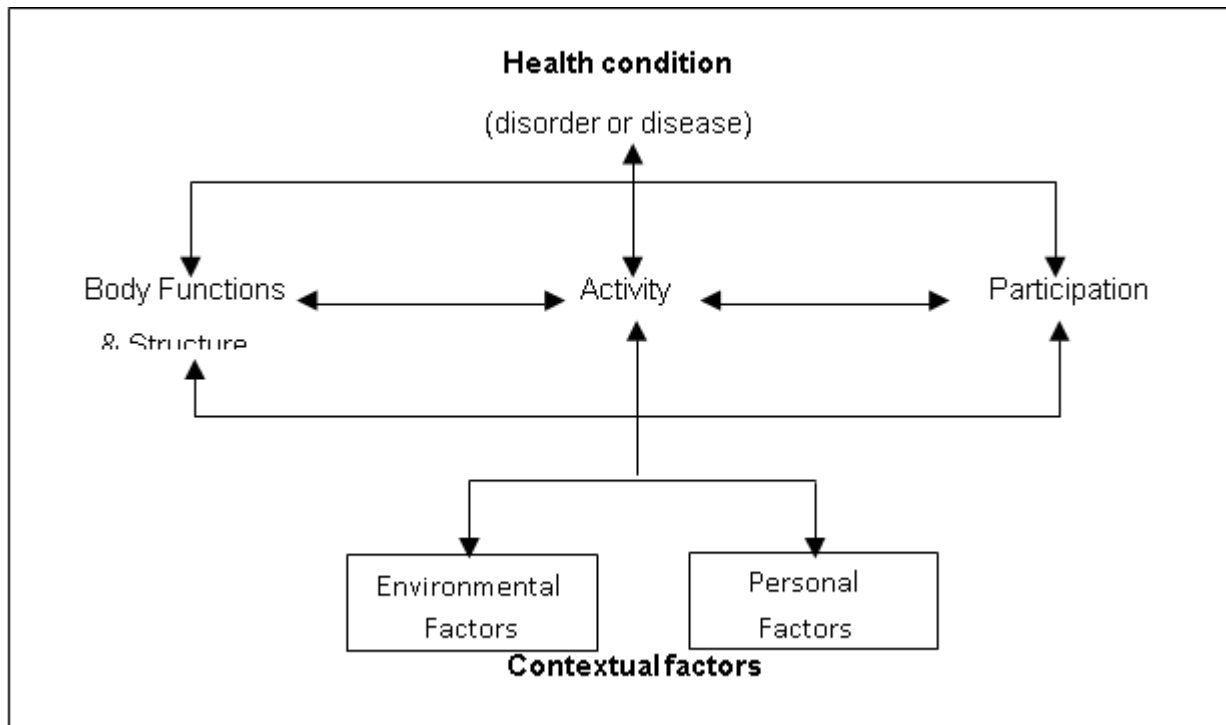


Figure 1: The model of disability and its components (from International Classification Functioning, Disability a Health, WHO 2001, p9)

2.4 DISCLOSURE OF MENTAL ILLNESS IN THE WORKPLACE

MI, MH and stress related disability are ill-defined, complex and controversial issues in the workplace context (Bender & Kennedy, 2004). It has been reported that concealment of their diagnosis or secrecy can be a major stressor for individuals who fear being stigmatized (Wheat et al., 2010). Despite many challenges encountered by employees with MI the issue of disclosing one’s MI is an important one in every workplace for many reasons (Dewa et al.,2004).

A multi-stakeholder study conducted by Brouwers and colleagues (2020) identified four important sub-themes which positively influence disclosure of mental illness in the workplace: to whom it is disclosed, the timing, preparation, and the message content one is disclosing. In answering who to disclose to, it is said to be a very difficult situation, despite the recommendation by Bender and Kennedy (2004) that the direct supervisor might be the best person to disclose to. On the contrary the outcome of a vignette study revealed that there were employers who said they are seven times more likely to recommend hiring a wheelchair user than a person taking medication for anxiety and depression (Emsley & Coetzer, 1996). Another study also revealed that senior managers expressed that prefer to

work with inexperienced staff, rather than a qualified person with depression (Bender & Kennedy, 2004). A further study by the Chartered Institute of Personnel and Development (2007) said that concealment cannot be uniform due to different personalities and how each individual can open up on personal secrets. Given the discussion above, there is a school of thought which argue that there are no specific models which describe the ideal place or messages the employees with MI disclose their status, but each individual and the environment they find themselves, will determine when to disclose (Karpansola et al, 2005). To address the issue of work-related accidents caused by undisclosed mental illness, of which 2,8% causes fatalities, in Korea it is recommended that a number of assessment tools for job stress and depressive disorders be used in the workplace to examine mental health (Jeon and Kim, 2018). In countering this, there is an argument, that says rather than exposing employees to multiple assessment for one or two mental illness, available instruments measuring mental abilities relevant to job requirements can be used as standard tools for many disorders (Miller et al., 2009). To this end evidence shows that people who use specialist mental health services can be supported in maintaining competitive employment through a tested approach known as individual placement and support (IPS), without disclosing their mental illness at the workplace (Dewa et al., 2004). With this kind of approach, the employee remains composed, focused and confident and this help to reduce work related stress and enhance productivity at the workplace.

2.5 INITIATIVES TO ADDRESS THE ISSUE OF MENTAL ILLNESS IN THE WORKPLACE

In its quest to ensure that member countries are taking issues of mental health as a priority, the United Nations General Assembly in 1991 took a resolution on the Principles for Protection of Persons with MI and the Improvement of MH care referred to as MI Principles (United Nations, 1991). These MI Principles became the foundation of any legislation or policy, which aimed at addressing issues of MI and MH, ranging from right to quality care and treatment to the right to live and work in the community (Cameron, 2013). Under the right to life and work in the community, legislation on MH should provide for employment opportunities and the protection of person with MI from discrimination and exploitation in employment (United Nations, 1991). For countries to have comprehensive and well-conceived legislation, the WHO designed a checklist which accompanies the Resource book

on MH, human rights and legislation (World Health Organization,2005) which has shaped many countries' legislation on MH in the workplace.

It is important that there is an interface between the MH legislation (Act) and policy (World Health Organization, 2005). While the two might be equal drivers towards the protection, promotion and improvement of lives of those with MI, the legislation is more of a regulatory tool (Cameron, 2013). The MH policy provides a framework for the implementation and enforcement of the legislation (World Health Organization, 2005). Though complementing the legislation, the policy is a tool that provides practical guidance for any plans and programmes, like the establishment of high quality MH facilities and services, developing a robust procedural protection to promotion of MH in the community (World Health Organization, 2005). The policy, in summary, is the vehicle for the realization of the legislation's hopes and aspiration.

The baseline requirement to address issues regarding MH in the workplace is by ensuring that there are policies and programmes developed and implemented. WHO broadly defined MH policy as "an official statement by government or health authority that provides the overall direction for MH by defining a vision, values, principles and objectives, and by establishing a broad model of action to achieve that vision" (World Health Organization, 2014:23). Having an explicit MH policy and plan is helpful to improve the quality of MH services as this sets out what activities and strategies will be implemented. (World Health Organization,2014). Though the benefit of having a clear MH policy and plan is not in doubt (Chisholm et al., 2016), many countries do not have these, and even if they do have these, they are generally only partially implemented. According to the WHO Atlas 2014, among 168 countries participating in the survey, 10% did not have a mental health policy/plan at all, 14% have a mental health policy/plan but which was not being implemented, and 61% of the countries had a policy/plan but which was only partially implemented. Only 15% of the countries had a fully implemented policy or plan (World Health Organization,2014).

MH policies should explicitly state how the prevention, promotion, and treatment of MI will be conducted (World Health Organization,2009). However, in the majority of the countries with a policy or plan, the contents are not comprehensive enough to promote integration of MH service delivery into other systems such as social care, justice and development services (Rathod et al., 2017). MH policies in the workplace seems to be a highly neglected area.

Though many countries have policies at the national level (Wynne, 2014), at the workplace level the number of written policies are minimal. For instance, research conducted by Vickerstaff et al. (2012) reported that in Ireland 74% of companies do not have written policies on how to deal with MH in the workplace signifying a serious omission in addressing and considering MH. As a result many employees with MI seek treatment either from government or non-government institutions (Bartholomew,2016).

Two positive examples of workplace MH policies are the British Telecommunications (Lichfield, 2007) and the Norwegian oil company Statoil (Bergh et al.,2014). The British Telecommunications policy is a comprehensive workplace MH policy which includes the prevention, promotion and treatment aspect of MH. The Norwegian oil company Statoil focuses mainly on the management of psychosocial risks in the workplace. The 2011 report on the European Agency for Safety and Health at Work outlines good practice for MH promotion in the workplace. The report sets out two important principles, namely, risk management and health promotion, including how to integrate enhancing and promoting the health, safety and wellbeing of employees at work into a comprehensive approach (Europe Agency for Safety and Health at work, 2011). A study conducted by Sieberhagen and colleagues in South Africa, to investigate the role that legislation and management might play to ensure occupational health and wellness, revealed that “the South African Labour Act is not clear on the definition of occupational health and still favours physical health. This is clear as there is lack of guidance in the case law and statutes dealing with psychological stress. This leads to the lack of adequate policies to govern employee’s health and well-being” (Sieberhagen et al., 2009:07).

As signatories to the United Nations Convention on the Rights of Persons with Disabilities, countries are required to promote, protect and ensure full enjoyment of human rights and equality of people with disability under the law (United Nations, 2006). Like with all other disabilities, people with MI should enjoy the provisions made in Article 27 of the convention, which speaks to the issue of work and employment of people with disability. Section A of Article 27 specifically prohibits discrimination in all forms of employment, such as recruitment, continuance of employment, career advancement and further emphasizes the importance of safe and healthy working environment.

In summary, interventions in the workplace should include two primary features: prevention of MI and promotion of MH (LaMontagne, 2014). This will assist in ensuring that people with MI are employed, they maintain their employment, and support is provided for them to remain productive and employed and people without MI should retain their good mental health. According to LaMontagne and colleagues (2014:03) there are three threads to an integrated intervention approach to workplace mental health: “protecting MH by reducing work-related risk factors, promoting mental health by developing the positive aspects of work as well as worker strengths and positive capacities, and addressing MH problems among working people regardless of cause.”

MH promotion as defined by Pollet (2007) is the process of enhancing protective factors that contribute to good mental health. MI prevention is aimed at the reduction of the occurrence, frequency and the re-occurrence of MI, and also decreases their respective impact on the individual, their family and society at large (Barry et al.,2013). Promotion of MH in the workplace should not be reactive but proactive. Chopra (2009) suggests that workplace programmes aimed at addressing MI should be educational through improving MH literacy and developing skills for early intervention and promotion of help-seeking with regard to MI. In High Income Countries (HIC), health and wellbeing promotion are concepts incorporated in the institutional stress and wellness programmes which support positive MH as integral to the workplace culture (Garbarino et al, 2013).

Studies have been conducted on the effectiveness of different health and wellbeing interventions in various workplaces, including employees’ assistance programmes, health promotion programmes, health productivity management and health risk appraisal. Garbarino and colleagues (2013) concluded that the effectiveness of these interventions in the workplace setting depends on the growing awareness of the needs of individuals and of the organizational environment.

2.7 MENTAL ILLNESS IN NAMIBIA

Nationally representative studies conducted in African countries have reported a high prevalence of MI (Kessler et al., 2011). Although it is difficult to get recent data on the prevalence of MI in Namibia, a study dating back to 2006 showed us that 10% and 2-3% of the adult population have common mental disorders (CMDs) and serious mental disorders

(SMDs) respectively; while around 1% of children have behavioural problems at any given point in time. Nigeria, in comparison, shows a high prevalence rate of between 20% - 30% of CMD's and 12% of SMD's (World Medical Association, 2013).

A recent unpublished study conducted by Bartholomew reported that MH interventions lag behind in many parts of the world and the Namibian context is no exception (Bartholomew, 2016). Traditional and cultural interventions have been the preferred way of dealing with MI rather than medical or psychological interventions, particularly in non-Western countries (Constantine et al., 2004). For instance, a study conducted in northern Nigeria reported that indigenous treatments are preferred over modern health care system (Kabir et al., 2004). "Traditionally, the Ovambo tribe in northern Namibia attribute MI to the influence of witches, curses, and angry ancestors, and, as a result, seeking treatment from traditional healers is very common" (Bartholomew, 2016:14). In Namibia, modern MH services started quite recently after independence in 1990. Before independence, persons affected by MI and those who were considered to be dangerous were usually sent to South Africa for evaluation and treatment (Feinstein, 2002).

Similar to other low- and middle-income countries (LMICs), the number of healthcare providers trained in MH is limited. The ratio of MH professional to the population in Namibia is around one psychiatrist for every 520,394 people with the recommended ratio being at least 1 psychiatrist to 30,000 people according to the WHO (Mwaopara, 2016). Though emergency MH services are provided at district hospital level, MH services are primarily restricted to two sites in Namibia: Windhoek Mental Health Care Centre (National Referral Hospital) and Oshakati Psychiatric Unit (Intermediate Hospital) (The Republic of Namibia, 2006). In 2015, 26,000 mentally ill patients (both in outpatient clinic and inpatient services) were treated in Windhoek Mental Health Care Centre (Haindula, 2016). This centre has around 112 beds.

According to the head of the Psychiatric Department at the Intermediate Hospital Oshakati (personal communication with Dr. Famuyiwa Peter, October 20, 2017), in 2016, the psychiatric unit records showed that the center had 18,903 registered patients (16,847 outpatients, 2,056 in patients), who had been receiving psychiatric services. He further stated that in 2017 the register indicated that among registered patients only 152 were inpatients, 1,203 were outpatients, and only 54 patients were seen for the first time. For a number of

years, the unit had only one psychiatrist, and since October 2017, two medical officers, three senior registered nurses, 14 registered nurses and 14 enrolled nurses provide mental health services in the unit. The unit does not have its own social worker, psychologist and occupational therapist. This lack of sufficient mental health professionals at one of the main psychiatric facilities reflects the insufficient numbers of mental health workers to meet the ever-increasing demand of mental health care at the facility. This has a negative impact on the provision of quality services.

In terms of mental health policy, a National Health Strategy Framework published in 2010 (Ministry of Health, 2010) set a goal to improve mental health services at the primary health care (PHC) and hospital level. The framework emphasizes that advocating for mental health, integrating mental health into PHC, increasing the number of specialized and non-specialized mental health professionals, intensifying community mental health care, and involving other stakeholders and non-government organization (NGOs) are required to improve existing mental health services in Namibia. But up to now the mental health services are still below standard. The WHO Mental Health Atlas (World Health Organization, 2017) rated the Namibian Mental health system governance as very poor, in terms of both mental health policy and legislation which are only partially implemented. The country is still using the old Mental Health Act (Act no 18 of 1973), which is currently under review for amendment to be conformity with other international instruments which deals with MI. The World Health Organization (2014) rating of Namibia being reasonably in line with human rights conventions, with the recently revised National Mental Health Policy (2005) being very helpful in addressing any shortfalls in the current Act.

One reason why these policies are only partially implemented is answered by the MH Atlas profile on Namibian MH (World Health Organization, 2014). This report shows that there is a serious lack of manpower to ensure the popularization, implementation, monitoring and evaluation of these very important documents. Raja and colleagues (2010) recommend that to integrate and strengthen MH care policies and services, government budgetary allocations should be more inclusive of MH and should be decentralized and easily accessible. However, in LMICs, budget allocation for health is generally less than two USD per capita (Reddy et al., 2005), and below 0.5% of their total health care budget for mental health annually (Lopez et al., 2006). Even though the figure looks better in high-income countries, devoting over 50 USD

per head of the population and about 5.1% from their total annual health care budget, it remains insufficient to manage the disease burden from MH disorders even in these high-income countries (McDaid et al., 2006). Furthermore, as is the case in many countries, the major share tends to be spent on hospital services where the services are not accessible to the majority in primary care (Docrat et al., 2019). To my knowledge, as a senior public servant working within the Ministry of Health and Social Services in Namibia, there has been no ring-fenced budget for mental health within the last two decades. This explains to some extent, the lack of implementation of existing policies as well as the lack of revision of these.

Namibia is one of the countries which signed and ratified the CRPD in 2007 and one of the 89 countries who also signed and ratified the Optional Protocols of CRPD. With this in mind Namibia gave significance to this Convention by setting up a Department of Disability Affairs led by a Deputy Minister in the Presidency. In an effort to ensure that people with disability have a voice, the Federation of People with Disability was established serving as an umbrella body for all organizations dealing with issues of disability in Namibia. This Federation falls within the ambit of the Ministry of Health and Social Services. As disability is a cross cutting issue, the government recruited a person with disability who oversees the implementation of the National Plan on Disability in all Ministries. There is only one organization which represents people with MI and is a member of this Federation – the Mental Health Association of Namibia (MHAN). Article 25 of the CRPD emphasizes the provision of health services, including early identification and intervention, and services designed to minimize and prevent further disabilities (United Nations, 2006). In line with this provision the physical and mental health of people with disability are taken care of. There are two significant initiatives that highlight the need of people with MI: (i) the renaming of the Psychiatric Hospital from ‘Groendakkies’ to Mental Health Center and (ii) the integration of mental health in Primary Health Care.

In order to address mental health problems at the work place, WHO recommended that a work place mental health policy should be developed separately from the broader health and safety policy (World Health Organization, 2005). It is important to gather information regarding issues related to mental health in the workplace and understand how people with mental illness are treated in the workplace. Human rights policies and other legislation at the international and national level provide a good framework for ensuring that people with

mental illness have equal opportunities for employment and support in the workplace. However, there is a little information in Namibia on how these policies and laws address mental illness in the workplace. To this end, this research will aim to obtain in-depth and meaningful information on mental health policies and practices in Namibia and to provide a baseline level to allow for ongoing monitoring of progress in this area. Targeting the public sector is beneficial for various reasons: it is the biggest employer in the country, and it is the custodian of all legislation including those laws which aim to create conducive work environments, protect the rights of all citizens and it should set good examples to be emulated by all other sectors.

CHAPTER 3: METHODS

3.1 STUDY CONTEXT

The last census conducted in 2010 reported that Namibia's population stands at 2.3 million people, with more than 450 000 residing in the capital city Windhoek (Namibia Statistic Agency,2011). Windhoek is a hub of both administrative and economic activities of the country, and houses the head offices of all government ministries and services. The census showed that the labour force for Namibia represent 69% of people within working age in more than 20 industries, while 31% are unemployed or in search of employment (Namibia Statistic Agency,2011). This study was conducted in Windhoek, targeting the population within the government service, in 16 Ministries which were created in 1990 with the transition to a democratic government with few changes in portfolios since then.

3.2 STUDY DESIGN

An exploratory qualitative study design was employed including a brief review of selected documents. This was seen as a relevant design to investigate a problem which is not clearly defined as yet in Namibia. It was conducted to have a better understanding of the existing problem, but was not expected to provide conclusive results. The study used this research design as a medium to identify issues that can be the focus for future research. Dash (2019) refers to it as a grounded theory approach or interpretive research as it was used to answer questions like what, why and how, in this case how mental health and mental illness are managed in the Namibian civil service.

3.3 SAMPLING AND RECRUITMENT OF PARTICIPANTS

The sampling strategy was purposive to meet the needs of the study. The selected participants had to have sufficient experience as implementers or recipients of the various HR policies and strategies and be knowledgeable on MI through having worked with people with MI or have experienced MI.

There were three sampling strategies which were applied to select the participants for this study: 1) selection of government ministries which had been in existence since independence as the target group; 2) selection of participants for individual interviews or focus groups

discussions (FDGs) from HR departments from the selected Ministries, the Public Service Commission (PSC), the Medical Review Board and relevant trade unions active in the public sector; and 3) the selection of adults with MI for FDGs or individual interviews who were employed or unemployed and had experienced workplace policies in action in relation to their MI, and their support people, who were member of the association who do not have MI.

Table 1: Total number of participants by category

Category of participants	Total number	Description of Participants	Mode of data collection
Public Service Commission	12	Commissioners, Manager and other staff members	1 FGD*
Human Resource Practitioners	12	HR Heads and Officials in 9 Ministries	2 FGDS
Medical Review Board	1	Member of the Board	1 Interview
Workers Unions	2	A Representative from each of the two unions representing employees in the public service	2 Interview
Members of Mental Health Association of Namibia	8	People with MI Support people	2 FGDS
Boarded Staff	4	Medically boarded, former employees in the public service	2 FGDS
Total Number of Participants	39		

*FGD: Focus group discussion

3.3.1 Selection of Acts, Rules and a Policy dealing with human resources issues and mental illness in government.

The sampling of the documents reviewed was based on government (public sector) Acts, rules and a policy which make provisions that address or would be relevant for MI and MH in the workplace. Five documents were selected and reviewed; namely the Public Service Act no13

of 1995, Public service staff rules, the Public Service Pension Fund Act no 24 of 1956, the Government Institution Pension Fund (GIPF) rules and the National Mental Health Policy.

3.3.2 Selection of participants for interviews and focus group discussions (FGDs)

A total of 39 participants were selected to participate in the research through a purposive sampling method as follows:

- a) Public Service Commission: Initially the plan was to invite only the chairperson and any other two Public Service commissioners to participate, as the Public Service Commission (PSC) is the mandated entity responsible for oversight of the public service. The PSC Board and Management realized the importance of the study and therefore requested a focus group discussion, instead of three individual interviews. This group discussion was attended by 12 participants, which included The Chairperson, two Commissioners, the head of the institution and six heads of departments, whereby one came to share her MI experience as an employee of the PSC. There were two staff members responsible for the recruitment and releasing of employees from work who also participated. Among other important functions, the PSC's main responsibility is the appointment of suitable people to specified categories of employment in the Public Service. With these appointments it ensures that equal and non-discriminatory opportunities are availed to all, through the implementation of the Affirmative Action Employment Act 29 of 1998. They were in a good position to provide information on issues of MH policies and guidelines in the public service as the PSC advises and gives directives in terms of disciplinary matters, cases of misconduct, appeals, grievances and termination of employment.
- b) Selection of Ministries: out of a total of 24 Ministries (see Appendix A), 16 ministries were selected, based on the fact that these ministries have been consistently in existence for the last 28 years, since Namibian independence. Newly created ministries and others that were transformed as per preferences of each political administration were not included in the study, as their workforce size is generally small and some do not have HR departments but only one or two people dealing with HR issues with a direct link to the Public Service Commission Secretariat. The selected 16 Ministries were in a better position to have long standing records, experience and more information on how mental illness is being addressed in their respective Ministries.

12 officials in the Human Resource Department representing only 9 of 16 of the selected ministries participated in the study. Three ministries delegated two participants instead of one, while the other ministries sent one participant as requested. The seven Ministries which could not delegate any participants gave as reasons that the HR Officer they delegated was on annual leave already, or that they had only received the invitation from the Permanent Secretary the morning of the meeting and that they had other pre-arranged engagements within the ministry. The delegated officials were HR practitioners, who had worked for more than eight years in the department and who were well versed in all related laws and procedures in the Public Service. The participants from these ministries were at different levels/ ranks, most of them in managerial positions.

c) The Medical Review Board (MRB) and the Government Institute of Pension Fund (GIPF):

The two institutions' roles are interlinked as the MRB provides recommendation on the fitness of the employee to work or to be boarded, while GIPF determines whether an employee will be boarded permanently (disability) or temporarily (ill health). We were only able to interview one representative of the MRB and did not manage to secure an appointment with any GIPF representative. A questionnaire was sent to their office but a response was never received.

d) Union representatives: The employees of the government are members of three different worker's unions which represent the employee's interests. These unions bargain on conditions of service and act as representatives of the employees during disciplinary hearings. Two unions, represented with one member each, were interviewed on how they ensure that any mental illness related needs of their members in the public service is addressed. The third union did not participate explaining that they do not have any representative who was well versed in issues of MH.

e) Mental Health Association of Namibia (MHAN): Eight participants were drawn from the Mental Health Association of Namibia (MHAN) to participate in two FDGs. The Association participants represented the following categories of its membership: five people with MI who had experience working in both the public and private sectors, and with three having lost employment due MI and two were still employed although their employers knew about their MI. The other three participants were family members or friends of people with MI and support people who were activists in the organization, but who did not have

any MI. The two groups held their discussions on the same date, same venue in two separate rooms. MHAN membership includes people with mental illness and relatives and friends of people with MI who are employed or who lost employment due to MI or looking for employment. The participants from MHAN were instrumental to this study as they shared practical experiences of what it means to have a close member of the family, or a friend who has attempted to obtain employment in the public service, or even to be an employee with MI in the workplace. MHAN members were asked for potential participants who had been medically boarded who could be recruited as participants. This led to an additional four participants with MI, they all worked for the public services, who were not members of MHAN participating in two Focus Group Discussions (FGDs).

3.3.3 Inclusion criteria for all participants:

- Any adult between the ages of 18 and 65 years, with some knowledge of the subject matter (HR policies and implementation and/or MI) and who was willing to participate
- Must have been a member or representative or employee of the selected structures for more than one year
- Should be in a non-acute condition during the interview for MHAN members.

3.3.4 Exclusion criteria for all participants:

- People with a current severe MI episode.
- Representatives from any structure other than the selected ones.

TABLE 2: Summary of objectives, participants and data collection methods.

Objective	Participants/Data sources	Data collection method
<p>To explore how mental health issues are addressed in human resources policies and implementation plans in a sample of government ministries in Namibia</p> <p>To analyse how various policies used in the public service to address MH issues conform with the National Mental Health Policy</p>	<p>HR policies and implementation plans relating to government operation, especially with regard to issues of MH.</p> <p>Review of the National Mental Health Policy</p>	<p>Review of documents setting out policies and implementation plans to identify reference to MI and MH</p>

To explore the understanding of MI by Human Resource Practitioners	<ul style="list-style-type: none"> • HR Practitioners • Union Representatives • Public Service Commissioners 	<ul style="list-style-type: none"> • Focus Group Discussions • Individual Interviews
To explore the processes used and the efforts put in place to ensure that employees with MI are: <ul style="list-style-type: none"> • recruited and • retained in their positions. 	<ul style="list-style-type: none"> • HR Practitioners • The Public Service Commissioners • Union’s Representative 	<ul style="list-style-type: none"> • Focus Group Discussions • Individual Interviews
To obtain information on the experiences and perspectives on how MH is addressed from people with MI and support people and advocates	Members of the MHAN and other people who had been medically boarded because of their MI	<ul style="list-style-type: none"> • Focus group discussions

3.4 DATA COLLECTION

3.4.1 Review of existing policies

The documents which were reviewed are policies, implementation plans and regulations dealing with issues that are of relevance to MH and people with MI at the workplace and which cut across the entire Public Service. The review process included the Human Resource Policies and related implementation plans set out by the Public Service Commission Act, focusing on recruitment, disciplinary and termination procedures (four documents), and the National Mental Health Policy (one document). The review solely focused on the sections that are relevant to issues of MI in the workplace. Hard and electronic copies of the documents were used for the review. This review assisted the study to get more background information, to determine the implementation of programmes available, and informed the topic guides for the FGDs and interviews.

3.4.2 FGDs and individual interviews

There were seven FGDs in total: (i) two comprised of the 12 Human Resource Officials (four participants in the first group and eight participants in the second); (ii) one with 12 participants from the PSC; (iii) two with the eight members from the MHAN (one with five people with mental illness and the other group with three support people); (iv) and two with four young people medically boarded due to mental illness (two in each group). In addition, there were three individual interviews conducted with the two representatives from the unions and one representative from the MRB. The intention behind interviewing

representatives from two unions was to get their different opinions on issues of MH in the Public Service, because they represent quite different constituencies. One union is affiliated to the ruling party and is mostly perceived as promoting government's agenda more than its membership, while the other one is seen as representing the interests of the workers.

In the FGDs participants provided in-depth data which gave the researcher a better understanding of the perceptions, insights, attitudes, experiences and beliefs on MI as well as additional information which the researcher might not have considered initially. The study used Jack's case study scenario and question guides (See Appendix C) as instruments to guide the discussions in the focus groups as it enhanced better understanding on what the study is all about and helped the participants to elaborate more by sharing experiences and providing opinions and information. Background demographics questions were also asked of all participants, such as the gender, age, in what capacity they are serving and the length of time they have been involved in this capacity for the public service participants.

All participants from MHAN were well enough to contribute meaningfully to the discussion. Three of these were family members and support members from the association.

3.4.3 Setting of the interviews

All focus group discussions and individual interviews were conducted in a quiet room which was conveniently located for the participants and at a day and time that was suitable for the participants.

3.4.4 Process of data collection

Given the researcher's role in government and the seniority of the PSC Commissioners and the participant from the MRB, the researcher decided to conduct only this FGD and those with MHAN participants, and the individual interviews with the union representatives. The rest of the FGDs were conducted by the research assistant with the support of a note-taker/transcriber appointed and trained by the main researcher. For those FGDs conducted by the research assistant, the researcher sat aside but still in the room, and assisted with note-taking and the recording process. All FGDs and interviews were audio recorded. Where the researcher was facilitating the discussions and interviews the research assistant and note-taker/transcriber took notes and managed the recording.

3.5 DATA ANALYSIS

3.5.1 Document Analysis

The researcher identified key terms within each document, which were grouped into a number of themes regarding MH or MI and any other information regarding the management of MI specially in the workplace. As most documents did not have electronic versions of all documents, a manual process was used to analyse the documents.

3.5.2 Interviews and Focus Group Discussion Analysis

The study used a framework analysis approach, because this is an applied research study that is aimed at meeting specific information needs to provide outcomes and recommendations (Gale et al.,2013). After each data collected process, there was a brief analysis of data to allow the use of the findings to guide the discussion in later interviews and FGDs. this brief analysis was also used to understand when there was saturation of themes or if further interviews were required. This was possible as the researcher was present in all discussions and able to gauge when data was saturated and the gaps to be explored in later discussions.

Once the interviews and FGDs had been transcribed and translated, the analysis followed the five stages of qualitative analysis as guided by Lacey and Luff (2012):

- (i) **Familiarisation:** After each session of data collection, the note-taker/transcriber transcribed the information from the audio recordings. The researcher checked the accuracy of these through listening and reading. After verification of the transcripts the researcher made notes, coding and summarising all the major ideas.
- (ii) **Identifying a thematic framework:** The themes were guided by what programmes and support should be provided for employees with MI from the WHO MH policy service guidance package (2005) and other emerging themes from the literature review. These included but were not limited to:
 - Understanding of MH issues, specifically the participant's knowledge on MH and MI
 - The knowledge on the policies used and how they are aligned with the MH Policy
 - What strategies they apply in implementing the policy, including the plans they have (HR, MRB and PSC discussions)

- How they ensure the implementation and evaluation of the policy, such as the oversight, supervision and enforcement of the policy. (HR, MRB and PSC discussions)
 - How the participants manage MI (government and union participants) in the workplace or experience how their MI is managed (the MHAN participants).
 - Barriers and facilitators to the management of MI in the workplace.
- (iii) **Indexing:** Each focus group and individual participant's transcribed interview was coded using the thematic framework set out in point 2 above with sub themes in each as they arose.
- (iv) **Charting:** The data were analysed by using headings from the thematic framework to create charts of data in order to easily read across the whole dataset.
- (v) **Mapping and Interpretation:** Mapping of data was done through grouping the information collected according to various parent themes.

QSR Nvivo software was used to analyse both the documents and the data, as it helped me to manage the data collected in answering the research questions.

3.6 ETHICAL CONSIDERATIONS

Ethics was paramount to this research as the information obtained was sensitive and confidential. It was of utmost importance to keep the interviews as neutral as possible without any kind of confrontations or accusations levelled against the participants. This was addressed clearly in the training of the research assistant and note-taker/transcriber. The application for ethics clearance was submitted to the National Commission on Research Science and Technology in Namibia and the University of Cape Town Human Research Ethics Committee (See Appendix D). As a Deputy Minister of Health prior to and during the time of the data collection, the researcher decided not to facilitate or engage the HR officers during the FGD, but rather to take backstage and take notes. This was to minimise any influence I could have on the participants and allow them to participate freely in the discussion. Throughout the study, especially in the sessions I took part, I introduced myself as the researcher and encouraged participants to look at me in that regard. The research assistant and note-taker/transcriber both signed a confidentiality agreement to ensure that they will keep all information confidential.

3.6.1 Informed Consent

Before the commencement of any interviews or FGDs, the researcher held a brief information session where the participants were provided with information regarding the research. The participants were informed that their participation in this study was voluntary and that they could withdraw at any time if they felt uncomfortable to proceed. Other information included the purpose and the procedures of the study, with emphasis on how their identity and the information they provided would be protected. They were assured that the data collected would only be used for the purpose of study. The researcher further handed out the consent forms that were in English and assisted those who needed translation into Afrikaans and clarity before they signed. The sample of the consent letter is attached (Appendix B).

3.6.2 Confidentiality

The study guaranteed high levels of confidentiality, which were maintained throughout the study. The participants' identities and information were protected by ensuring that the researchers adhered to all considerations which were stipulated, including the informed consent signed by the researcher, the research assistant, the note take/ transcriber and the participants. No names or any code that would prompt obvious identification of the participants were used during the research or reporting process. When analysing the data, no names of participants were used, with only reference to a groups or departments being made and, with no titles or position of those who participated. In the acknowledgement section, the researcher only thanked the institutions, but not the participants individually. Completed questionnaires, signed consent forms, a draft report of the analysed data and other materials were locked up in a safe place. The data which has been captured and saved on the computer is protected with a password known only to the researcher. All materials used during the study will be discarded five years after the completion of the study. When presenting the results to various stakeholders, no information will be linked to a specific participant or the institution he/she represented. Throughout the study the researcher ensured adherence to the Helsinki Declaration of 2013 principles of ethical research (World Medical Association, 2013) .

3.6.3 Risks and Benefits

There were minimal risks for the participants beyond feeling a little uncomfortable or emotional when answering some of the questions. While there was no direct benefits, some of the participants acquired additional knowledge on MH issues just by listening to others with more insight or experience, which may help them to reflect on their own situations.

3.6.4 Financial benefits to the participants

The participants were not paid any monetary compensation but were provided with refreshments and three participants were reimbursed for the transport based on public transport rates.

3.7 CONFLICT OF INTEREST

The researcher believes that her position as a Deputy Minister in the Ministry of Health and Social Services before and at the time of data collection for the study might have had minimal effect on the data collection, but participants reflected the reality of how they were addressing the issue of MI in their various ministries openly without any obvious fear. They even pointed out issues in the ministry which they thought could be addressed to improve services for the members of the public service who visited or were admitted to MH facilities run by the Ministry of Health and Social Services. In order to reduce influence in the way the participants responded, the researcher decided to conduct interviews with Public Service Commissioners, unions and people with MI and their support persons. The researcher did not conduct the FGDs with HR and the MRB participants. These groups which the researcher attended, dealt more with policy issues, than the implementation of the policies, while the unions represent the interest of the employees. As the researcher is no longer Deputy Minister at the time of completing this dissertation, the findings of the research will enable the researcher as a member of parliament serving in the Social Affairs Portfolio Committee of the National Assembly to spearhead the advocacy for the implementation of the recommendations.

CHAPTER 4: RESULTS

4.1 DOCUMENT REVIEW

In this section of the study five legal documents were reviewed – two Acts and their associated rules (four documents), and the National Mental Health Policy of Namibia (2005). The Acts and Rules included the Public Service Act 13 of 1995 and its associated Public Service Staff Rules, and the Public Service Pension Act 24 of 1956 as Amended and its associated Government Pension Institution Fund (GIPF) Rules. The reason these documents were reviewed together with the rules was because, in both Acts, the processes and other stipulated provisions were elaborated in the rules.

In the Acts and Rules documents the review looked for any reference to MI or MH and, if neither had been used, looked to identify other terms that were used, such as severe psychiatric illness, psychological disorders, and MNS disorders (mental, neurological and substance abuse) which were found in the GIPF rules. If none of these terms were used, the review identified which terms were used in relation to MI or MH and any general health or illness terms used in all documents. The terms MI and MH were only used in the Mental Health Policy, and the most common terms used in all other documents were either ill–health or illness.

The review further pinpointed the legal provisions in the laws which had direct reference to MI in the workplace. These provisions ranged from recruitment and management to the boarding of the people with MI in the public service. The last part of the review was to identify any provisions which may impact on people with MI either positively or negatively.

The fifth document reviewed was the Namibia National Mental Health Policy. For this document the analysis looked at identifying provisions and guidelines which promote employment and retaining of employment for people with MI. The review also identified provisions on how MH issues in the workplace should be addressed in order to create a healthy environment which is beneficial to both the employees and the employers.

4.1.1 Public Service Act 13 of 1995 and Public Service Staff Rules

These two documents are the blueprints for the administration of human resources in government. All participants, except six from the Mental Health Association of Namibia (MHAN), made reference to the provisions in these documents, indicating that the Act and its

associated staff rules are familiar to public service staff. In the Act, there is a section that makes provision for when a public servant has to be recruited, daily operations within the government office, and the exit of staff from government employment, including boarding of staff on account of ill-health. The provisions in the Staff Rules include the process that needs to be followed when a member of staff is to be referred to the Medical Review Board (MRB) and what is to be done when they have been assessed and a recommendation made on whether the staff member can continue working or be medically boarded.

The Public Service Act only mentioned boarding due to ill-health with no specific illnesses mentioned in this document:

“ Any staff member may be discharged from the Public Service - on account of continued ill-health”- (Public Service Act, p21)

“Whenever it is considered necessary for a Public Servant to be examined with the view to ascertain whether or not he/she should be retired on ground of ill-health, the Permanent Secretary will make arrangements for the Medical boarding review.” (Public Service Staff Rules, p92)

4.1.2 Public Service Pension Fund Act 6 of 1956 as Amended and GIPF Rules

These two documents are both administered by the GIPF, with the rules being used as a guide by the Medical Review Board which is appointed by the Minister of Health and Social Services. The Public Service Pension Fund Act 6 of 1956 is a very old document, though it has been amended several times in recent years and most of its provisions refer to the Union of South African jurisdiction. In the act there is only one provision which gave effect to the drafting of the rules:

“The rules of a fund shall be in either of the official languages of the Union and shall contain provision in regard to the following matters, that is to say the conditions under which any member or other person may become entitled to any benefit and the nature and extent of any such benefit.” (Public Service Pension Fund Act, p14)

In the rules there is a section as quoted below, which classifies diseases which can give rise to a medical assessment and boarding on grounds of ill-health or disability. There is no mention of MI, and ill-health and disability seem to be used interchangeably, with the

mention of a number of conditions which are linked to illness and disability like cognitive disablement and central nervous system disorder.

From the GIPF Rules, the study identified the provisions quoted below which speak to the processes and administration for the member of the Public Service who goes on early retirement due to ill-health and disability. The main issue, with regard to whether the staff is boarded due to ill-health or due to disability, is the provision of the benefits to be received after being boarded. The participants interviewed for the study claimed that most of the staff preferred to be boarded due to disability as the benefits are better than when one is boarded due to ill-health. According to the participant from the MRB the classification is very outdated and does not make medical sense, as treatable diseases such as liver, kidney and many more are classified as disabilities. The rules further do not include any provisions for management of staff with MI specifically in either of the documents. There are however provisions for temporary leave with full payment and reinstatement of the members, but it does not stipulate the eligibility criteria. The rules further outline punitive measures for non-disclosure of a medical condition. The following quotes are an indication of the provisions elaborated on in this section on the two instances staff which can be boarded, due to ill-health and disability.

“With the approval of the trustees, a member who is in ill-health of a protracted nature caused through no fault of his/her own and who, in terms of a decision by the commission, does not qualify for the benefits set out in Rule 6, may retire early at any time prior to his/her normal retirement date; provided that the trustees receive proof satisfactory to them of the member's ill-health. For the purposes of this Rule, the trustees shall satisfy themselves as to whether a member is in ill-health and should they so decide, the member shall be deemed to have retired and shall receive a pension vesting on the first day of the following month. Such pension shall be calculated in accordance with Rule 3.1(2.)” (GIPF Rules, p24)

“If at any time prior to normal retirement date the Commission considers a member to have become totally and permanently disabled as a result of disease or illness, to the extent that such member can no longer pursue his/her own or a similar occupation for which he/she would be qualified by his/her training and experience, the following provisions will apply.” (GIPF Rules, p33)

In the rules, there are provisions which specify the grounds on which a staff member can be boarded, either due to ill-health with no specific diseases mentioned or due to illness or diseases mentioned which cause disability. This brings in a lot of confusion in terms of understanding when a staff member is to be boarded due to ill-health and due to disability. Neither the Act nor the rules mention anything about MI, although in the rules among the diseases or illnesses which determine whether a staff member will be pensionable on disability grounds, a few organic brain disorders are listed. This seems to negate the role of non-organic psychiatric conditions such as severe depression and anxiety.

The rules make provision for monitoring and observing of boarded staff whose function is restored from disability, but the reason for consulting on their progress is more about reviewing their benefits for disability, such as lowering the benefits if the person regains function, rather than reinstating their employment.

“The Trusteed shall be entitled, from time to time, to call for and obtain such medical evidence as they may require to determine the extent of continuous disablement of a MEMBER who is in receipt of a disability income benefit in terms of this Rule. If, in the opinion of the Trustees, the Member is no longer disabled as contemplated above, the disability income benefit granted in terms of Rule 6.1 above shall cease and the Member shall thereafter receive a Pension equal to the Pension that would have been payable to him/her had he/she not been disabled, as calculated by the Actuary.” (GIPF Rules, p36)

“Member who becomes disabled as a result of one of the conditions below, their benefit will not be reduced in terms of this provision: central nervous system disorders which are organic in origin and severely degenerative or cognitive disablement which is irreversible and organic in origin to such an extent that the member requires continual personal assistance or direct supervision.”(GIPF Rules, p36)

4.1.3 National Mental Health Policy of Namibia (NMHPN) - 2005

This policy has five distinct aspects which are addressed in the document and will be highlighted throughout the presentation in this section:

1. The Mental Health Policy addresses the major MH challenges facing Namibia and defines approaches for intervention.

2. The policy has a clear strategy on how to promote MH health in the workplace by advocating for comprehensive promotion of mental health programmes.
3. It emphasises protecting the human rights of people with MI in all contexts.
4. It further sets out guidelines for management of MH problems by putting up relevant structures and legislation.
5. The Policy proposes a multi-sectoral coordinating structure for effective advocacy and management of MH issues.
6. The policy is used as a guideline in preparation for drafting new laws or amendments of existing laws such as the Mental Health Act (1973) and other relevant documents dealing with mental health. The Mental Health Policy further creates a harmony and is an enabler of conducive laws.

The policy mentions the establishment of the National Inter-sectoral Mental Health Action Group (NIMHAG), which will be the coordinating body for issues of mental health, but that is not established yet. Its composition includes all major stakeholders, ranging from Ministries, employers to community members. Its functions are promotion of mental health, and prevention, treatment, and rehabilitation of mental illnesses, being an advisory structure to the Ministry of Health and Social Services (MHSS) and liaising with Other Ministries and other organizations to achieve the national goal of Health.

The policy has made provisions directing the Ministry of Labour and Social Welfare (MLSW), which is part of NIMHAG to ensure that issues of mental health take centre stage in labour relations and that the wellbeing of people with mental health problems are taken care of as highlighted in the following quotes from the Policy document:

“Collaborate with employers to introduce the mental health policy in the workplace and support the establishment of employee assistance programs (NMHPN, p14).”

“Encourage the public and private sectors to establish sheltered employment workshops for persons with mental disorders (NMHPN, p9).”

“Promote the employment of people with disabilities through the Employment Equity Act (NMHPN, p9).”

“Protect people with mental disorders in the workplace by safeguarding their legal rights, in keeping with the Labour Act (NMHPN, p15).”

“Provide vocational counselling services (NMHPN, p20)”

The current Mental Health Policy was drafted in 2005, to address new developments in the field of MI and to provide more recent understanding that MI can be managed and those with MI can be productive and live a productive life.

The analysis of the five documents highlights the key barriers and enablers to the management of MI in the workplace. One barrier is the lack of any specific reference to MI or MH, even in the rules, where MI is one of a number of ‘other conditions’. An enabling factor is that there are laws that guide the procedures that are required for recruitment of staff or those for medically boarding, including on the grounds of MI. The NMHPN is a very important document and speaks to issues of MI and MH, aimed addressing the prevention of MI and promotion of MH in the workplace.

4.2 STAKEHOLDER PERSPECTIVES – FOCUS GROUP DISCUSSIONS AND INTERVIEWS

The results will be presented according to the participant groups, being: the Public Service Commission (PSC), HR Officials, unions, Medical Review Board, medically boarded staff members, and the Mental Health Association of Namibia (MHAN).

Table 3 presents the summary of the 39 participants. Participants from the different Ministries and unions are, by definition, employed in the Public Service, while five of the participants are unemployed and 3 are employed in private companies. For both groups from MHAN and the participants from the two Unions, their years of experience are based on membership or leadership positions in their respective organisations.

Table 3: Demographic information of participants

Group	Sex		Years in the Position /Membership
	Female	Male	
Focus Group Discussion			
Public Service Commission	6	6	1 - 20
Human Resource – 1	5	2	8 -23
Human Resource – 2	2	3	Few months -
Mental Health Association of Namibia - 1	2	3	2 - 14
Mental Health Association of Namibia - 2	3	0	5 - 14
Medically Boarded Staff - 1	2	0	Not applicable
Medically Boarded Staff - 2	1	1	Not applicable
Interviews			
Unions -1	0	1	12
Unions -2	0	1	10
Medical Review Board	0	1	18 Months

4.2.1 Public Service Commission (PSC) - FGD

The Public Service Commission (PSC) is an administrative structure under the Office of the Prime Minister and was established in accordance with the Public Service Act no 2 of 1990. “Its main responsibility is to advise the President and the Government on the appointment of suitable people to specified categories of employment in the Public Service, with special regards to the balance structuring” (Government of Namibia, 1990). These appointments ensure that equal and non-discriminatory opportunities are made available to all, through the implementation of the Affirmative Action Employment Act 29 of 1998 and other related laws. The PSC is further the custodian of the records of civil servants pertaining to disciplinary matters, cases of misconduct, appeals, grievances, and termination of employment. Members of the PSC were identified as relevant participants to this study as they can provide information on issues of Mental Health policies and guidelines in the Namibian public service. The FGD was initially planned as three separate interviews with the Chairperson and any other two Public Service Commissioners. The PSC Board and Management realised the importance of the study and therefore requested a FGD instead of individual interviews. This

group discussion was attended by twelve participants, which included Commissioners, management, and some junior staff members of the PSC. Participants were working on the recruitment or management of grievances, or facilitating processes leading to the discharge of staff members from the public service.

(a) Understandings of mental illness and mental health

All participants expressed a general awareness of MH, but there were diverse levels of understanding of the meaning, what it entails, the determinants and other aspects relating to both MI and MH.

(i) Mental illness (MI)

Eight of the participants defined MI as a condition of mental instability, and two referred to it as a disturbance of the brain, or as a condition that is affected by the weather, because it occurs when it is cloudy or raining. Only two of the respondents referred to the word 'madness' as a definition of MI.

"Mental illness is a behaviour that occurs in certain individuals especially in the rainy season, if it is cloudy they are more affected." (P2 FGD- PSC)

"Mental illness is a sickness where the person's brain is affected or disturbed and their brain are not functioning normally, the thinking is also not proper." (P10 FGD- PSC)

"Truly speaking I am an HR Practitioner, with little knowledge on diseases, to me I know that people are suffering from madness." (P3 FGD- PSC)

(ii) Mental Health (MH)

All participants described MH as the state of having a healthy mind, while three revealed that it was first time that they heard the term and just guessed when responding.

"Okay, mental health is a disease free condition, mental health is someone who is not having a mental problem" (P4 FGD- PSC)

"The world is moving forward to reduce stigma, thus they are using this Mental Health concept for both the well and the unwell in terms of mental issue and to me is totally encouraging" (P1 FGD- PSC)

"Mental health on the hand is the complete wellness of the brain, that drive the person to think and act in a very appropriate manner" P 10 (FGD- PSC)

(b) Causes of MI

Seven participants attributed the existence of MI to physiological factors and a chemical imbalance in the brain, while five said the causes might be traditional practices or beliefs such as witchcraft and the appearance of clouds. Eight of the participants said the cause was sudden negative life events which have a psychological impact on the person.

“I know one instance where a woman walked in my office and she was seriously, severely depressed due to challenges cause by circumstances they lived in.” (P5 FGD- PSC)

“The causes are best describe as witchcraft and obviously everybody will link the action to something that happened the day before.” (P12 FGD- PSC)

(c) Types of MI

The participants’ knowledge about the different types of mental disorders was minimal, with only one of the participants narrating her journey with postnatal depression. Two knew about a few people with illnesses such as bipolar, schizophrenia and depression, because they directly dealt with the files of most of the staff referred for medical assessment due to MI.

“And it took me eight months or so, to fight this postnatal depression, in loneliness and with so much fear.” (P7 FGD- PSC)

“I deal directly with the files of all staff referred for medical assessment due to psychiatric problems, in the process I got to know different types of mental disorders such as depression, bipolar.” (P9 FGD- PSC)

(d) The behaviour, reaction and coping with MI

The participants had different views on the ways in which people with MI behave. The main comments centred around people with MI being scary and creating fear in others, being aggressive, or changing and becoming withdrawn.

“I have seen it all, from staff who become very angry, you can see that anger from the facial expressions to staff members who just change to the opposite of how you know in no time.” (P6 FGD- PSC)

“Those changes are really scary, sometimes it’s accompanied by aggression and in other instances, just that frightening quietness.” (P4 FGD- PSC)

“I saw colleagues who just withdraw, once joyful people who just suddenly goes in their own corners, no discussions or interest in anything.” (P1 FGD- PSC)

(e) Treatability of MI

Most of the participants said that MI is treatable, with a few commenting that the treatment is more about symptom control therapy than a treatment.

“Treatability for me is really not so clear, but I believe that the medication is more of a control measure rather than a complete treatment.” (P11 FGD- PSC)

“The medication they get from the doctors are working only when they are taken regularly, it works in specific times otherwise the symptoms are not managed.” (P3 FGD- PSC)

“It is treatable, as I have a colleague who was highly depressed and had suicidal thoughts, after been admitted and put on treatment, he changed and developed a positive outlook on life.” (P2 FGD- PSC)

(f) Disclosure of mental illness in the workplace

(i) Willingness to disclose

A participant in the group described incidents where staff members had felt that they needed to share their issues with their colleagues, but never did and were constantly in tears. In one instance, co-workers assumed that the person had something she wanted to share with them but was just not able to do so, until one day she started to scream in the corridors, apparently seeing snakes and lions. Ten of the participants had never come across anyone who showed a willingness to disclose. All participants commented that, generally, it is never easy to reveal a personal condition to anyone, even common diseases such as diabetes, especially in the work environment.

“There was this colleague going in and out our supervisor’s office, like three to five times a day, but when she is there she just looks at him and comes back to her desk. Then she starts crying and we could not ask her, as she never spoke to us in the office.”
(P11 FGD- PSC)

“Our illness remains our personal information, we do not share it with colleagues at work and disclosing mental illness is even worse.” (P7 FGD- PSC)

(ii) Barriers to disclosure

The participants reported two barriers to disclosure of MI. The first is that MI is culturally and morally seen as a taboo. The second is that on the government employment application form, it is one of two major issues (the other being criminal offences) that one is requested to declare and they appear at the same place on the form. One participant, the mother of someone with Bipolar, said her son no longer completed government application forms as the question was a deterring factor to him. It would be easier if this question were moved to the medical questions section, which includes other conditions such as disabilities and other health issues.

“Mental illness is a taboo in our country, nobody is ready to disclose, even to relatives.”
(P8 FGD- PSC)

“I have to declare here that our application form for employment, especially the question on Mental illness placed with the declaration of criminal records.... It is very biased and my son who has mental illness decided not to complete any government employment application for the last five years.”(P9 FGD- PSC)

(g) Management of mental illness

The participants in this focus group mentioned that management of MI is complex as it is not only about the affected people’s treatment, but also about many aspects in the operation of HR. These aspects include the knowledge and understanding of the different MI conditions, and the guidelines and processes as guided by various legislative instruments, which include the staff rules and the Employee Wellness Policy. These factors are discussed below.

(i) Knowledge of MI

The lack of knowledge of MI was highlighted by the PSC group participants as the main reason why the HR Practitioners and many officials in PSC are unable to assist staff with MI or even put measures in place that will help them to remain employable. The group commented that the discussion on this topic was long overdue, as the amount of people being medically boarded on account of MI has become worrisome. Most participants revealed that they have, on many occasions, requested for training or to take part in discussions or any other information sharing about MI and MH in the workplace. This request was especially for HR officials in all Ministries and the staff who are dealing with grievances and medical boarding of civil servants in the PSC Office. One request was that they need to be educated on MI in order to enable them to deal with this issue appropriately.

“The issue of mental illness is becoming worrisome and we honestly lack knowledge of even being able to understand what mental illness is. Therefore, I call upon the PSC to organise for a training and other platforms to discuss this issue.” (P2 FGD- PSC)

“We in this office and the HR practitioners across the whole government lack knowledge in managing issues of mental illness and it pains me seeing young people being boarded. We need training.” (P9 FGD- PSC)

“The truth is that we have been calling for these trainings and discussions. I have letters to this effect in my office, nearly every month we are writing discharging/ boarding letters for people and that is draining us psychologically as we do not know how to help in keeping these people employed.” (P5 FGD- PSC)

(ii) Legislative instruments on mental health, processes, and implementations

The participants in the PSC group responded that there were clear HR rules that they followed when dealing with cases of people with MI, especially when these people had to be discharged/medically boarded from public service due to their MI. One of the participants described the whole process according to the legal provisions when a recommendation for an employee to be discharged from the public service was received from the HR department of any Ministry. They however recognised the inconsistency in terms of the processes which would take place prior to their receiving such a request. In some cases, if the Medical Review Board had recommended that an employee was fit to work, but HR in the specific Ministry

did not agree with that recommendation, HR could appeal to the PSC. In these cases, the PSC could appoint an independent/private psychiatrist to do an assessment. It was also mentioned that the rules were silent on the remedial process and time to be followed by the HR department before a decision to recommend boarding was sent to the PSC. All recommendations that the PSC received were reviewed by an analyst and then discussed at management level, whether for absenteeism, disciplinary issues or ill-health, before referral for relevant actions.

One legislative issue the participants mentioned was the lack of harmony in the implementation of the laws across different governmental structures and how it was making their work difficult. This was especially the case for the Government Institution for Pension Fund (GIPF) Act and the re-employment of capable, healthy, young people who had been re-assessed and certified to be fit for work after two or three years.

“We have so many laws, regulations and policies with so many contradictions on the well-being of the employees, they are not well harmonised and that gives us difficulties to implement.” (P12 FGD- PSC)

“We are sitting with young professionals who only worked for a few years and are boarded – termed early retirement due to disability/ill-health. No reassessment, no re-entry on permanent basis in public service, retiring at 23 years, it’s very painful.” (P1 FGD- PSC)

“One thing that is not clear is how the people who are boarded are being recruited again only on an annual contract basis, but cannot be recruited as permanent staff in the public service. It is very confusing.” (P4 FGD- PSC)

The Employee Wellness Policy document was mentioned by nine of the participants as one of the tools designed to afford staff members an opportunity to be heard and provided with the necessary support for what they experience physically, mentally and emotionally. In relation to this policy, six of the participants attested that there is an employee wellness policy, while six others could only recall a decision that was taken to have a wellness unit in each Ministry. There was much discussion about wellness programmes, and the description of such a wellness programme was that it was more focused on physical fitness than other components of holistic wellness for the staff. This discussion raised the question of whether the policy was

even in existence, and whether it was making an impact. None of the participants mentioned how they are implementing the policy.

“The current wellness programme is more on the physical aspects, nothing on emotional, psychological or even financial literacy.” (P7 FGD - PSC)

“I know that there was an induction where HR was supposed to host a wellness unit and we went through a document, but that was still in a draft form.” (P3 FGD - PSC)

“I always hear about the wellness policy at meetings and other HR platforms, but when I request a copy, I am told that it is a draft.” (P10 FGD - PSC)

(h) Recommendations

The FGD participants suggested a number of recommendations for managing MI for everyone dealing with issues of MH in general and especially in the Public Service. The recommendations are as follows:

- That more research be conducted in various Ministries to underpin the causes of MI among employees, especially those that are regularly recommended for assessment due to MI.
- That training on MH be set up for HR focal people or to have a person with a medical background or a medical doctor in the Public Service and located in the PSC Offices, who will deal with all issues experienced by staff members with MI in government.
- That there should be awareness training to be able to deal with these cases properly, or having a social worker in a workplace who can provide support and counselling to those who have MI to live positively with the illness, such as in the case of HIV.
- In order to avoid fragmented care for employees, the HIV units existing in many Ministries could be transformed and capacitated to deal more generally with employees' welfare, including MH.
- HR is overloaded and is not the right place to place the welfare of the staff members.
- That some of the terminology in the staff rules and other legislative documents should be revised as it creates confusion. An example of this that was mentioned is the word “discharged”. The participants were grateful for the opportunity to take part in this study and expressed their hopes on how they would like this study to make an impact in addressing important issues raised.

“On behalf of my colleagues, the staff of the Commission, we are really moved by your research. In summary I would like to say, all the laws, policies, guidelines need to be revisited and be realigned with the situation at hand. Mental illnesses are taking a toll on us all, due to many reasons in our daily life. We need to deliver to the expectations and keep our staff happy in whatever way, and laws that are vibrant will help us to achieve this”. (P11 FGD-PSC)

4.2.2 Human Resource Practitioners (2 FGDs)

There were 12 participants from Human Resource Departments, representing only nine of the 16 selected Ministries who participated in the study. Three Ministries delegated two participants instead of one, while six Ministries sent one participant as required. The six Ministries who did not send representatives gave the following reasons for this: (i) the HR Officers were on annual leave, or (ii) they had only received the invitation from the Permanent Secretary the morning of the meeting and they already had other pre-arranged engagements within the Ministry. The FGDs with HR Officials took place over two consecutive days at the same venue. On the first day, only four participants from three Ministries arrived. On the second day, eight participants from six Ministries participated. The delegated officials were HR practitioners who had worked for more than eight years in the department and who were well versed in all related laws and procedures in the Public Service. The participants from these Ministries worked at different levels, with most of them in managerial positions.

(a) Understandings of Mental Illness and Mental Health

Most of the participants in HR Group 1, who came from the Ministries of Education, Works and Transport, Defence, and Mines and Energy, had extensive knowledge on MI and MH issues. These participants could name the types of MI and explain how people behave, and some also said that they had developed an interest in knowing more about this subject. The participants in HR Group 2, who represented the Ministries of Agriculture, Finance, Justice, Environment, and Home Affairs, could define MI. When defining MH, all seven participants used their own understanding, and three expressed that they had never heard the term before.

(i) Mental Illness (MI)

Participants were able to name a number of mental disorders and defined MI as a condition affecting a person's ability to think, act and behave properly and that can be influenced by different factors. MI was described like seasonal illness, where a person can be well for a long period, become ill for one or two weeks, and then be well again. MI was also described as a lifetime disease which creates confusion and aggressive behaviour, and it is possible for one person to have multiple MIs at the same time. Participants said that MI causes people to change, to behave like wild animals, and to stop having an interest in life. Many of the participants in the group agreed that MI is a disease of the mind and they knew that it is also referred to as a mental disorder. Some of the participants explained that, when sick, "the mind can do weird things" unconsciously, and they simply call it "the sickness of the brain". Some participants could differentiate the many ways the illnesses present themselves, and how these affect a person's behaviour and cause them to act in a totally different way.

"The term which is commonly used is mental disorder and disorder is an unstable state of mind. "(P3 FGD –HR 1)

"The person's mind moves to another level and mostly does many weird things unconsciously. "(P1 FGD –HR1)

"Mental illness as the word itself says, it's the sickness of the brain. "(P3 FGD –HR2)

"This condition present itself in many ways and thus [causes] the affected person's mind to act and behave abnormally. "(P4 FGD –HR1)

(ii) Mental Health (MH)

The majority of the participants had heard about the term MH, but did not know its definition, with two participants sharing that it was their first time hearing about MH. However, in their attempts to formulate a definition, they concluded that MH is the wellness of a person's mind. It is when they are thinking and acting rationally, and that a healthy mind is "thinking right and acting decently" without embarrassing oneself or others. They further felt that MH can be achieved if one identifies and addresses situations that lead to the MI.

“Somebody is healthy, thinking right and acting decently without creating embarrassment for himself. “(P1 FGD –HR2)

“On the other hand, mental health is what we are striving to attain by ensuring that you identify and address situations which led to the illness. “(P4 FGD –HR1)

“I never heard the term mental health, but I can only give you the layman’s meaning, which I believe is that desire to have a well-functioning mind. “(P7 FGD –HR2)

“Yes, mental health is now to me when there is an intervention after identifying a mental illness and provide treatment for those that are affected, while ensuring they remain mentally healthy. “(P3 FGD –HR1)

“This mental health issue is new to me, but my guessing says it’s the ideal state of the mind that everyone should have. “(P6 FGD –HR2)

(b) Treatability

On the question of whether MI is treatable or not, some of the participants agreed that it is treatable when the person is willing to cooperate and depending on the severity of the illness. The majority, however, agreed that MI is not treatable but that the medicine given can make the disease symptoms more controllable and manageable.

“I think there are two factors to the treatment of mental illness, let me say the most important one is the willingness of the person to be treated and then the severity of the illness. “(P1FGD –HR1)

“I know of many people who have been treated, yes it’s treatable. “(P2 FGD –HR2)

“For me I am not so sure about the treatability, but surely about managing of the symptoms. Many people in all Ministries I work, who were said to be mentally ill, had

seasons when they are 100% well and other times when they become unmanageable.
“(P3 FGD –HR2)

(c) Causes of MI

Participants in the two groups could only mention four causes of MI, namely alcoholism, HIV/AIDS and drug abuse, and one participant said that MI is inherited as it runs in the family and is genetic.

“The main cause is HIV/AIDS if a person is not counselled well and the abuse of alcohol and drugs. “(P7 FGD –HR2)

“Mental illness also runs within families – you will find a whole family suffers from one mental illness. “(P4 FGD –HR2)

(d) Types of MI

These groups' familiarity with the different types of MI came from their interaction with the records of staff members who suffered from MI, such as depression, dementia, schizophrenia, bipolar mood disorders and anxiety. They said they came to know about these disorders as they send the staff members with MI for an assessment when considering medical boarding. The participants described aggression, rudeness and being withdrawn as some of the characteristics of how some people with MI behave. People suffering with MI were easily identifiable by observing changes in their behaviour, including that many of them become very withdrawn, isolating themselves from colleagues, while some easily become angry and started frequently absconding from work.

(e) Disclosure of MI in the workplace

The participants felt that disclosure of MI is a personal matter like any other disease and remains the choice of the employee to disclose or not. One participant said that there had been a number of recommendations to move the question on MI in the government application form for employment from the general questions where it is currently located with the criminal record questions, to the medical section with all other health-related questions. The participants expressed their desire to know the conditions of all the vulnerable

groups in the public service and to know how to help them to lead a productive life, both in their personal life and at the workplace.

“I wish as an HR Officer I could be informed on conditions fellow employees are suffering from, in order to render the necessary support required by each.” (P2 FGD – HR1)

“Mental illness is a medical condition and knowing about it could rightly fit in the medical questionnaire with all other illness and physical disability.” (P5 FGD –HR1)

(f) Legislative instruments on MH, processes and implementations

All the participants reported that the staff rules are the main guide they use when dealing with staff members in all HR aspects as it incorporates a number of issues, such as how to deal with a staff member absconding from work for a long period with or without the relevant documentation. Some participants felt that, although the rules are clear, they as HR Officers look at every situation differently. They also mentioned the availability of the Employee Wellness Policy, which is still in draft form, with some participants saying that they had never seen the draft and only knew of the HIV/AIDS Policy. Two participants, one from the Ministry of Education and the other from the Ministry of Mines and Energy, responded that they had already operationalised the policy, and the Ministry of Works and Transport already had a unit with staff responsible only for that. Others said they only had activities where staff members would come together once a year for tournaments, health talks and physical examinations. The participants said that the Ministry of Defence was the only one with a department of health services, in which the division of mental and psychological services is located.

“The matter of fact remains that the staff rules are clear as a guide to deal with such cases. It also allows us to use our own discretion on each case we are dealing with.” (FGD –HR1)

“We are all human and we take a lot of issues in consideration when dealing with each case, we do not use a ‘one shoe fits all’ approach.” (P1FGD –HR2)

*“The only workplace policy we have on diseases is the HIV/AIDS Policy, nothing else.
“(P7 FGD –HR2)*

*“I wanted you to take note that there are certain ministries which have a Wellness Unit; they employ a Health and Wellness Officer and mine is one of those few.”
(P5 FGD –HR1)*

“I know that there is a draft policy of wellness, but what I am not sure is whether it is operational in some Ministries or not.” (P3 FGD –HR2)

“At military all are operating in a different fashion. We have a health Directorate where all our health issues are taken care of and we have Psychologists at all our Battalions.” (P2 FGD –HR1)

(e) Recommendations

The recommendation of the HR Practitioners focused mainly on structural and law reforms. One of the structural issues raised was having a coordinated division lead by a person with medical knowledge who would be in the position to deal with health issues. They requested training on MH issues to equip the HR and PSC staff with relevant information regarding MI. Both groups called for the review of policies, regulations and laws, to bring them in line with the current situation and effectively address issues with regards to MH. One document they mentioned is the National Mental Health Policy.

“The wellness of the employees of each institution contributes towards its success or failure, thus the wellness policy should be finalised and implemented with a well established structure.” (P4 FGD –HR1)

“There is a need of an internal Medical Expert in the Office of the Prime Minister, who will be of assistance to the HR to understand some conditions as those conditions are different and not everyone understands them.” (P1FGD- HR1)

“My recommendation is for PSC to have a well-coordinated desk, which will help HR divisions throughout the government on health issues and grievances-solving in order to minimise work related stresses and tensions, which might be the main cause of mental illness. “(P5 FGD –HR1)

“I recommend that we receive training on mental illness, detailing the behaviour of the person when under attack, maybe on how we can be of help to prevent and promote an environment where our staff with mental illness will remain employable. “(P3 FGD –HR1)

*“The National Mental Health Policy is outdated and it needs an urgent review. “
(P7 FGD –HR2)*

“There is this issue in government when one has to be discharged either due to disability or ill health; those guidelines need to be reviewed. “(P2 FGD –HR2)

4.2.3 Medical Review Board (MRB) - Individual Interview

The Medical Review Board (MRB) and the Government Institute of Pension Fund (GIPF) were referred to during the interviews and FGDs as the main players when it comes to the way in which employees with MI are treated in the Public Service. These two institutions’ roles are interlinked, as the MRB provides recommendations on the fitness of an employee to work or to be boarded, while GIPF determines whether a boarded employee receives their benefit – classified as permanent (disability) or temporary (ill health) – or whether they can change an employee’s status from ill health to disability as per their own review format.

The researcher was only able to interview one representative of MRB and did not manage to secure an appointment with GIPF representative. A questionnaire was sent to their offices and no response was received. In this interview, the researcher did not use either of the two question guides which had been used for the previous FGDs, but instead used questions drawn from the interviews and FGDs conducted previously. As the issues previously raised had been more about the legislative documents, and their processes and implementation,

this interview focused on those issues, but not on the general knowledge of MI and MH. In concluding this interview, the participant was asked to give a few recommendations for addressing the issues raised during the interview. One of the main issues raised in other group discussions was the possibility for the PSC to change the rules to minimise boarding incidents and instead rehabilitate the affected staff members while in service. All quotes from the participant are presented in italics in each paragraph below.

(a) Legislative instruments on MH, processes and implementations

The MRB participant outlined a number of issues with processing requests for people to be medically assessed and a number of discrepancies in the law. In terms of launching an application, he said there are three ways in which one can request to be medically boarded: (i) through the HR of each Ministry to the PSC; (ii) because of a prolonged illness which lasts more than twelve months; and (iii) by the request of the staff him/herself. The first way it is when HR writes to the Medical Review Board to assess the staff member, while in the second instance those staff members did not require assessment as they are known to have been sick for more than 12 months continuously. For the third way HR just reaffirm the request for boarding of the staff member from the medical doctor based on the records in their possession but this is the least used way to board a staff medically. Most of the people who request to be boarded this way were advised to go for voluntarily early retirement or resignation.

The other issue raised in this regard is inconsistency in the process of forwarding the applications, as some are sent with the staff member's medical records and recommendations from the HR to the PSC, while others are sent from the Permanent Secretary's office requesting for medical assessment without any notes from HR in that Ministry. The participant revealed that there are a very limited number of psychiatrists in the country, and most of them who operate privately do not claim from the government medical aid, instead requesting an upfront payment from the person being assessed. There is therefore only one psychiatrist available for 90% of the staff with MI who are recommended to the board for assessment. The participant however elaborated that the MRB only uses psychiatrists in the public sector or Senior Medical Officers for regional cases where there are no psychiatrists.

On the formulation of the guidelines, the MRB participant said that there are two things that are very much outdated and do not medically make sense, namely the classification of diseases as disabilities and the reason for boarding as disability or ill-health and MI is not defined as either. Although he had an issue with the wording, it became more complex as many people asked him to change the reason for boarding either from ill-health to disability or vice versa. This is because there are different benefits and conditions for disability and ill-health boarding. The participant said that the regulations allow for extended sick leave for up to 12 months, but some illnesses require a longer rehabilitation period. The MRB had therefore also identified this as a shortcoming in the law. According to the participant, the use of sick leave and absenteeism records as the basis for requesting medical assessment or consideration for medical boarding due to MI could be ambiguous as the reasons for not coming to work might not be solely related to one's physical health.

The other issue he mentioned was that, even though the guidelines make provision for reassessment and appeals, there is no provision for the reversal of a decision of boarding due to disability. According to the participant, this was something the board thought should be reconsidered. The participant explained that the board would use their discretion to conclude on the fate of each employee they assessed. In many cases, they would use their expertise in occupational health and try to be as humane as possible by not boarding people who could work. The board receives applications requesting that people be boarded on different medical grounds from all Ministries, with the most applications being received from the Ministry of Education and the Ministry of Safety and Security. Applications received for staff members to be assessed due to MI represent nearly a quarter of all applications. The participant further said that during the last 18 months the board had 42 out of 180 cases where the staff contested or appealed the board decision for them to be medically boarded. He also suggested that the law make provision for re-assessment, but there currently is no provision for staff to be re-employed even if they are found to be fit for work.

"I came across some guidelines that were developed by GIPF and I found it a bit challenging because they are classifying some diseases as disabilities, for example liver disease. It's even mentioned a liver disease is a disability, a kidney disease is disability, bone disease is a disability, cardiac (heart) disease is disability."

“I saw all the applications were approved on a disability basis. You know the wording is like, the staff member is permanently unfit for further Government services due to disability.”

“The board started to use its own discretion, to decide whether the case can be classified disability or not. “

(b) Recommendations

Most of the recommendations from the MRB representative were about the regulations and how to allocate roles to the stakeholders involved in the process of staff members being medically boarded. The participant further urged for the review laws to permit temporary boarding, with proper guidelines on the assessment processes drawn up with input from all stakeholders. The differentiation of ill-health from disability was recommended. It was recommended that sick leave, whether given rightly or wrongly, not be used as the basis for requesting assessment, but that medical practitioners issuing sick leave certificates in unethical ways should be punished.

4.2.4 Workers unions - 2 individual Interviews

The government employees are members of three different workers' unions which represent the employees' interests. These unions negotiate the employees' conditions of service and can act as legal representatives of the employees during disciplinary hearings. Two of the unions were represented by one participant each, who were interviewed on different days to find out how they ensure that their members' MI is addressed in the public service. The third union did not participate and their reason was that they do not have any representative who is well versed in issues of MH.

(a) Understanding MI and MH

(i) Mental Illness

Neither of the participants could define MI, but they were able to describe awkward actions by people with MI, such as people speaking to themselves and presenting scary facial expressions.

“Those people are seen from far, speaking loud as if they are with someone, but he is alone. When he comes to you he is making a scary expression with teeth out. It’s very awkward and you can see them from far.” (Interview - UNIONS 1)

(ii) Mental Health

Although one participant was not sure what MH was, he referred to a healthy brain, which is thinking and acting rationally and being able to concentrate to the fullest. The other participant defined it as the process which is needed for one to be at peace with oneself and others.

“I don’t think I know what mental health is, but let me say it’s when a person is having a healthy brain, functioning well, helping to think and act rationally, by knowing exactly what one is doing, most person with healthy minds concentration is complete and that really is good.” (Interview – UNIONS 2)

“I find mental health to be a process which is complete, to enable one to be at peace with himself, co-workers and his family.” (Interview – UNIONS 1)

(b) Behaviours, reactions and coping with MI

The participants claimed that some members of both unions with MI behaved in ways which were not acceptable or seen as odd.

“I had a female member of one of our affiliate Unions, who ran into my office naked, accusing the Union representatives of conspiring with their employers to get rid of her; and others come in and start speaking to themselves.” (Interview – UNIONS 1)

“It’s going tough with some our members, they sometimes stand in front of the office or at the reception and start saying threats to kill some people, mentioning people’s names, ooh it’s scary. (Interview – UNIONS 2)

(c) Relevance of discussing MI in the workplace

The Unions were asked about whether they find MI to be a relevant subject in the workplace. The participant from Union 1 said that he sees it to be relevant, as with most other health

issues affecting many in the workplace. This participant believed that the world is changing fast, there is an increase in moral decay, and technology is taking over the work of most employees, which leads to people losing their employment, badly affecting their lives. The participant from Union 2 raised concerns about the lack of social cohesion, where people no longer interact with each other, even in families. This participant further said that these times are very difficult and that more of an effort needed to be made to look after everyone's MH, rather than just their physical health.

(d) Types of MI

The participants stated that the only mental condition they knew about was depression, as many of the union members had been diagnosed with it due to work-related stress.

(e) Causes of MI

Unresolved work-related grievances and unfair dismissal were two of the causes of MI named by one of the participants, especially among workers. The other participant said that alcohol abuse is the main cause of MI.

“The workers are mostly frustrated and stressed because of workplace disputes that take many years to be resolved.” (Interview – UNIONS 2)

(f) Disclosure of MI in the workplace

The participant from Union 2 indicated that the issue of disclosure was not something that should be treated like a question paper, where you have to give a yes or no answer. He expanded by saying that some of their members disclose their MI to the union leaders without being asked. Therefore, he feels that it should not be a big issue whether an employee discloses their MI or not, as long they can do their work. On the other hand, both participants said it would be good and beneficial for both the employee and employer if the employee disclosed their MI. By doing so, it would help with the management of any situation, especially when the employee is not feeling well in general. The thinking is that disclosure could enhance the relationship of the employee with MH with their employer and co-workers. However, one participant from Union 2 said that an adverse effect of disclosure could be that others might start rejecting and discriminating against the employee with MI if they know about it.

“So for us as a union I will say that nobody should disclose their mental illness, as that will make them more vulnerable.” (Interview – UNION 2)

(g) Legislative instruments on MH, processes and implementations

When both participants were asked about whether their unions had workplace policies addressing employees’ well-being, they said that they were not employers, but representatives of employees and do not draft policies. They only advocate and compel employers to have policies that will promote the well-being of their members in the workplace in all sectors. The participants praised Namibia for having good laws in every sector, except the one about the well-being of civil servants. They further mentioned the lack of implementation of those laws as the biggest problem in the public service. The Union 1 participant said that most of the legal documents, which are supposed to address the well-being of the employees, were either too old to speak to the current issues or they did not promote better living standards for the workers. The participants mentioned the workplace wellness policy, which had been in its initial draft form for nearly 10 years. Adding to this, they claimed that the reason this policy was taking long was due to the lack of consultation, and the government’s not understanding wellness and its lack of capacity. They said that the government might be in the process of looking for a foreign consultant to finalise the policy. One participant from the Unions said that the guidelines used by the Medical Review Board, which had caused a lot of pain for many employees, were outdated. This participant further added that the GIPF benefits guidelines, which were used to determine the monthly allowance for boarded staff members both due to disability and ill-health, were inhumane and promoted below-decent living standards with below-market-related benefits. The participants mentioned that the supervisors of most of their union members developed undesirable workplace tendencies, for example, mistreating junior staff members in their departments, and were not held accountable at all. One participant revealed that they took the government to court to challenge the constitutionality of the question on the job application form about whether a person applying for a job suffers from psychiatric problems, because it was discriminatory and not in the progressive spirit of the Constitution of Namibia. In conclusion, both participants said that affirmative action was not being used effectively to curb discrimination and to advantage employees, such as those with disability and with MI.

“Those guys at GIPF are not sensitive and follow those outdated laws which marginalise the staff who are discharged from public service like robots and they do not care about their well-being.” (Interview – UNIONS 2)

“We challenged the government for that discriminatory application for employment form and we resolved through arbitration to do away with that. To date they still didn’t do anything.” (Interview – UNIONS 1)

(h) Recommendations

The participants listed a number of recommendations, ranging from the reform of operational guides in the PSC to clear definitions of disability, wellness and ill-health. It was further stipulated that the Unions be consulted on issues regarding the public service and that there should be a way to provide equity for employees with MI through a quota system for employment. They further called upon the government to cease using foreign consultants, as there were many challenges to implementing most of the laws they made, and the laws were mostly based on their personal experiences rather the conditions on the ground. The participants lastly urged the government to do away with the question about MI in the government employment application form due to its discriminatory connotation.

4.2.5 Mental Health Association of Namibia (MHAN) - 2 FGDs

MHAN membership includes people with MI and relatives and friends of people with MI (support people). Members of MHAN with MI are employed or have lost employment due to MI. Eight participants recruited from the Mental Health Association of Namibia (MHAN) participated in the FGDs. These included five people, two of whom are currently employed in the private sector, one who had lost employment in the public sector and was currently unemployed, and two who had lost employment in the private sector due their MI. The other three participants were family members or friends of people with MI and support people who were activists in the organisation, but who did not have a MI. The support people from MHAN were instrumental to this study as they shared practical experience on what it means to have a close family member with MI or a friend with MI who has attempted to obtain employment in the public service, or to be an employee with MI in the workplace. The FGDs took place in

the same venue and at the same time for each group, with five participants with MI with the researcher in one room and the support people with the research assistant in another room.

(a) Understanding MI and MH

(i) Mental Illness

Out of the five participants with MI, three preferred to use the phrase 'mental disorder' instead of MI, as they argued that it is not an illness but rather a disorder that occasionally disables a person's mind and affects their daily functions. One participant with MI explained that it is a sickness that attacks the brain and it varies from mild to severe, while another said that it does not matter whether it is called a disorder or illness, it affects the brain and causes confusion.

"Mental illness a condition of the state of mind which can result in mental disability, it is also called the disorders. There are so many types of conditions and people react differently. "(P1 with MI; FGD – MHAN)

"Mental illness/disorder I think as by the classification is a condition that disables the mind to function normal." P2 with MI (FGD – MHAN)

"Mental illness is sickness that attacks the brain of the person, some start talking alone, others will become scared of things from their imagination and others become sad and want to kill themselves." (P3 with MI FGD – MHAN)

"While mental illness – I prefer to refer to it as mental disorder – is that condition when the mind is severely disturbed and does not operate rightly and one is disabled to carry out daily duty with ease or effectively." (P1 Support; FGD – MHAN)

(ii) Mental Health

One participant with MI expressed her disappointment that there was no information promoting MH or about what MH really is. Participants from the support group described MH as an ideal state of mind and emphasised that it is a requirement for complete health.

"Mental Health is the perfect side or the healthy outcome." (P2with MI FGD – MHAN)

“Mental health is the ideal state of mind, where everyone is mentally health and functions normal with the given parameters of his or her ability.”

(P2 Support FGD – MHAN)

“Mental health is about mental well-being and educating yourself and others about on how to keep your mind and spirit healthy and well.” (P4 with MI FGD – MHAN)

“That’s the ideal condition everyone of us is striving to see, mentally as without mental health there is no health as they always affirm in our meetings.”

(P1 Support FGD – MHAN)

(b) Behaviours, reactions and coping with MI

The participants with MI responded to the question about how a person with MI behaves or reacts, with examples such as talking alone, developing fear for no reason, having imaginary (sometimes very scary) thoughts. Three of the participants – two of the people with MI and one of the support people – said that some people with MI develop sudden suicidal thoughts.

“These disorders are caused by happenings in our lives which affect your brain – your mental states is become confused, a little out of control and not be able to take charge of what we are doing.” (P3 Support FGD – MHAN)

“I only want to emphasise that these disorders are very complicated and a person can just become afraid to go out or even having imaginary thoughts of dragons or snakes.”

(P1 with MI FGD – MHAN)

“The matrix the disorders are always being determined by many factors and that makes some people to start thinking of killing themselves.” (P2 Support FGD – MHAN)

(c) Types of MI

All five participants with MI were service users and, as part of their introduction they were requested to mention the MI they had been diagnosed with. Those mentioned included Bipolar, Schizophrenia and Anxiety. One participant from the support group had a health

background and was familiar with different MIs, while the other two participants named Schizophrenia and Bipolar as the only two disorders they knew.

(d) Causes of MI

The group attributed the causes of MI to many factors including job loss, divorce, neglect in childhood, and drug and alcohol abuse. They said that very few disorders are inherited compared to other disorders.

“Mental illness can be a result of stress, depression, constant worrying about something.” (P1 with MI FGD – MHAN)

*“It can also result from abuse in early childhood, witnessing traumatic events.”
(P3 with MI FGD – MHAN)*

(e) Treatability of MI

The participants said that there is a combination of factors which contribute to the effectiveness of any treatment, including commitment from the person with MI. One person highlighted that the effectiveness of MI treatment goes hand-in-hand with the readiness of the mind to receive treatment. A participant with MI said that sometimes doctors take too long to diagnose the right MI, prescribing many different medications, which affects treatment. It was however agreed by all participants from both groups that medications alone are not good enough; there is a need to provide both pharmacotherapy and psychotherapy as treatment for MI.

“One thing about these disorders, they are manageable when taking your medication continuously.” (P1 with MI FGD – MHAN)

“Effectiveness of any treatment needs a lot of commitment, and there are issues like the commitment to take medication well as prescribed, not using alcohol while on treatment, eating and resting well all these together will bear the good results of managing illness perfectly” (P5 with MI FGD – MHAN)

“Yes, it is treatable, depending on a combination of many things from your own understanding, your house and family, what you eat and drink and your interaction with others.” (P3 with MI FGD – MHAN)

“I think our Doctors find it difficult to get the right treatment from the beginning, as one struggles to be normal and only become used to the medication after a long period.” (P2 Support FGD – MHAN)

*“Yes, it is treatable with a combination of both Pharmacotherapy and Psychotherapy, this both need to be hand in hand for an effective treatment.”
(P1 with MI FGD – MHAN)*

(f) Disclosure of MI in the workplace

All five of the participants with MI said that they were never asked to disclose their MI, and two said they thought that it was not necessary at all. Three of the participants with MI said they had disclosed for different reasons: (i) to ensure that she continued with her treatment, (ii) for the employers to make an informed choice about whether to hire him, and (iii) for support and awareness in case she was not feeling well. The other two participants with MI and one from the support group felt that it would be ideal for everyone to declare their MH status, but the truth is that disclosure might put the people with MI in a more vulnerable position, and they may lose their employment or not be recruited at all.

“I felt the need to inform my employer just for him to know and for making a choice, whether to employ me or not based on the truth I presented.” (P 3 with MI FGD – MHAN)

*“At least just to let them know so that they can assist where they can as well as to understand him when my mood changes or when I have to go for follow ups.”
(P 2 with MI FGD – MHAN)*

“Informed for support, to call family members when need arises or to be taken to the hospital.” (P1 with MI FGD – MHAN)

“Did not inform because I was not asked to talk about my mental illness.”

(P1 with MI FGD – MHAN)

“Though it is good to disclose, it could negatively cause some rejection and the Employee might lose his/her job.” (P3 Support FGD – MHAN)

(g) The importance of joining MHAN

When asked about the importance of joining MHAN, all five participants with MI said that they had joined the association mainly to connect with people in the same situation as them and to get support, as most had been feeling lonely and rejected. They also said that they learned from the others about how to deal with their situations and to encourage one another. Two participants from the support group said that they were members of the association so that they could give moral support to their family members.

“I joined because I really wanted to understand my condition better and to connect with others in the same situation like me.” (P4 with MI FGD – MHAN)

“I have found real support and it gives me strength to have a positive outlook about life.” (P1 with MI FGD – MHAN)

“I had been very lonely until I joined the Support Group and now we are sharing problems related to mental health and that is really good.” (P5 with MI FGD – MHAN)

“I am only here to give moral support to my husband who is having a mental illness.” (P3 with MI FGD – MHAN)

(h) Legislative instruments on MH, processes and implementations

Three participants with MI and two from the support group said that they had little knowledge about the laws or policies which protect people with MI and which advance issues of MH, but they believed that such policies were important. One participant with MI mentioned that he had come to know the GIPF Act when he received a copy of it along with

a form to complete to start receiving his monthly allowance after having been medically boarded from public service. One participant from the support group informed the researchers that her workplace HR policy has a chapter on employee wellness, but nothing specific on MI. Only one participant from the support group shared that she had read a number of laws, regulations and policies on HR in the public service. She said that there was a wellness policy administered by a wellness officer, but the content was very limited to HIV/AIDS with little information on other conditions, and its implementation was not effective.

“We have an HR Policy that is more on the wellness of the employees. It is broad and it does not address anything about mental health.” (P2 with MI FGD – MHAN)

“Such policy will assist with others to understand our conditions and it might also be important in providing the needed support to the employee with mental illness.” (P1 Support FGD – MHAN)

“Yes, we have a wellness officer and an employee Wellness policy, with more information on HIV/AIDS, and a very brief chapter on more than 10 non-communicable diseases.” (P3 Support FGD – MHAN)

(i) Recommendations

The participants with MI said that one thing they had come to realise was that people lack information on MI and this why they discriminate, even in their own families. The recommendations of this group were focused on attitudes and how to create awareness among communities on issues of MI. They also spoke about how stock shortages of medications in public clinics affected them and requested assistance with a grant. The participants recommended a review of a number of legislative instruments, especially those which help to keep people with MI employed and to ensure that boarding is done in a better way.

4.2.6 Medically Boarded Staff – FGD

This group of participants was added as a FGD based on the information which was shared in previous FGDs and interviews. The participants of MHAN, and the Unions narrated about their situations and gave the researchers nine names to invite to participate in the study, but unfortunately only four were willing to participate. Their inclusion as a focus group was necessitated by the fact that they might have first-hand information on how the medical boarding process was being carried out and how it had impacted them personally. This group of service users had a number of issues in common, including the fact that they had all been discharged from public service at a young age, based on the processes in different legal documents. They had all recovered from their MI and some had been employed on temporary contracts by the same Ministry which had previously declared them unfit to work, while others were privately or self-employed. Although a FGD had already been conducted with MHAN as part of this study, not all people with MI are members of the association, another reason why this final FGD was conducted.

There were many staff members, young and old, who had been medically boarded due to MI. For this qualitative study, however, it was necessary to interview only a few people who had been medically boarded between the ages of 20 and 45 years; that is, still too young to be retired. However, due to the fact that most were unwilling to take part, we ended up with two FGDs of two participants each. One FGD was held in Windhoek with two participants, one woman and one man. The woman was currently employed as a teacher at a private school, while the man was unemployed. The other FGD was conducted in Oshakati in northern Namibia where the participants had gone on leave for festive season. The two participants were both female and had been employed as teachers on non-permanent annual contracts for 5 – 8 consecutive years with the Ministry of Education. The results that will be presented in this section are from both FGDs.

(a) Understanding MI and MH

The participants could rightly distinguish MI from MH and all could define both terms in detail. They discussed the issue of treatability, with two participants saying that MI is treatable, and the other two saying that the treatment provided is more about controlling the symptoms than treating the underlying illness.

(i) Mental Illness

The group defined MI as a condition which affects one's concentration and mind; they also said that the various disorders are different and affect people differently. It was further mentioned by one participant that with MI, the mind stops functioning in the right order and this causes fluctuations in one's moods, mentioning things such as being extremely happy for no reason. One participant defined MI as "the disease of the mind" which is a result of instability in life, and he concluded by saying that MI only occurs in the absence of MH.

"Mental illness is that time in our life, when your mind is affected, your concentration and behaviour are also affected." (P4 FGD- BOARDED)

"These illnesses are different from each other and the reaction are also different." (P1 FGD- BOARDED)

"Mental illness is the disease of the mind, caused by instability in ones live." (P3 FGD- BOARDED)

(ii) Mental Health

A participant in this group responded that MH is a term which refers to both MI and MH, and it entails prevention, diagnosis and treatment of MI. MH is thus seen as a necessary effort to keep the mind healthy. Others defined MH as a healthy mind which operates effectively and helps one to become more productive. They also emphasised that MH is a needed cornerstone to a healthy being.

"Mental health is a good term as it talks on both those who are sick and those who are healthy. Even Ward Sixteen, their stamp changed from Psychiatric Hospital to Mental Health Centre." (P4 FGD- BOARDED)

"Mental health is the mental health that everyone should have and it can be attained if mental illness is prevented via awareness and education, if those who are sick are given the necessary support and treatment." (P1 FGD- BOARDED)

"In the instance of mental health it's when your mind is healthy." (P2 FGD- BOARDED)

“I think, my colleague from my Ministry actually provided a more comprehensive definition, I know that the one is the absence of the other.” (P3 FGD- BOARDED)

(b) Types of MI

Three of the four participants knew how people who are affected by MI react during an episode, but could only name depression, anxiety and Bipolar as disorders. One of the participants only knew about the symptoms of her mood disorder, but did not know what it was called as she was not interested in knowing.

“I didn’t even read anything about my condition, all I know is that my condition is to do with moods swings, moving to the extremes when it occurs, like being over excited for no reason.” (P2 FGD- BOARDED)

“This led me to be diagnosed with severe depression and anxiety.” (P1 FGD- BOARDED)

“I have been boarded for 7 years and I am suffering from Bipolar disorder.” (P4 FGD- BOARDED)

(c) Causes of MI

Two participants responded that alcohol abuse, drug abuse and life events that leave one confused could cause MI in many people. The other two participants shared that they did not have general knowledge about the causes of MI, but from their personal experience, rejection and emotional abuse were the main causes.

“The use of substance and drugs and happenings that leave you confused, like being dropped by someone you love or a death of a loved one.” (P4 FGD- BOARDED)

“I was infertile, I couldn’t get children after nine years of marriage and mocking, abuse both verbal physical had been my daily order from my husband and the community. This led me to be diagnosed with severe depression and anxiety.” (P1 FGD- BOARDED)

(d) Behaviours, reactions and coping with MI

Participants responded differently to knowing that they were suffering from MI and had different coping mechanisms. One participant took time to understand the condition and to

see how she could live positively with the illness, while another said she had not yet accepted the disorder and was still in denial. The others explained that knowing that one is suffering from MI is devastating in itself, and learning to live with the illness is more difficult when one is discriminated against and labelled. These are two of the most painful reactions from those close to one, which make regaining a healthy mind more difficult.

“Really, I think I didn’t come to term with my condition, like this madam here, I think I am in denial.” (P2 FGD- BOARDED)

“Discrimination and labelling from family and friends are too painful and can stop one from accepting and coping with your illness.” (P1 FGD- BOARDED)

(e) Treatability of MI

On the question of the treatability of MI, there were a number of thoughts and explanations, with one being that it was very difficult to say whether a treatment was working. One participant believed that treatment was more effective when both pharmacotherapy and psychotherapy were combined from the onset, in addition to a very positive attitude. Another one felt that MI was not treatable, and all that medication did was control people and make them drowsy. The same participant further said that treatment could make people very dependent on the medicine as without it, one would always still feel sick. There was one participant who believed that MI is treatable with a positive mind. The concluding message from this group is that MI treatment is not about curing but rather managing the illness.

“As that term treatability, one cannot say with certainty whether the treatment is effective or not. Maybe one can say that it’s treatable, when you have an aggressive intervention from the beginning, like psychotherapy and pharmacotherapy from the onset.” (P3 FGD- BOARDED)

“You become addictive, I think that is not the right word to use, but more zombie type of life. You can’t be normal if you don’t take pills, you become very dependent on the treatment.” (P2 FGD- BOARDED)

“Yes, it is treatable, but it also need that positive mindset of the patient too.” (P4 FGD-BOARDED)

“I don’t know what you mean by treatable, all I know is with medication it is manageable, talking for myself as I have been managing my condition very well for the last six years, by taking my medication regularly.” (P1 FGD- BOARDED)

(f) Disclosure of MI in the workplace

The participants identified three aspects which are fundamental to the disclosure of MI in the workplace: (i) the willingness of people with MI to open up about their illness, (ii) to whom they are willing to disclose and (iii) the barriers that make it difficult for people to disclose their MI, especially in the workplace. This last aspect seems to be the most complex one.

(i) Willingness to disclose

The participants all expressed that they were willing to open up to people close to them about their MI, although not all of them had disclosed it. They also all agreed that it is not easy unless the one with MI understands the illness themselves and is ready to reach out a hand for support, which in most cases helps them to cope with the illness. Despite this understanding, one of the participants said that she did not tell anyone about her condition as there was so much negativity around the issue of MI and thus she was afraid of being called names. Another participant said that it was a milestone for him to disclose his MI as it had made it easy for people to understand him when he was not well and to ease the burden of the illness on him when he talked to them.

(ii) Barriers towards disclosure

The barriers to disclosure mentioned by the participants were stigma and discrimination. One participant revealed that she had lost most of her friends and loved ones after disclosing her MI to them. Another participant compared the stigma of having a MI to that of having HIV, saying that the reactions one receives from people who know that you have a certain MI are similar with HIV. The other participant believed that incorrect perceptions and misunderstandings of MI cause people with MI to be looked at like monsters and therefore lead to the inhumane treatment of people with MI in general. All four participants agreed that they did not have the desire to disclose their MI in the workplace; one termed doing so

as “digging their own grave”, saying that one’s illness would be used against them as a reason not to employ them or to get rid of them. The group further said that, if a situation dictated that disclosure was necessary, the employee with MI would need time to do so systematically based on the relationships they would have built.

“There is so many issues, the first and the biggest one is the red ribbon attached to mental illness, you know is like have HIV in those days.” (P4 FGD- BOARDED)

“Stigma and discrimination are the foundation of rejection of us, people with mental illness.” (P1 FGD- BOARDED)

“Many people have a wrong perception and lack of understanding about my condition, make people even your own family make you feel worthless, some will act time you are a monster, the whispering everywhere you are moving and really a lot of inhuman treatment.” (P3 FGD- BOARDED)

“I am NOT talking about hearsay things I have been there. I lost friends, lovers, brothers and co-workers, just by virtue that I am suffering from MI.” (P1 FGD- BOARDED)

“That’s digging your own grave, your condition will be as evidence against yourself, the day you do that, expect to exit that institution in the nearest future.” (P2 FGD- BOARDED)

(g) Mental health legislative instruments, processes and implementation in the workplace

Two members of the group said that they only knew about the draft workplace wellness policy. One had seen it on the table of her HR officer’s office, while the other one had received a copy when staff members were asked for input. The participant who got a copy recommended that MH issues be included in the policy but did not know whether this had been done. Another participant said he had never seen the wellness policy, but knew that the rules clearly stipulated the process of dealing with staff members with various sorts of illnesses, including MI. Two participants could link the staff rules to the MRB Guidelines and the GIPF Act. However, they claimed that the processes were not followed strictly and there

was an aspect of “selective morality” in the implementation of these rules, guidelines and laws. All the participants pointed out that there were many discrepancies when it came to the way different ministries dealt with their employees who they recommended for boarding, despite using the same documents. One participant expressed her disappointment in the way people with MI were treated when they were looking for clarity on the way they were being discharged from public service. One participant, who got work in a private institution after being boarded by the government, said that she had been appointed as the employee wellness focal person and that she was going to draft a policy for her institution.

“I don’t have any idea, even if there is anything, is maybe at the HR or at the head office. Not at our level, really.” (P1 FGD- BOARDED)

“The wellness policy she’s talking about is news to me, the only documents that my lawyer got was the staff rules, guidelines used for the medical review and GIPF Act. In the Staff rules and the Medical review guideline there a lot of diseases listed there, for consideration for boarding, referral for medical assessment and mental illness is listed there.” (P2 FGD- BOARDED)

“I got a copy of the Employee wellness draft policy for my input, but what I am telling is it overloaded by sport and HIV activities. Those I recommended mental health to be included, I am not sure whether it’s there.” (P4 FGD- BOARDED)

“I was appointed to be the focal person of employee well-being, and I am busy drafting a wellness policy that will look to the holistic well-being of the employees.” (P3 FGD- BOARDED)

(h) Recommendations

The group had a number of recommendations, ranging from law reform in terms of the processes and implementation of the laws to the attitudes of the HR staff in most of the Ministries. The participants called for policy reform so as to have firm guidelines, to address important issues around employee well-being, and to maintain consistency and a firm sequence in the processes leading to boarding. They further requested for the law to include the consideration of the permanent re-appointment of staff members with MI who have

recovered. Removing the question about MI from the criminal record questions on the employment application form was also suggested. They ended by pleading to those in society who do not have MI to understand them and to treat them with dignity, and for HR Officers to be in much less of a hurry to recommend them for boarding.

4.3 Synthesis of findings

4.3.1 Understanding of Mental Illness and Mental Health

The responses in this section lead to the conclusion that participants had diverse levels of understanding of MH and MI. All participants had a general understanding of MI, with very few who admitted not having any knowledge of what MH is. A number of HR officials, the participants from MHAN and the Boarded staff had better insight of what MI and MH is, as they could mention the types of MI with their causes and how one behaves when diagnosed with a specific MI. The other participants however could only mention how people with MI behave and what signs can lead to a person being identified as having a MI, but could not name any type of MI. The issue of treatability of MI was also described differently by the different participants. The participants with MI were speaking from their personal experiences, while others were speaking from their observation of what they had seen.

4.3.2 Disclosure of mental illness in the workplace (P74)

All participants agreed that disclosing MI in general is not easy and believed it could be even more difficult when one has to do it at the workplace. They said this is due to the discrimination, stigma and labelling surrounding MI. Five of the participants with MI said they disclosed their MI status to their employers, as it could give them a peace of mind and relieve them from the burden on their minds before disclosing. However, that disclosure was used against them, making them more vulnerable, with two even losing their employment. All participants agreed that it should be a personal decision when, how and to whom they disclose their MI.

4.3.3 Legislative instruments on mental health, processes, and implementations

Throughout the study, the issue of laws, their implementation and the impact made can be seen as a key factor in determining how MI is managed in the workplace. Three key points emerged.

First, the knowledge of the policies used and how they are aligned with the MH Policy differs as a high number of government officials had a good understanding of these policies, while only half of the participants with MI were familiar with the relevant policies.

Second, in terms of the strategies applied in implementing the policy, including plans, participants from the HR, MRB and PSC groups indicated that there are no clear guidelines designed for employees with MI. There are however ones used for sickness and boarding on account of ill-health. They further outlined the inconsistencies which they experience in different Ministries when dealing with cases of employees with MI. The MRB participant expressed the difficulties in following the GIPF rules in the process of medical boarding due to the fact that they are outdated.

Third, in terms of implementation and evaluation of the policy, such as the oversight, supervision and enforcement of the policy, all participants agreed that the fact that laws do not specifically address the issue of MI, indicates that there is a need for such laws to be reviewed. The participants from HR, MRB and PSC groups, agreed that most of the cases they are dealing with are for medical boarding due to MI, but without a specific law, they use personal discretions and emotional consideration as human beings.

4.3.4 Management of mental illness

This question was only asked as an additional prompting for the PSC group to get an understanding of their roles in managing MI. The information provided by the participants suggests that their role is to consider recommendations made especially on whether processes have been followed and whether the staff member should be referred for a medical assessment or not. It came out clearly that the PSC does not deal directly with staff members, but through their HR in the different Ministries. The PSC participants recommended training for all including themselves. The group could not provide any information on the management aspect, due to lack of knowledge.

4.3.5 Recommendations

The recommendations from all the groups are similar and directly speak to the laws and the attitude of the officials and the employees with MI. The participants from the Public Service, Human Resource and Medical Review Board mostly highlighted issues of a legislative nature which are hampering effective ways of addressing the issue of mental health in workplace. These groups also recognized that a number of them lack information which is necessary for them to be able to manage these cases, especially when files are presented with specific recommendations. All participants admitted that there is a certain level of discrimination against employees with MI and therefore recommended that this should be addressed through a number of measures including laws and programmes. There is an overwhelming call for wellness programmes to be well structured and to set up, in a central office. The recommendations from the Unions, MHAN and Boarded staff also call for the review of some laws and highlighted the need to address the way HR officers are treating employees with MI.

4.4. Conclusion

The result presented in this chapter form the basis of the discussion in the next chapter. The document review opened up an opportunity for a better understanding of laws which serve as guidelines for addressing the operation and other related issues in the Namibian Public Service. The information provided by the participants gives a broader perspective on how the participants understand, view and experience issues of MI and MH, the laws and policies relating to this, and, importantly, what they think should be done to address any gaps or shortfalls in addressing MI and MH issues in the workplace

CHAPTER 5: DISCUSSIONS

5.1 INTRODUCTION

The purpose of this chapter is to discuss the findings presented in the previous chapter and how they address the objectives of the study as listed below:

1. To review the national policies that govern the human resources management within the public sector, and any policies specifically addressing MH at a national level
2. To explore the understanding of MI and perceptions of how it is managed within the public sector in Namibia from the following stakeholders:
 - Human resources practitioners
 - Public service commissioners
 - Medical review board members
 - Trade unions
3. To obtain information on the experiences of and perspectives on how MH is addressed from people with MI and their support people

This section presents and compares the main findings from the objectives to regional and international literature, policies and practices. This will be followed by a review of the limitations of the study and will be rounded off by a conclusion and recommendations.

5.2 DOCUMENT REVIEW

The results from the review of the five documents identified a number of issues. These are as follows: (i) outlining provisions which deals with MI and MH, (ii) Identifying possible alignments in the two Acts and rules, bench marking from other countries, and (iii) the Mental Health Policy as an important document in advancing MH issues in any Acts, rules or policy.

5.2.1 Outlining provisions which deal with mental illness and mental health

The provisions in the four documents speak to illnesses, disability and health in general. The Public Service rules only refer to the boarding on account of 'ill-health', while the GIPF rules stipulate that an employee can be boarded due to illness or disability. The link between the processes of the two sets of rules is that the Public Service Rules set out the initial process of boarding and the GIPF rules guide the boarding and post-boarding processes. It is however

not clear how the disability issue is taken care of in the Public Service Rules, as there is no mention of it beyond giving it as a reason for boarding. There is no specific mention of MI in either set of documents. The GIPF rules mentioned a number of cognitive and central nervous system disorders which are organic and irreversible in nature. However, these are mentioned only as a reason for not reducing the disability benefit. Staff with these conditions are permanently boarded when they become permanently disabled to the extent that they can no longer pursue their own or a similar occupation. The lack of any mention of other mental or substance use disorders that affect Public Service staff is noteworthy as these are known to result in significant disability and cost to the Public Service and affected individuals (Carson et al.,2011).

5.2.2 How the Acts, Rules and Mental Health Policy align with each other

The two Acts are different from each other in terms of content and their mandates and operations, while the Mental Health Policy is more of a guiding document which promotes MH more generally in all government programmes. The Mental Health Policy further provides principles that guide the drafting of laws that promote the employment of people with MI. The Public Service Act and its rules outline the processes in the recruitment, retaining employment and termination of employment in general, and the MH Act provides a framework for how this can be achieved for people with MI specifically. However, the participants said that the MH Policy in Namibia has not been used or implemented to achieve those provisions which would go some way to ensuring that people with MI are employed, or they retain their employment and process of the termination of employment. As a benchmark from other countries, the Canadian government had taken a deliberate action to reform its laws, to create a conducive environment for people with MI, including legal and policy initiatives to address psychosocial hazards (which include the protection of workers with MI) and putting in place the legal framework and promotion of support in the process of returning to work of people with MH problems (Lippel, 2011). This reform is in line with the World Health Organization's (2013) Global Plan of Action on Worker's Health as endorsed by the World Health Assembly, which resolved that the assessment and management of health risks at the workplace should be improved in order to create better working environments for people with MI. Both the Public Service Act and rules and Pension Act with the GIPF rules lack

any information about an assessment for mental ill-health and its related disability. This is in part because a staff member with MI's readiness or ability to work cannot be made solely on the basis of a medical diagnosis – it requires a broader assessment of functioning. Such practices by the Namibian public service (or lack of these) may have led to the exclusion of people with MI from work, who experience psychosocial disability, but who are capable of working, thus turning their impairment into a more severe experience of disability (Van Niekerk, 2020).

While it is important to have an assessment process for anyone being recommended for medical boarding, it is also important to recognise that a person with MI's work ability is not dependent only on their impairment. The context of the workplace is also crucial to assess as to its contribution to facilitating or hindering a person's continuing employment (Van Niekerk, 2020). It is important that boarding should be the last option, after all interventions have been exhausted. Therefore, Mokoka and colleagues (2012) recommend a number of interventions, such as vocational rehabilitation services, as a way to retain occupational capital and prevent repeated absenteeism, and highlight the benefits of a supervised and mentored work rehabilitation programme, the return of employees to their duties in a graded gradual way, and that occupational therapists could be the most appropriate professionals to assist in such programmes.

5.2.3 The Mental Health Policy as an important document in advancing mental health (MH) issues.

The Mental Health Policy of Namibia is well drafted and highlights emerging themes in the development of a better workplace for all including people with MI. This document provides a solid foundation on which a number of laws could be drafted or reformed in order to address the disparities which exist in dealing with MI in the workplace in Namibia. As set out in the document review in Chapter 4, there are five important issues this policy identified and which could transform the way people with MI illness are treated in any workplace, not only in the public service and they are as follows: (i) addressing major challenges facing people with MI; (ii) the importance of having a clear strategy on promoting mental health in the workplace; (iii) the importance of protecting human rights of people with MI; (iv) strategies for managing people with MI in the workplace; and (v) proposes a multi-sectoral coordinating structure for effective advocacy and management of MH issues.

1. Addressing major challenges facing people with MI in general is not only a problem within Namibia, but is a global concern. The challenges include developing strategies to promote the mental wellbeing of the whole population, to prevent mental health problems and to provide treatment and care that support the recovery of people with MI (WHO – Europe 2005).
2. Promoting mental health in the workplace is in line with WHO guidelines which outline a comprehensive process which addresses not only the needs of individuals, but also assesses the MH of the organization, to reduce absenteeism, improve wellbeing and increase productivity (WHO, 2000).
3. The emphasis on protecting the rights of people with MI is paramount when ensuring access to equal opportunities, with mental health being part of those human rights (Asabne et al.,2018). The report reviewing evidence on different types of human rights violations experienced by people with mental and psychosocial disabilities in LMICs identified discrimination at all stages of the employment process as one of the main kinds of human rights violations. Such violations occurred frequently and had the highest impact. One example given was that people with mental and psychosocial disabilities tend to be underpaid and overworked (Drew et al., 2011)
4. Strategies for managing the needs of people with MI in the workplace is described in the Mental Health Policy of Namibia but is not implemented in any institutions in Namibia as yet. It is reported that in order to improve MH in the workplace, guides which identify ways on how to promote MH should be developed and the following should be include in these guide; (i) how progress will be monitored, (ii) ways to acknowledge efforts made, and (iii) ensuring that people in authority understand the need for these programmes (Goetzal et al, 2018).
5. The Namibia Mental Health Policy proposes a multi-sectoral coordinating structure for effective advocacy and management of MH issues, but this structure has not yet been formed. This study anticipates that the establishment of this coordinating body in Namibia will bring a new dimension to the management of MH by effectively identifying relevant opportunities and gaps. Through this process a National Mental Health strategy (NMHS), like the one developed in Ethiopia, might become a reality. The Ethiopian NMHS places integrated care at its centre, by training required staff to upgrade their skills in identifying and treating people with MI. It also coordinates and

acknowledges efforts of other key players like NGO's and traditional healers (Fedaku & Thornicroft, 2014). A structure that is comprised of different stakeholders like the Ethiopian NMHS would be an effective tool to advance the management and promotion of mental health in the workplace.

5.3 FINDINGS ON THE PARTICIPANTS PERCEPCTIVES FROM THE INTERVIEWS AND FOCUS GROUP DISCUSSIONS

The main findings of this study highlight the following themes: limited knowledge of MI, poor legislation, issues around the disclosure of MI, boarding on account of MI and confusion between MI and disability, generally and more specifically in the assessment process for medical boarding.

5.3.1 Limited knowledge of mental illness (MI)

The study identified that all participants had limited knowledge about MI, although they provided a number of anecdotes on how they would recognise people with MI, which included the types of behaviour of those affected and how people around them react to their behaviours. The meaning of MI, as described by participants, is summed up in the statement that "the state of the mind is not well" with participants naming a number of factors contributing to the instability of the mind. The different groups of participants had different levels of understanding. The participants from the Mental Health Association of Namibia (MHAN), some from the HR representatives and the participants boarded due to MI responded to this question with ease and with examples from their personal experience of what MI is. They could mention the different types of disorders by names and explained how those who are suffering from a certain MI behave and could link symptoms to a specific MI. The MHAN and the medically-boarded participants also had personal experiences to share on how they had felt when they were in the acute stages of MI and how they felt when on treatment. The HR group participants gave examples from their experiences in dealing with the staff members with mental illness, while the PSC group participants had no or few practical encounters with people with MI and gave theoretical responses from textbook knowledge. This was despite one of the PSC participants narrating her journey with depression.

The findings reflect those from another study that showed the lack of knowledge on MI to be 15 – 20 times greater if a manager had not had contact with a person with MI (Brayn et al.,2018). Both Union participants explained MI by describing the awkward actions exhibited by people with MI, such as people speaking to themselves and presenting scary facial expressions, and related these to relevant cases they had contact with in their work. There were two participants one from HR group and another from the PSC who used derogatory and mocking phrases such as “madness” and coming from the “groendakkies” (Green Roofs) referring to the mental illness and the mental health center respectively. Such terminology is recognized as being outdated and stigmatizing (Hanish et al.,2017).

The question of treatability of mental illness generated much debate in all groups, There seems to be a difference of opinion on treatability even within the MHAN and the medically-boarded participant groups. The difference of thought was also observed between the people with MI, within both MHAN and the medically-boarded groups. Some of the participants said that MI is treatable by taking medication, while others said the medication taken is more about controlling the symptoms, compared to other treatments like anti-hypertensive and other treatments for chronic diseases, which seemed to be understood by the participants as addressing these latter conditions directly rather than just treating symptoms. A further view was that the most effective treatment is a combination of medication and psychotherapy, a view reflected in the literature Mintz (2006).

The study participants mentioned the employee Wellness Policy which had been in the drafting phase for nearly eight years at the time of data collection. The policy was to become the legal guideline which could assist HR Officials with the management of MI in the workplace. The Mental Health Policy strategy is to ensure that all legislation and programmes dealing with MH are aligned and finalizing the wellness policy with that understanding would be beneficial. This will address the concern raised by a number of participants that the current situation leaves it to individual ministries to decide how to manage employees with MI. These decisions are often made without having the required knowledge as described by some of the HR participants. These participants said this makes it difficult for them to deal with the people with MI effectively.

In a review of studies looking at the effect of positive psychology interventions conducted in the workplace revealed that “positive psychology interventions seem to be a promising tool for enhancing employee well-being and performance. As a side-effect, positive psychology

interventions also tend to diminish stress and burnout and to a lesser extent depression and anxiety” (Meyer et al.,2013).

The overarching finding is that the participants from the Unions, HR and PSC reflected on their lack of knowledge on MI and repeatedly expressed the appreciation for the study and called for training on MI. Heinrich and colleagues (2015) show that training on MI will significantly improve mental health literacy and reduce stigma. They however emphasised that the training should not only be theoretical, but should include extensive interaction with those employees with MI (Heinrich et al.,2015).

The ability of participants to define mental health was very limited, with some participants saying they were hearing the phrase for the first time in the discussion group and guessed its meaning. Those who had heard the term before could not define it, but mostly referred to the desired or positive outcome of the interventions or treatment for MI. Participant from MHAN, both those with MI and the support people, appreciated the change of names from ‘psychiatric hospitals and clinics’ to MH care facilities’.

5.3.2 Poor legislation

Only one participant from the MHAN support group mentioned anything with regard to the National MH Policy. However, the rest of the participants with MI and all other groups discussed other laws in the Public Service which affect how people with MI are being recruited and retained in employment.

It was evident from the participants that they are well-versed with the necessary legal instruments guiding the Public Service in processes and management issues regarding staff members. The study identified five important legal instruments. The Public Service Act and its rules are administered through the office of Prime Minister, who is the head of government and under which the Public Service Commission (PSC) and all ministries operate. What was apparent from the brief document review was that these laws are outdated and do not reflect current understandings of disability, and other HR dynamics, like recruiting and retaining people with MI and other disabilities employed. Outdated legislation tends to perpetuate attitudes of people with MI as charity objects and as dangerous, enhance stigmatization and promote unwarranted criticism towards them (Murthy, 2010).

From the discussions with HR practitioners it is clear that there are laws and policies that have been in drafting status for nearly 10 years. Two such policies are the Employee Wellness Policy (mentioned above) and the Mental Health Act that has been in the review process for the last

eight years. Merhej (2019) attributes such delays from her experience in India to the lack of commitment by those in power to ensuring the protection of human rights by putting in place mechanisms which will enable them to control and monitor any violation of the rights of people with MI. Fox and Korris (2006) argue that there are a number of factors that contribute to these delays, such as the amount of legislation required or elements to be included in the each piece of legislation, the need to meet quality standards for good interpretation and implementation, and the perception that such legislation is very complex. The other issue raised by participants was about laws being coordinated and administered by different entities, which makes it difficult to create synergy. This lack of coordination is not unique to Namibia, as many laws and policies tend to be overlapping or have delineated roles which sometimes make it difficult for co-operation among different entities dealing with a specific issue (Ndua, 2018). In the delineation process an institution is assigned certain roles as per the governing laws which gives it a sole mandate on the specific issue. An example is the delineated role of the GIPF to determine the condition on which people would be medically boarded and their benefits after being boarded. Adding to this, the participants reported that some laws are not complementary to each other and the implementation in each Ministry is different and thus very inconsistent.

5.3.3. Disclosure of mental illness

Whether an employee with MI should disclose his/her MI or not elicited different responses, highlighting three aspects which are fundamental to disclosure: (i) willingness to disclose, (ii) readiness to disclose and (iii) identifying to whom to disclose. Each of these is discussed followed by a summary of advantages and disadvantages of disclosure.

(a) Willingness to disclose

The responses showed that there were a number of participants who indicated a willingness to disclose for one or other reason. One participant with MI from MHAN group said she was already on treatment, when she started working and she disclosed in confidence to her supervisor, as she would have to go for follow up appointments every month. Another participant with MI from the same group said that he saw it necessary to disclose, for the employers to make an informed choice whether to employ him or not, knowing his MI. This

willingness to disclose is supported by the analysis of Rüsç and colleagues (2012), which confirms that people with stress and behavioural related disorders have good intentions and are mostly willing to disclose and to seek treatment.

The participants from MHAN with MI, including two of the medically boarded participants, expressed that from their experience they were willing to open up to people close to them about their MI, though not all of them had disclosed. When those with MI who had not disclosed, responded to why they did not disclose the reasons ranged from stigma and discrimination, being afraid of rejection by family and friends through to saying that disclosing at work is like “digging your own grave”, as this will cause them to lose their employment. Stuart (2006) supports this when saying that employees with MH problems will go to extra lengths to ensure that co-workers and managers do not find out about their MI, even avoiding assistance programme and shunning effective treatment options (Stuart,2006). All participants agreed that it is not easy to disclose, unless the person with MI understands the illness themselves and is ready to ask for support, which can help them to cope with the illness. This sentiment is supported by Rüsç (2011) who emphasized that willingness to disclose one’s MI is associated with a better understanding of the MI by the person with MI.

(b) Readiness to disclose and barriers to disclosure

The readiness to disclose a MI was determined by two factors according to the participants. First it was the way society views MI as a moral and cultural taboo according to some participants in the PSC group. The second is how MI is viewed in relation to employment in institutions such as government ones. Stigma and discrimination arising from social and cultural understandings of MI were reported in all groups as key barriers to disclosure. The disclosure or non-disclosure process is complex, and the outcome is influenced by many factors, most of which cannot be influenced by the individual with MI (Brouwer et al.,2020), as reflected by what the participants experienced after they disclosed the MI status. One participant disclosed her MI for her own good as she was supposed to be visiting the doctor often for her treatment and that disclosure made it easy for her as the employer understood her situation and was able render necessary support for her not to miss her routine visits and treatment. Two medically-boarded participants said that their disclosure made one to lose most of her friends and the other to be faced with stigmatization, and they felt that having MI is worse than being HIV positive.

On the institutional side, one issue mentioned by a number of participants was the government employment application form. This form does not request information about MI within the general health section but asks about it in the same section as having any criminal offences. This form, therefore, suggests that MI is in the same category as having a criminal record, thus creating a barrier to disclosure. The form is not only gives MI a criminal connotation, but is an explicitly discriminatory tool, which does not give non-disclosure as an option. A recent European longitudinal study on attitudes toward disclosure in employers showed that 42% of employers agreed that a mental policy was a positive step, but, due to the fear of perceived public stigma, employees will default to a position of non-disclosure (Stratton et al., 2018).

(c) Identifying whom to disclose to

The responses to the question on whom to disclose to were different for the different groups. The HR and the Union participants highlighted incidents of their personal encounters with people with MI during the recruitment or while in employment or even after being discharged from the service. The MHAN and the medically boarded participants spoke from their personal experiences, while the PSC group participants had little experience on the issue of disclosure. However, all participants said disclosure could be good and beneficial for both the employee and employer. By doing that it will help with the management of any situation, especially when the staff member is not feeling well. Participants expressed that disclosure could enhance the relationship of the staff member with MI with their employer and co-workers. However, a study conducted by Boehm and partners (2018) concluded that relationship quality and concrete leadership behaviour of co-workers are essential in encouraging people to disclose their MI to them. The participants from MHAN and medically boarded participants felt that it could be good to disclose to someone the employee with MI is comfortable with, like a supervisor. This is confirmed in Jones (2011) findings on disclosure characteristics in identifying the disclosure recipients, where 63% of the employees preferred to disclose to their supervisors, compared to 37% who preferred to disclose to co-workers. Giving another dimension to this argument is a study by Pandya and colleagues (2011) who reported that 45% of employees who disclosed their MI to their supervisors did not see any difference in the treatment after disclosure, while 34% reported that the way they were treated after disclosure worsened, 18% said that they were treated better than before and

3% were unable to express their experience. In the same study, 52% of the employees who disclosed to a co-worker reported no changes in the way the colleagues treated them after disclosure, 35% felt they had been treated worse and only 13% felt they had been better treated (Pandya et al,2011).

(d) Advantages and Disadvantages of Disclosure

Despite the fact that disclosure might be seen to be a positive initiative from the employee, there could be a number of both negative and positive outcomes of this gesture. An advantage, as some participants said, is that it could make it easy for people to understand the MI, to render support when the employee with MI is not well and to lessen burden of the illness on them by sharing their experience with others. It can create an opportunity for the employer to put systems in place to enhance promotion of mental health in the workplace.

There could equally be a number of disadvantages, such as fear of name calling, inhumane treatment, or loss of employment due to the negativity around MI, manifested as stigma and discrimination. The study findings are supported by those from the focus group study conducted by Brouwers et al (2020) concerning (dis-)advantages of disclosure. They identified four themes as advantages (improved relationships, authenticity, work environment support, friendly culture) and two as disadvantages (discrimination and stigma).

5.3.4 Boarding on the grounds of mental illness

The study found a number of discrepancies in the process of boarding of employees on medical grounds, especially on grounds of MI. The only process the participants mentioned starts with the recommendation for one to be assessed for MI and then depending on the outcome, the staff will be boarded or declared fit to remain employed. The process requires no representation by the staff member being assessed, either personally or through the Unions and is mostly handled by the MRB.

The study found that MI as a reason for assessment represents nearly a quarter of all medical boarding applications (20 - 25 in every 100 applications received). The participant from the MRB described two possible outcomes or reasons for applying for boarding – ill-health or disability. While there are no clear specifications on the conditions for early retirement of a staff due to ill-health, the classification of diseases and illness that is used to determine eligibility for pension due to disability include both mental and physical illness with no

mention of functional components to the assessment for eligibility. There are regulations making provision for extended sick leave for a maximum 12 months, but a few participants said that some illnesses need a rehabilitation period that is longer than that. Another issue raised was that there are guidelines that make provisions for reassessment and appeals but with no provisions for a reversal of disability decision. This suggests that a person's disability status can never change to one of 'being employable' which contradicts the understanding of disability as an interaction of the person's illness (such as MI) with the context in which they work and live. It is essential that employees with MI maintain employment through a conscious and active process from both the person and the organisational structures (Ditton, 2012). Lack of specialized services to enable better management of the boarding process from the PSC was highlighted by three of the PSC group participants. The process could be enriched by adopting a recovery-oriented approach, and facilitating people to actively identify, choose and use their own strategies to maintain employment with occupational therapists forming a key role in facilitating this (Ditton, 2012).

5.3.5 Confusion between mental illness and disability

The issue of disability was repeatedly mentioned by participants, especially in relation to the medical boarding of staff with MI. Most of the participants, especially from the HR group, used the words mental illness, sickness and disability interchangeably when explaining a number of procedures and processes, highlighting the problems in understanding and defining disability noted by Chaudhury and colleagues (2006). As briefly described in Chapter 2, disability is the outcome of the interaction between a person with a health condition (MI in this case) and the content in which the person lives (e.g. the workplace with outdated rules and regulations, stigma and lack of knowledge on MI) as set out in the ICF (World Health Organization, 2001). Sartorius and colleagues (2006) highlighted this in their analysis where they propose that the MI should not be the criterion for assessing a person but rather their ability to function. Norstedt (2019) concludes that people with hidden disabilities have unique concerns not experienced by individuals with recognizable disabilities. People with MI often do not have visible signs of their disability. The interchangeable use of 'illness' with 'disability' as reported by many participants and the equating of having an illness (e.g. listed as liver, kidney and other disorders in the regulations) as not being able to function in the workplace is problematic and outdated in the way that disability is understood.

5.4 PERTINENT ISSUES FROM THE DOCUMENT REVIEW AND QUALITATIVE FINDINGS

A number of issues raised by participants from the different groups has related to the provisions in the documents reviewed. Many of these issues are also cross-cutting and need an approach which will tackle this in a harmonious manner. Combining the major findings and summing up the pertinent issues identified in the document review the following are the major issues identified:

- Lack of acknowledgement of MI in the workplace in the two Acts and two sets of rules; outdated terminology and approaches to managing MI in the workplace
- The Mental Health Act no.13 of 1975 has been reviewed, but not finalized with amendments. Therefore, the delays in revising this Act will hamper any effort to align all necessary provisions dependent on the Mental Health Act in other related Acts and policies;
- The content of the documents is reflected in the inconsistent and at times unclear application of the rules and regulations as expressed by the public service participants and negative experiences described by the MHAN participants and medically boarded participants.
- Synergy between the findings in the document review and the experiences described by participants confirms the urgent need to revise the documents and implement clear strategies for managing mental health, wellness and mental illness in the workplace including application of current understandings of illness, disability, functioning and the rights of persons with MI.

5.5 LIMITATIONS

Although the inclusion criteria required HR staff to have worked at least for one year in their position, those who had worked for a shorter time (e.g. two years versus the 40 years of others) had not necessarily had occasion to manage a person with MI in their context. They were more limited in their ability to respond to the questions.

The interviews of the PSC participants, which were changed to a FGD attended by both Commissioners and Staff (following the request from the PSC), raised issues which had never

been discussed in any of their institutional platforms before. This had the effect of prolonging the discussion and creating a bit of tension between participants. This was managed by emphasizing the objectives of the study. This highlighted the importance of addressing the issue of MI in the workplace and importance of taking this process further within government and parliamentary structures.

Given the qualitative and more exploratory nature of the study, the focus was on hearing from relevant stakeholders. However, the range of stakeholders that could be included at this stage was limited by the size of the study. The next step is to do more in-depth research within different Ministries using more action-research approach where participants start working on addressing the issue as part of the research process.

A further limitation is that the study did not differentiate between common and severe mental disorders (CMDs vs SMDs). Reference was made to depression and work-related stress and anxiety as well as severe mental illnesses such as schizophrenia and bipolar without looking at the differences in experiences. While this is a limitation, it did provide a strong sense of the experiences of people with any MI in the workplace. Further research can attempt to differentiate more clearly between these two types of MI.

5.6 DISSEMINATION PLANS

The report will be presented to the Public Services Commissioners at a debriefing session. The summary of the findings will be published in the local newspapers, using the social columns, as it is published free of charge and it is aimed for educational purposes. The findings will be written up for publication in relevant academic journals.

As a parliamentarian, the researcher will also use her position to start looking at potential avenues for revising the relevant policies, acts and rules to ensure they reflect current understanding of disability and mental illness and best approaches for managing MI in the workplace. She will also be in a position to alert Parliament's oversight structures to the lack of implementation of the Mental Health Policy.

5.7 RECOMMENDATIONS

A number of recommendations were made by the participants of the different groups. These recommendations are cross-cutting and many will be addressed when the Mental Health

Policy is fully implemented. There are however recommendations on issues which are not reflected in the Mental Health Policy, but specific to individual structures. These are as follows:

- The Public Service and Government of Namibia
 - Training should be set up for HR focal people in MH or to have a person with medical background or a medical doctor in the Public Service and be located in the PSC Offices, who will deal with all issues to with staff members with MI in government. As suggested above, this recommendation should include the development of a team of people including not only a medical doctor but also at least an occupational therapist.
 - There is a need for awareness training of all personnel working with people with MI including having a social worker in the workplace who will provide support and counselling to those with mental illness to help them live positively with the illness, like for HIV.
 - In order to avoid fragmented care for employees, the HIV units existing in many ministries could be transformed and capacitated to deal more generally with employees' welfare including MH.
 - HR departments are overloaded and are not the right place to situate the welfare of the staff members.
 - The Public Service application for employment form must be revised so that the disclosure of MI is not placed in the same section as the declaration of any criminal records. This was seen as highly discriminatory by participants and the suggestion is that it be moved to the health section.

- Research
 - More research must be conducted in various ministries to underpin the factors affecting the mental health of employees, such as causing excessive anxiety through work-related stress or exacerbating an existing mental illness, especially for those ministries which are referring many employees for assessment due to MI.

- Civil society organisations such as MHAN:

- There is a need to establish more organisations which will create awareness and educate the community and family members about MH and how to treat and support the people with MI.

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5.8 CONCLUSION

This study explored the processes, management and legal provisions on how MI is being addressed in the Namibian Public Service. In order to understand this, the study conducted interviews and FGDs with selected participants within the public service, members of the association for people with MI and their support people, unions representing employees in the public service and participants who were medically boarded due to MI. The study further reviewed five documents dealing with processes of recruiting people in the public service and laws which guide the assessment of employees before being medically boarded and determining their benefits after been boarded. The Mental Health Policy was also reviewed, as a document which outline issues which are important in promoting MH in the country. The findings of this study are clustered in three components: (i) legislative aspects which show that there are weak and outdated laws addressing MI in the workplace and a lack of implementation of the Mental Health Policy which is promoting MH, (ii) limited knowledge in terms of understanding MI and the difference between MI and disability, and (iii) the absence of a clear process on how to deal and manage employees with MI.

It is worth noting, however, that throughout the study there were exciting and enlightening information which resulted in mixture of positive and negative feelings. The appreciation for such a discussion by all participants was overwhelming and very humbling. As per discussions, this was a land mark study in the most least spoken about area of MI. Due to the structure and focus of the study, many participants were left with more information which they desired to share. It is, however, important to note that when comparing this study with available all over the world, especially from the African continent, little to no studies have been conducted on MI in the workplace and little effort had been put in place to address and enhance the employability and retaining of employment by people with MI. The researcher will hold a post - research briefing with all stakeholders to present the findings and discuss the way forward on addressing some immediate findings of the study. The researcher will further share the

recommendations for reform of laws, and structural and administrative issues with relevant authorities.

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APPENDIX A: MINISTRIES OF THE REPUBLIC OF NAMIBIA

	NAME AT THE FORMATION IN 1990	YEAR OF FORMATION	CHANGES EFFECTED AND THE YEAR	CURRENT NAME OF THE MINISTRY
1	Agriculture, Fisheries, Water and Rural Development	1990	Fisheries was moved and Rural Development was taken to Local government 2005	Ministry of Agriculture
2	Mines and Energy	1990		Mines and Energy
3	Foreign Affairs	1990		International Relations and Cooperation
4	Defence	1990		Defence
5	Local Government and Housing	1990	Rural Development was added 2005	Urban and Rural Development
6	Wildlife and Tourism	1990	Forestry was added 2005 Forestry was moved to Agriculture 2005	Environment and Tourism
7	Justice	1990		Justice
8	Labour and Man Power	1990	Social grants payouts division was added from Health 2005	Labour, Industrial Relations and Employment Creation
9	Health and Social Services	1990	Rehabilitation was added	Health and Social Services
10	Lands, Resettlement and Rehabilitation	1990	Rehabilitation was moved to Health	Land Reform

11	Works, Transport and Communication	1990	Communication was moved to information	Works and Transport
12	Trade and Industry	1990		Industrialization, Trade and SME Development
13	Education	1990	Arts and Culture was added 1995, removed in 2000 and added again in 2015	Education, Arts and Culture
14	Finance	1990		Finance
15	Information and Broadcasting	1990	Communication was added	Information and Communication Technology
16		1990	Police and Correctional Service were moved to a new Ministry in 2000	Home Affairs and Immigration
17		1995	Became a Ministry in 2015	National and Economic Planning
18		2000	The Ministry was dissolved in 2000 and reformed 2015	Higher Education, Training and Innovation
19		2015		Poverty Eradication and Social Welfare
20		2000	Separated from Home Affairs	Safety and Security
21		2000		Gender Equality and Child Welfare
22		1995		Fisheries and Marine Resources
23		1995		Sport Youth and National Service
24		2015		Public Enterprises

1 -16 Are the Ministries which have been in existence since independence and only some of the functions were moved or added and 17- 24 These are those Ministries that was formed later, ranging from (1995 -2015)

APPENDIX B: CONSENT FORM

TITLE OF RESEARCH PROJECT: MENTAL HEALTH IN THE WORKPLACE: EXPLORING HOW MENTAL ILLNESS IS ADDRESSED IN THE NAMIBIAN PUBLIC SERVICE.

Dear Mr/Mrs/Miss/Ms/Dr _____

PURPOSE OF THE STUDY: This study will explore how mental health and mental illness is understood and addressed in human resources policies, processes and procedures and mental health programs in the Public Service.

RESEARCH PROCESS: I will collect data from 33 participants the Public Service Commission (3), Workers Union Representatives (6), 16 selected Ministries, and 8 from members of the Mental Health Association of Namibia (MHAN).

NOTIFICATION: All interviews will be audio recorded to ensure that valuable information gathered during the interviews is captured and the context of the information can be reviewed in detail. Following the interview, the recorded material will be transcribed.

CONFIDENTIALITY: The information and opinions provided by the focus group and individual interview participants are viewed as strictly confidential, and only members of the research team will have access to the information. All focus group participants will be requested to keep the information of the group confidential. No data published in dissertations and journals will contain any information through which any participants might be identified. Your anonymity is therefore ensured.

WITHDRAWAL CLAUSE: You may withdraw from the interview or focus group at any time and withdrawal from or refusal to participate in the study will not have any negative impact on you or your work.

POTENTIAL BENEFITS OF THE STUDY: While there will be no direct benefit to you, the recommendations made in this study will be shared with policy makers to advocate for possible law reforms and improved implementation plans to manage mental illness in the workplace. It will further ensure coherence in both the laws and programs and prompt for mechanisms which will monitor the implementation of these policies and programs in the public service.

INFORMATION: If you have any questions concerning the study, you should contact the supervisor A/Prof Marguerite Schneider at the Alan J Flisher Centre for Public Mental Health, University of Cape Town, Tel:+2721 4066308; marguerite.schneider@uct.ac.za or the Prof Marc Blockman, chairperson of the University of Cape Town Human Research Ethics Committee at Tel: +27 21 406 6338 or marc.blockman@uct.ac.za

CONSENT:

I, the undersigned (full name) have read the above information relating to the project and have also heard the verbal version, and declare that I understand it. I have been afforded the opportunity to discuss relevant aspects of the project with the project leader, and hereby declare that I agree voluntarily to participate in the research. I further give consent that the Researchers should record my voice and all information I am sharing, solely for this research purpose.

I have received a signed copy of this consent form.

Signature of participant:

Signed at on

WITNESSES

1

2

APPENDIX C: QUESTION GUIDES

QUESTION GUIDE FOR THE FOCUS GROUPS – HR/PSC/MRB

1. Institution:
2. Position/ Capacity:
3. Age:
4. Sex:
5. Duration serving in the position:
6. What do you think is meant by Mental Health and Mental Illness?
7. Is mental health treatable according to your knowledge?
8. Do you have staff members who reported to your department about suffering from any mental illness when recruited or during the time that they are employed with your Ministry?
9. What do you think is keeping people away from informing the employers about their mental illness

Present Jack Case Study by reading it to the participants

10. Can anybody indicate whether the case sound familiar or you dealt with a similar case like that before?

11. What could you have done differently?
12. What could have guided you to deal with it in a different manner?
13. Do you have a workplace mental health policy or any guiding document in your Ministry? Please Elaborate!
14. What does your Employee Wellness entail?
15. Any recommendation for future consideration for issue of mental illness in the workplace

QUESTION GUIDE FOR THE FOCUS GROUPS – MHAN/BOARDED STAFF

1. Position/ Capacity:
2. Age:
3. Sex:
4. Member Since:
5. Why did you become a member of MHAN?
6. What do you think is meant by Mental Health and Mental Illness?
7. Is mental health treatable according to your knowledge?

Present Jack Case Study by reading it to the participants

8. Can anybody indicate whether this case study sound familiar or any of you ever been in Jack position.
9. What could have been done differently in Jack Case!
10. Who of you ever declared his mental illness to a colleague or an employer?
11. If any of you did, why did you? If not, why not
12. Does your work place have a mental health policy, an Employee Wellness programme, or any programme. What does it entail?

13. Any recommendation for future consideration for issue of mental illness in the workplace

INTERVIEW QUESTIONNAIRE - UNIONS

1. Institution:
2. Position/ Capacity:
3. Age:
4. Sex:
5. Duration serving in the position:
6. What is your understanding about Mental Health and Mental illness?
7. What is your personal view on the relevancy of these two concepts?
8. Do you know anybody suffering from mental illness, name the disorder, please?
9. Do you think that an employee with mental illness can be productive?
10. Do you have Human Resource Policy/ any other addressing mental illness in the workplace?
11. How are you ensuring the implementation of the policy to address mental illness?
12. Do you have other supporting initiative for employees with mental illness apart from the policy?
13. Any recommendations that will enhance the capacity of employees with mental illness to divulge their conditions and to remain in the employment?

APPENDIX D: ETHICS APPROVAL



FHS016: Annual Progress Report / Renewal

HREC office use only (FWA00001637; IRB00001938)			
This serves as notification of annual approval, including any documentation described below.			
<input checked="" type="checkbox"/> Approved	Annual progress report	Approved until/next renewal date	30/08/2020
<input type="checkbox"/> Not approved	See attached comments		
Signature Chairperson of the HREC			Date Signed 21/2/2019

Comments to PI from the HREC

Principal Investigator to complete the following:

1. Protocol Information

Date (when submitting this form)	16 August 2019		
HREC REF Number	277/2018	Current Ethics Approval was granted until	30/08/2019
Protocol title	MENTAL HEALTH IN THE WORKPLACE: EXPLORING HOW MENTAL HEALTH IS BEING ADDRESSED IN THE NAMIBIAN PUBLIC SERVICE		
Protocol number (if applicable)			
Are there any sub-studies linked to this study?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> 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.			
Principal Investigator	A/Prof Marguerite Schneider		
Department / Office Internal Mail Address	Alan J Filsher Centre for Public Mental Health, RMH Campus, 46 Sawkins Rd, Rondebosch		

1.1 Does this protocol receive US Federal funding?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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