Mental health policy development and implementation in South Africa: a situation analysis

Phase 1. Country Report

Crick Lund
Sharon Kleintjes
Victoria Campbell-Hall
Sithembile Mjadu
Inge Petersen
Arvin Bhana
Ritsuko Kakuma
Beauty Mlanjeni
Philippa Bird
Nathalie Drew
Edwige Faydi
Michelle Funk
Andrew Green
Mayeh Omar
Alan J. Flisher

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Executive Summary

Introduction

There is growing recognition that mental health is a crucial public health and development issue in South Africa. Neuropsychiatric conditions are ranked 3rd in their contribution to the burden of disease, after HIV/AIDS and other infectious diseases. For the first time a major representative epidemiological study has revealed that some 16.5% of South Africans suffered from common mental disorders (depression, anxiety and somatoform disorders) in the last year. This figure does not include schizophrenia and bipolar mood disorder, which place an additional burden. A review of existing studies revealed that about the same proportion (17%) of children and adolescents suffer from mental disorders. There is no evidence that there are any differences between socially defined racial groups or cultural groups in the prevalence of mental disorders.

In South Africa these patterns are exacerbated by the history of violence, exclusion and racial discrimination under apartheid and colonialism. The trauma and abuses meted out during the apartheid era have been well documented in the findings of the Truth and Reconciliation Commission (TRC), as have the effects of these acts on the mental health of victims. There is also emerging evidence that mental ill-health is strongly associated with poverty and many aspects of social deprivation associated with poverty.

Although mental ill-health imposes a significant burden, there is good evidence that a range of clinical, social and economic interventions can have a positive benefit for the mental health of our communities. Depression can be effectively treated with low-cost antidepressants or psychotherapy; antipsychotic drugs are cost effective interventions for people with schizophrenia; hazardous alcohol abuse can be effectively dealt with by providing brief interventions by trained primary care workers; and for adults and children with chronic mental disabilities, community-based rehabilitative models provide low-cost care.

Yet mental health is not given the priority it deserves. The aim of this study is to examine mental health policy and systems in South Africa, with a view to identifying the key barriers to mental health policy development and implementation, and steps that can be taken to strengthen the mental health system in the country. This study forms part of a broader international mental health research consortium based in Ghana, South Africa, Uganda and Zambia, which aims to investigate the policy level interventions that are required to break the vicious cycle of poverty and mental ill-health, in order to generate lessons for a range of low- and middle-income countries.

Methodology

The study made use of quantitative and qualitative methodologies. Quantitative methods were employed to assess current mental health resources and service utilisation. Qualitative methods were employed to provide an understanding of the processes, underlying issues and interactions between key stakeholders in mental health policy development and implementation.

Quantitative instruments included:

- o World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2
- o The WHO Mental Health Policy and Plan Checklist
- o The WHO Mental Health Legislation Checklist

Qualitative instruments included:

- o Semi-structured interviews conducted at the national and provincial level
- o Semi-structured interviews and focus group discussions conducted at the district level

The fieldwork for the study was conducted between 1 August 2006 and 31 March 2007.

Results

1. General contextual issues

Based on interviews with a wide range of stakeholders in South Africa, the study results indicate that there is inadequate public awareness of mental health, and limited knowledge about the causes of mental illness. Partly as a result, mental health is given low priority on national and provincial policy agendas, across a range of sectors. There is also evidence of a vicious cycle of poverty and mental ill-health, which is poorly understood and inadequately addressed in policy or service delivery. Stigma plays a key role in maintaining this state of affairs. Interviewees emphasised the importance of increasing participation of mental health care users in policy making, and providing support for families of people with mental health problems.

2. Mental health policy development

The Department of Health has not formally adopted and implemented a national mental health policy. Instead, a set of national "policy guidelines" were developed and approved in 1997. A chapter on mental health was also included in the influential "White paper for the transformation of the health system in South Africa", adopted in 1997. The translation of these policy guidelines into provincial mental health policies and plans has not be been consistent, with only 4 of the 9 provinces taking this step. The general policy making process in South Africa reflects our current historical context and the desire by the ANC government to maximise policy reform and improve service delivery to redress the injustices of the past. What is of interest from a mental health perspective is that the official process of policy making for mental health does not differ significantly from any other aspect of health policy development in South Africa. Instead the crucial difference appears to lie in insufficient political will to develop and implement a policy for mental health, particularly at the provincial level.

Since 1997, the national Department of Health has devoted energy and resources to the development, adoption and subsequent implementation of the Mental Health

Care Act (2002). It appears, from a number of respondents, that the new legislation is currently driving service reforms at provincial and district level. The Mental Health Care Act (2002) is consistent with international human rights standards, and is based on a thorough consultation process with a range of stakeholders. As a key instrument of reform (such as the development of mental health care within general health services and the facilitation of community-based care), the Act appears to be a highly appropriate and important milestone in the development of the mental health system in South Africa.

3. Mental health policy implementation and service delivery

In spite of its many positive features, the Mental Health Care Act in itself does not to appear to be adequate to bring about major reforms that are needed to the mental health system in South Africa. As a result there are major limitations to policy implementation. Among the most striking findings regarding policy implementation and current service provision in South Africa are the following:

1. There is wide variation between provinces in the availability of service resources for mental health. This includes human resources, facilities, budgets and information on current service provision. For example, the number of psychiatrists varies from 1 psychiatrist per 5,000,000 people (in North West) to 1 psychiatrist per 111,111 people (in the Western Cape) – a 45 fold difference.
2. There is generally a lack of accurate routinely collected data regarding mental health service provision. The result is that information on current service resources (budgets, staff, facilities) and provision (admissions, outpatient visits) is extremely sparse. If data are collected they are seldom made available, and if they are made available, they are seldom reported on systematically and used for planning.
3. Mental health services continue to labour under the legacy of colonial mental health systems, with heavy reliance on mental hospitals. There are 23 mental hospitals in the country, and 56% of mental health beds are located in these facilities. This is an outdated form of care, which is vulnerable to human rights abuses and stigmatisation of service users. There is an urgent need to develop community-based mental health services (which include community-based residential care, day services and outpatient services), in keeping with international best practice, before further deinstitutionalisation occurs.
4. Some progress has been made with the integration of mental health into general health care. Reforms that have occurred have been driven to a large extent by the Mental Health Care Act. For example, according to Department of Health officials, there are 131 district hospitals, 28 secondary hospitals, 14 tertiary hospitals (comprising 53% of all hospitals) that have been listed to provide 72 hour assessments of psychiatric emergency cases, in keeping with the provisions of the Act. However, there remain major concerns about the capacity of staff and facilities to provide adequate mental health care in these hospitals. There is also a need to extend the integration of mental health into primary health care clinics at the district level.
5. There is therefore an urgent need for mental health training of general health staff and public sector staff in a range of other sectors (such as education, social development, criminal justice, housing and employment). Evidence

from this report indicates that while some training does occur, it is frequently not monitored and evaluated, and where training of PHC staff takes place, it is not supported by ongoing supervision and the establishment of referral pathways to and from specialist mental health care. Although an Essential Drugs List (EDL) has been adopted for psychotropic medications in all provinces, there is currently a lack of clinical protocols at PHC level and standardised mental health training for health care providers.

6. There is some evidence of the establishment of consumer and family associations, often with the support of NGOs, such as the SA Federation for Mental Health, but the role of these associations in the formulation of policy and planning of services is limited. The national Department of Health does collaborate with the SA Federation for Mental Health, but currently this is the only national mental health NGO, and provincial level collaboration is variable.

7. Some important steps have been taken towards inter-sectoral collaboration, particularly at the national level. However, at the district level, and in many provinces, such inter-sectoral collaborations are the exception rather than the rule.

8. At the District level, it would appear that the focus of decentralization and integration of mental health care into primary health care remains on the emergency management and ongoing psychopharmacological care of patients with chronic stabilized mental disorders. While this is an understandable starting point, South Africa, as a middle income country 13 years into its democracy, should now strive towards increasing coverage and access of mental health care to all who need it – as set out in the 1997 White Paper. Decentralized psychopharmacological management of people with chronic mental health problems needs to be accompanied by community-based rehabilitation programmes for de-institionalization to be successful. Shifting the burden of psychosocial care for these patients to the community without supportive programmes is irresponsible and could result in the violation of human rights.

The wide variation in resources between (and within) provinces appears to be at least partially symptomatic of the lack of clear national mental health policy. Without clear imperatives from the national Department of Health, provincial Departments are free to address mental health according to their own priorities. This results in inconsistent approaches to resource allocation, inconsistent data collection, lack of standardisation of the training of primary health care staff in mental health, and a lack of formalised inter-sectoral collaboration with other Departments and stakeholders.

Discussion and Conclusion

Thirteen years after the first democratic election in South Africa, steady progress has been made regarding overall legislative and policy reform. There is now a need to step up implementation of the legislation, to adopt a national mental health policy and to translate policy into service delivery aimed at addressing key developmental priorities such as poverty, unemployment, social supports, HIV/AIDS, and crime and violence. Mental health is a crucial issue that is embedded in many of these challenges.

Strengths and Weaknesses of the Mental Health System in South Africa

There are several strengths in the South African mental health system. The mental health legislation has recently been reformed, with the promulgation of the Mental Health Care Act (2002), which is in keeping with international human rights standards. Many of the reforms currently being implemented in the country, such as the introduction of Mental Health Review Boards in all provinces, and the establishment of 72 hour assessment facilities in District general hospitals, appear to be driven by the new Mental Health Care Act. Compared to many other African countries, South Africa has relatively well resourced mental health services, including human resources, facilities and available psychotropic medications. Unlike many other African countries, a basic level of free emergency psychiatric services are provided, and disability grants are available for people with mental disabilities.

In spite of these strengths, there remain several weaknesses in the current system. These are:

1. The absence of an officially endorsed mental health policy, which provides the vision and overall national leadership for developing the mental health system.
2. The inadequacy of provincial plans and budgets to implement national mental health policy and legislation.
3. The lack of adequately trained staff to provide mental health services.
4. The lack of nationally agreed indicators for mental health information systems.
5. The limited scope of community-based mental health services and the continued dominance of mental hospitals as a mode of care.
6. The inadequacy of treatment protocols, referral pathways and standardised evidence-based training in mental health for general health staff.
7. The limited nature of inter-sectoral collaboration to address mental health.
8. The weak role of service users in mental health policy, planning and service development.

Steps that need to be taken to strengthen the Mental Health System and promote mental health

The next steps that need to be taken to strengthen the mental health system and promote mental health follow logically from the weaknesses identified above. These are:

1. Develop a national mental health policy, through a thorough process of consultation and consensus building with a range of stakeholders throughout the country. Guidelines on the process of developing such a policy are available from WHO: http://www.who.int/mental_health/policy/en/.
2. Develop provincial strategic plans for mental health, in keeping with national policy and legislation, which outline specific strategies, targets, timelines, budgets and indicators.
3. Develop a national mental health information system, integrated with the district health management information system, based on a set of nationally agreed indicators and a minimum data set. These information systems should be linked to and enable the evaluation of national policy and legislation implementation.

4. Develop guidelines for safe and effective mental health services within regional and district hospitals.
5. Build community mental health services that include three core components:
    a. Community residential care
    b. Day services
    c. Outpatient services (combining general health outpatient services in PHC and specialist mental health services).

    These community mental health services need to be developed before further downscaling of mental hospitals can proceed.
6. At district level:
    a. Conduct and evaluate mental health training programmes for general health staff at PHC level.
    b. Develop specialist mental health teams to support PHC staff.
    c. Develop clinical protocols for assessment and interventions at PHC level.
    d. Strengthen the role of consumer and family associations in policy development and implementation, as well as the planning and monitoring of services.
    e. Develop mechanisms for intersectoral collaboration between a range of sectors involved in mental health.
7. Develop a national mental health research agenda, based on identified priority areas.
8. Lobby for political support for mental health on the public agenda.
9. Conduct public education regarding mental health, developing positive and realistic images of mental health, promoting role models and influential champions for mental health to change discriminatory attitudes toward mental disability.
10. Emphasise the poverty-mental health link on the policy agenda, in order to inform wider social, economic and development policies. This implies that mental health should be a consideration in wider economic and social upliftment strategies in the country.
11. Develop a mental health user lobby for public participation in mental health issues, that is owned and driven by mental health service users.

To enable many of these recommendations, it is essential to train and build capacity for staff in the national Directorate: Mental Health and Substance Abuse, and the provincial mental health coordinators in policy development, planning, service monitoring and interpretation of research findings.

1. Introduction

There is growing recognition that mental health is a crucial public health and development issue in South Africa. Latest reviews of disease burden in this country rank neuropsychiatric conditions 3rd in their contribution to the burden of disease, after HIV/AIDS and other infectious diseases (Bradshaw et al., 2007). For the first time a major representative epidemiological study has revealed that some 16.5% of South Africans report having suffered from common mental disorders in the last year (Williams et al., 2007). This figure does not include schizophrenia and bipolar mood disorder. Furthermore, a review of existing studies revealed that about the same proportion of children and adolescents suffer from mental disorders (Kleintjes et al., 2006). There is no evidence that there were any differences between socially defined racial groups or cultural groups in the prevalence of mental disorders (Kleintjes et al., 2006; Williams et al., 2007).

The substantial burden of mental disorders is by no means unique to South Africa. In the year 2000, it was estimated that mental disorders contributed 12% of the global burden of disease and it is predicted that this will rise to 15% by the year 2020. Currently mental disorders make up 5 of the 10 leading causes of health disability, and by 2020 it is predicted that unipolar depression will be the second most disabling health condition in the world (Lopez et al., 2006). It is estimated that 1 in 4 people suffer from a diagnosable mental disorder during the course of their lifetime (WHO, 2004).

There is also emerging evidence from low and middle income countries that mental ill-health is strongly associated with poverty and many aspects of social deprivation associated with poverty (Flisher et al., 2007; Lund et al., 2007a). Mental ill-health is associated with food insecurity (Patel et al., 1997), inadequate housing (Araya et al., 2003; Reichenheim & Harpham, 1991), unemployment (Abas & Broadhead, 1997; Araya et al., 2001; Inandi et al., 2002), low levels of education (Araya et al., 2003), social fragmentation (Harpham et al., 2004) and violence (including domestic violence) (Harpham et al., 2005; Fleitlich & Goodman, 2001; Seedat et al., 2004; Stein et al., 2002; Ward et al., 2001). Indeed researchers have described the interaction of poverty and mental ill-health as a "vicious cycle" in which the conditions of poverty lead to high levels of stress, social exclusion, reduced access to social capital, malnutrition, obstetric risks, increased risk of violence, and thereby to increased prevalence and worse outcomes for mental disorders (Patel, 2001). In turn, mental ill-health leads to increased health expenditure, reduced productivity, job loss, and social drift into poverty (Saraceno et al., 2005).

In South Africa these patterns are exacerbated by the history of violence, exclusion and racial discrimination under apartheid and colonialism. The trauma and abuses meted out during the apartheid era have been well documented in the findings of the Truth and Reconciliation Commission (TRC) (Truth and Reconciliation Commission, 2000), as have the effects of these acts on the mental health of victims (Kaminer et al., 2001; Stein, 1998).

More recently, in spite of the political freedoms and human rights advances brought about by a new democratically elected government in 1994, there has been a growing trend of economic inequality, poverty and unemployment which has marked the social, economic and political landscape in South Africa. Between 1996 and 2001, the percentage of the population living below the $2 per day poverty line increased from 26% to 28% (an increase that was more prominent among African-headed households) (Bhorat & Kanbur, 2005). Income inequality has increased, with the Gini coefficient rising from 0.68 to 0.73 between 1996 and 2001 (Bhorat & Kanbur, 2005), a trend noted in several other middle-income countries (World Bank, 2007). Apart from other negative consequences, this trend is of particular concern from a mental health perspective, as national levels of economic inequality have been shown to be associated with higher rates of mental disorder (Pickett et al., 2006).

In spite of these disturbing trends and the growing burden of mental ill-health, there are encouraging signs that cost-effective interventions are available. During the last 40 years, anti-psychotic medications have revolutionised the care and treatment of people with schizophrenia and bipolar mood disorder, in a way that allows most people with these conditions to live relatively normal lives in the community (WHO, 2001). Cost-effective generic medications are now available for people suffering from common mental disorders such as depression and anxiety (Patel et al., 2003; Patel et al., 2004). Depression can be effectively treated with low-cost antidepressants or psychotherapy; antipsychotic drugs are cost effective interventions for people with schizophrenia; hazardous alcohol abuse can be effectively dealt with by providing brief interventions by trained primary care workers; and for adults and children with chronic mental disabilities, community–based rehabilitative models provide low-cost care (Patel et al., 2007a). Advances in a range of psychosocial interventions have been made and documented (WHO, 2001). Although many of these psychosocial interventions have been developed in western settings, several have been adapted and found to be effective in Africa and in many low- and middle-income countries (Bolton et al., 2003; Siskind et al., 2007; Patel et al., 2007a). The development of psycho-social rehabilitation (PSR) provides new directions for recovery, empowerment and re-integration into communities after periods of mental illness (WHO, 1996).

Beyond the clinical realm, there is emerging evidence that wider social and economic interventions can have a positive benefit for the mental health of communities. For example, the introduction of pensions in the Langeberg was shown to reduce levels of depression in households where pensioners resided (Case, 2004). Internationally, welfare benefits have been shown to reduce rates of common mental disorder among recipients (Plagerson et al., 2007). Participants in a micro-credit scheme in Bangladesh have shown reduced rates of emotional stress among women following 7 years of participation in this scheme, compared to non-participants (Ahmed et al., 2001). Education has shown a strong dose-response relationship in reducing rates of common mental disorders in low and middle-income countries (LMICs) (Araya et al., 2003).

In spite of all the emerging evidence of interventions that could enable us to address mental health systematically in this country, mental health is not given the priority that it deserves. We do not currently have a mental health policy in South Africa, and

budget allocations to service provision at provincial level are inconsistent and inadequate (Jacob et al., 2007). Many services continue to labour under institutional patterns of care, when international trends are towards the downscaling of psychiatric institutions and the provision of community-based mental health services (Geller, 2000; Thornicroft & Tansella, 1999). Where deinstitutionalisation has occurred in South Africa, it has been introduced as a cost-saving device, and has not been accompanied by the adequate development of community-based services (Lund et al., 2002). This leads to a "revolving door" pattern of care in which service users are discharged from hospitals but soon re-admitted because adequate services are not in place to support them in the community (Lund & Flisher, 2003). Services for children and adolescents are even less available than those for adults (Dawes et al., 2004). There are encouraging signs of change in South Africa, with the introduction of the new Mental Health Care Act (2002), which is based on internationally endorsed human rights principles. But concerns remain about the resources and political will within provincial health departments to implement the Act (Lund et al., 2007b).

In conclusion, we know that there is a major burden that is attributable to mental ill-health in South Africa. We also know that there are cost-effective interventions to address this burden. And yet policy development remains weak, with a consequent inadequate implemention of plans, and where there are reforms (such as the new Mental Health Care Act), there is a lack of political will and resources to implement these reforms at provincial and district levels.

This leads us to certain key research questions: What is the process of mental health policy making in South Africa? What is the substance of mental health policy and what status does it enjoy? How much of a priority is mental health for the South African government? What are the processes of implementing mental health policy and legislation? How successful are these processes at national, provincial and district level? What is the current situation regarding mental health service provision at provincial and district levels? What is the opinion of a range of key stakeholders in mental health regarding mental health priorities and current policy?

The **aims of this research** are therefore:

- o   to describe and understand the broad context in which MH policy-making takes place in South Africa,
- o   to understand the general situation regarding mental health needs and priorities,
- o   to assess the wider policy-making practices in the public sector,
- o   to describe and analyse the development of mental health policies and mental health law,
- o   to assess the appropriateness of the mental health policies and mental health law, including the involvement of stakeholders and their influence on the formulation of mental health policies and mental health law,
- o   to assess the current practices of implementing mental health policies and law at national and provincial level, and
- o   to assess the implementation of the mental health policy and law at district level.

The remaining chapters of this report will set out the methodology, results, discussion and conclusions of the study.

This research is conducted in the context of a wider international study of mental health policy development and implementation in 4 African countries: Ghana, South Africa, Uganda and Zambia (Flisher et al., 2007). This study, titled the Mental Health and Poverty Project (MHAPP), sets out to investigate the policy level interventions that are required to break the vicious cycle of poverty and mental ill-health, in order to generate lessons for a range of low- and middle-income countries. This report presents the findings of the first phase of the study, namely a situation analysis of mental health policy development and implementation in South Africa. The findings of this first phase will be used to inform a set of interventions, developed in partnership with the national Directorate: Mental Health and Substance Abuse in the Department of Health. The interventions conducted in the second phase will set out to address particular barriers to the successful development and implementation of mental health policy in this country. These interventions will be documented and evaluated, with a view to generating lessons that may be of value for future work in this country and in other low- and middle-income countries.

Summary: Introduction

- A representative epidemiological study has revealed that some 16.5% of South Africans report having suffered from common mental disorders in the last year. About the same proportion of children and adolescents suffer from mental disorders.
- There is evidence from developing countries that mental ill-health is strongly associated with poverty and many aspects of social deprivation associated with poverty. In South Africa these patterns are exacerbated by the history of violence, exclusion and racial discrimination under apartheid and colonialism.
- National levels of economic inequality have been shown to be associated with higher rates of mental disorder. In SA, the percentage of the population living below the $2 per day poverty line increased from 26% to 28% (an increase that was more prominent among African-headed households) between 1996 and 2001.
- In spite of all the emerging evidence of interventions that could enable us to address mental health systematically in this country, mental health is not given the priority that it deserves in South Africa.
- As part of a wider international study of mental health policy development and implementation in 4 African countries, this report presents the findings of the first phase of the study, namely a situation analysis of mental health policy development and implementation in South Africa.

2. Methodology

2.1 Introduction

The study makes use of quantitative and qualitative methodologies. Quantitative methods were employed to assess current mental health resources (such as budgets, beds, staff) and service utilisation. Qualitative methods were employed to provide an understanding of the processes, underlying issues and interactions between key stakeholders in mental health policy development and implementation. Findings were triangulated where possible, using two or more sources of data or research methods.

The fieldwork for the study was conducted between 1 August 2006 and 31 March 2007. Analysis and writing up was conducted from 1 April – 30 September 2007.

In developing the methodology for this study, a conceptual framework for understanding mental health policy development and implementation was formulated by the research team (Figure 1) (Flisher et al., 2007). This framework was used to guide our analysis of mental health policy development and implementation in South Africa, the data sources we explored and the stakeholders we interviewed.

In the development of policy, it is critical to align the policy with the mental health needs, context and particular health system of that specific country. By mental health policy we mean an organised set of values, principles, objectives and areas for action to improve the mental health of a population (WHO, 2005b). The likelihood of the policy being appropriate and feasible will depend on the processes by which it was developed and in particular, the extent to which it has included key stakeholders within this process (Walt & Gilson, 1994). It will also depend on the degree to which the policy is evidence-based.

In the implementation of policy, the existence of an appropriate policy may be a necessary condition for improved services, but is, of course, not sufficient. Three barriers to the effective implementation of policies are commonly experienced. Firstly, the policy itself may be too general and not be turned into a strategic plan or programme. Secondly, the appropriate health system may not be in place to support the policy. The third key constraint can be, at best, a lack of support for, or at worst, resistance to, the policy and programme at the implementation level. Such a lack of ownership may be experienced from a number of groups including professional groups, health service managers, service users or the wider community, partly due to the stigma often associated with mental illness.

Mental health is the product of a number of determinants, which may have their origins beyond the formally designated health sector. Hence there is a need for a multi-sectoral approach to both policy development and implementation. The Ministry of Health needs to take the lead in adopting a multi-sectoral approach and developing appropriate tools and relationships for working with district health systems and with non-governmental and private providers.

Figure 1. Framework for Mental Health Policy-Making (Flisher et al., 2007)

C O N T E X T

STAKEHOLDERS
Ministry of Health
Other Govt departments e.g.
education, housing etc.
NGOs e.g. users and families
Donors
Professionals

POLICY DEVELOPMENT
- Needs assessment
- Consultation & negotiation
- Assessment of options

EVIDENCE
- HMIS
- Research
- International experience

MENTAL HEALTH POLICIES, LEGISLATION

Other sectoral policies with MH implications

Health Sector MH policies

STRATEGIC PLANS AND PROGRAMMES

Other Sectors (Education, Justice, Employment, Social Services, Housing, others)

Health Sector

OWNERSHIP

PROVISION OF APPROPRIATE SERVICES AND INTERVENTIONS:
- Public providers
- Private providers
- Professional NGOs and Traditional Health Workers
- Family, Mutual Aid Groups, others

SYSTEMS

Level
National
Province
District

- Resource generation and allocation
- Infrastructure
- Monitoring / Supervision
- Referrals
- Coordination
- Governance/ Decentralisation

Global/regional trends and policies

Political environment

Socio-economic status (including level of poverty)

Cultural norms (including gender – related issues, stigma, etc)

General Population (promotion)

People at Risk (prevention)

People with Mental Disorders (treatment & rehabilitation)

LEGEND:

┌ ─ ─ ┐ Policy development

┌ ─ ┐ Policy Implementation

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2.2 WHO AIMS

Quantitative data regarding the mental health system in South Africa was gathered using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2 (WHO, 2005c). The WHO-AIMS tool has been developed to assess key components of a mental health system and thereby provide essential information to strengthen mental health systems. The instrument was developed following the publication of the World Health Report 2001 (WHO, 2001), which focused on mental health, and provided a set of recommendations. These recommendations address essential aspects of mental health system development in resource-poor settings. For each recommendation (domain of interest), items were generated and grouped together in a number of facets (subdomains). WHO-AIMS 1.1 consisted of 10 domains covering each of the 10 recommendations. In 2004, the pilot instrument was tested in Albania, Barbados, Ecuador, India, Kenya, Latvia, Moldova, Pakistan, Senegal, Sri Lanka, Tunisia and Viet Nam. The instrument was used in Albania to develop a plan to implement mental health services reform. The main conclusion from the pilot test was that the instrument is highly useful because it is comprehensive and collects key information that is useful for action. However, the length of the pilot instrument was a barrier to its use. Consequently, the pilot instrument was substantially revised and shortened. WHO-AIMS 2.2 consists of 6 domains (covering the 10 World Health Report 2001 recommendations comprising 28 facets and 156 items). The 6 domains are interdependent, conceptually interlinked, and somewhat overlapping. All 6 domains need to be assessed to form a relatively complete picture of a mental health system. The domains include:

- Domain 1: Policy and legislative framework
- Domain 2: Mental health services
- Domain 3: Mental health in primary care
- Domain 4: Human resources
- Domain 5: Public education and links with other sectors
- Domain 6: Monitoring and research

The instrument includes the WHO-AIMS Excel Data Entry Programme and a template for a narrative report.

2.2.1 Sample and procedure

The WHO AIMS spreadsheets were distributed to the following respondents:

- o the 9 provincial Departments of Health,
- o the 17 Mental Health Societies of the South African Federation for Mental Health,
- o professional boards of the Health Professions Council of South Africa for Psychology, Medicine and Occupational Therapy,
- o the South African Nursing Council, and
- o the South African Council of Social Service Professions.

The purpose of the study was to review all public sector and national non-governmental organisation (NGO) mental health service provision in South Africa. For this reason, a comprehensive overview of all mental health services in these sectors was necessary. Private-for-profit services were not included as they only provide services for a minority of the population, and are seldom utilised by those who live in conditions of poverty (Lund & Flisher, 2006).

Data were requested from services for the 2005 calendar year.

Although other NGOs provide services at a local or provincial level, the SA Federation for Mental Health is the only NGO that provides a coordinated national mental health service, and is the largest national mental health service provider in the NGO sector. It was therefore decided to collect data on mental health service provision in the NGO sector from only the SA Federation for Mental Health and its 17 affiliated societies.

In the provincial Departments of Health, the Provincial Mental Health Coordinators took responsibility for completion of the spreadsheet, gathering data from regional and district health services as appropriate, with the assistance of health service managers and lead clinicians.

In the Mental Health Societies, the head of the relevant society took responsibility for gathering data relevant to service provision at his/her branch.

The e-mailed spreadsheets were followed up with telephone calls, and (where necessary) faxed versions of the instrument. In many instances repeated checking of the data submitted by respondents was necessary, making use of telephone interviews to check each item.

In addition, preliminary findings were presented to a national meeting of Provincial Mental Health Coordinators in Pietermaritzburg, KwaZulu-Natal on 20 July 2007. This enabled the researchers to discuss the preliminary findings in detail, and allowed provincial coordinators the opportunity to double-check the data that they had submitted.

A draft version of this report was also sent to the Provincial Mental Health Coordinators and the national Directorate: Mental Health and Substance Abuse for review and checking in October 2007.

2.2.2 Analysis

The data were entered into 9 separate spreadsheets for each of the provincial Departments of Health, and a further 17 spreadsheets for each of the mental health societies. Data from these spreadsheets were then entered into a national spreadsheet, where numeric data were aggregated. Descriptive statistical analyses of relevant items were conducted. Nationally aggregated responses to items were then entered into the WHO AIMS narrative template.

2.3 Semi-structured interviews and focus group discussions

Qualitative methods included semi-structured interviews (SSIs) and focus group discussions (FGDs). As stated earlier, the primary purpose of using these instruments was to develop an understanding of the processes of mental health policy development and implementation in South Africa, and the articulation between various systems and interactions among stakeholders.

2.3.1 Instrument development

The SSIs and FGDs were developed over several months. The broad areas to be addressed were informed by the overall objectives of the study and the particular stakeholder(s) to be interviewed. Instruments with proposed questions and probes were then drafted by our Leeds partners (in the case of the national/provincial level interviews) and UKZN/HSRC partners (in the case of the district level interviews). These were reviewed by all members of the research consortium, and suggestions were made for further improvements. The instruments were also reviewed at a meeting of consortium partners in Durban in July 2006, before finalisation for fieldwork.

The semi-structured interviews were tailored according to the specific individual being interviewed. The following generic areas were covered:

1. Major development challenges facing South Africa
2. Key challenges facing the health system
3. Perceptions of mental health
4. Mental health needs and priorities in South Africa
5. The role of stigma in mental health
6. The role of government in addressing mental health needs
7. General policy making process in South Africa
8. Process of mental health policy and legislation development.
9. Role of various stakeholders in mental health policy and legislation development
10. Content of the current mental health policy and legislation
11. Implementation of mental health policy and legislation at the national and provincial levels
12. The research agenda for mental health.

A selection of SSI instruments is provided in Annex 1.

2.3.2 Sample and procedure

The sampling of respondents for the SSIs and FGDs was purposive. Respondents were selected either because they represented key organisations in mental health in South Africa, or they possessed information or had experience that was particularly relevant to study. Respondents were also selected based on the principle of maximum variation, in order to provide as wide a range of perspectives as possible on mental health policy development and implementation in South Africa.

2.3.2.1 National and provincial level

At the national and provincial level, a total of 64 stakeholders were interviewed in SSIs. As respondents were widely dispersed throughout the country, 59 of these interviews were conducted telephonically, using a speakerphone to facilitate recording of the interviews, and the remainder were conducted face-to-face. Telephonic interviews proved particularly useful with busy respondents who needed to change appointments or could best accommodate interviews before or after work hours, due to heavy work schedules. A schematic depiction of the stakeholders interviewed at the national and provincial level is provided in Figure 2.

Figure 2. Stakeholders interviewed at the national (macro) and provincial (meso) level
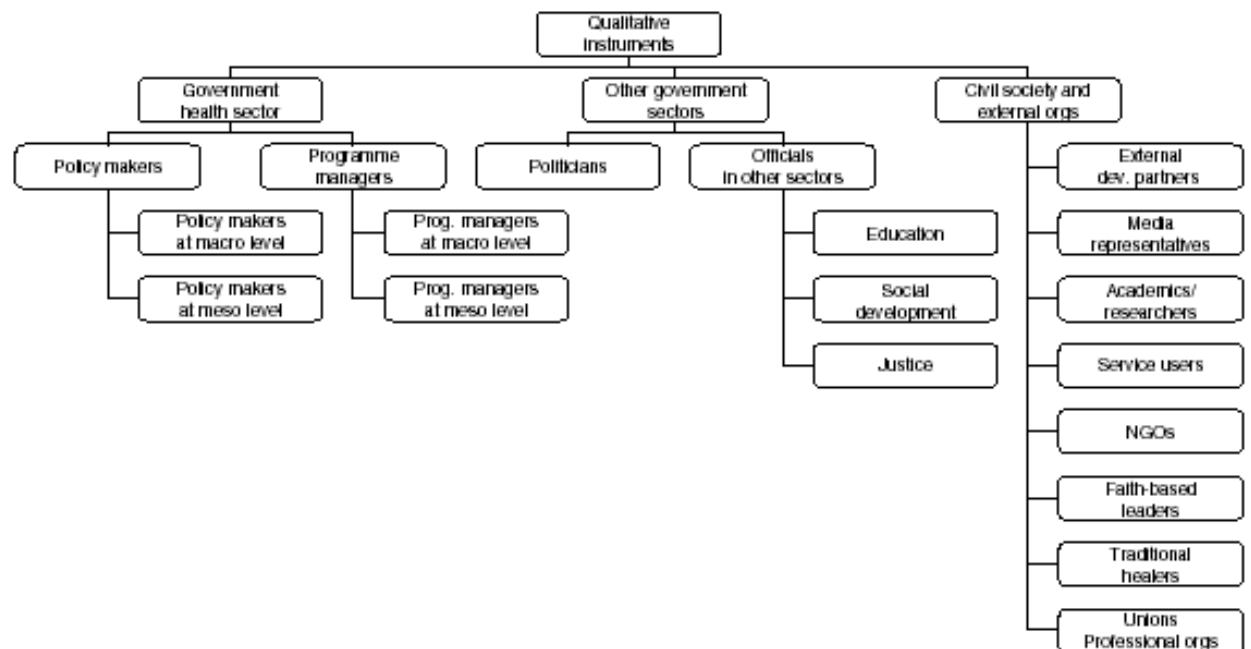
Actual respondents interviewed within the above framework are:

1. Respondent 01, mental health care user and mental health care user advocate
2. Respondent 02, policy maker, Department of Education
3. Respondent 03, research director, working for a health research organisation in SA
4. Respondent 04, director, mental health NGO
5. Respondent 05, provincial programme manager for mental health
6. Respondent 06, director, organisation supporting disability rights
7. Respondent 07, academic and mental health advocate
8. Respondent 08, policy maker, disabilities
9. Respondent 09, policy maker, Department of Social Development
10. Respondent 10, representative, South African Council for Social Service Professions
11. Respondent 11, mental health researcher and academic

12. Respondent 12, former provincial programme manager for mental health
13. Respondent 13, leader, national disability organisation
14. Respondent 14, provincial programme manager for mental health
15. Respondent 15, head of clinical service and department of psychiatry in one province
16. Respondent 16, director, provincial mental health NGO
17. Respondent 17, statutory board, Health Professions Council of South Africa
18. Respondent 18, provincial programme manager for mental health
19. Respondent 19, statutory board, Health Professions Council of South Africa
20. Respondent 20, provincial programme manager for mental health
21. Respondent 21, national policy maker, Department of Social Development
22. Respondent 22, provincial programme manager for mental health
23. Respondent 23, national policy maker, Department of Health
24. Respondent 24, director, provincial mental health NGO
25. Respondent 25, national policy-maker, Department of Health
26. Respondent 26, representative, South African Nursing Council
27. Respondent 27, director, mental hospital complex
28. Respondent 28, national policy maker, Department of Health
29. Respondent 29, academic and mental health practitioner
30. Respondent 30, policy maker, Department of Education
31. Respondent 31, director, provincial mental health NGO
32. Respondent 32, provincial programme manager for mental health
33. Respondent 33, public sector psychiatrist
34. Respondent 34, mental health care user and mental health user advocate
35. Respondent 35, mental health care user and mental health user advocate
36. Respondent 36, mental health care user and mental health user advocate
37. Respondent 37, mental health care user and mental health user advocate
38. Respondent 38, manager, NGO offering day, residential and work support services
39. Respondent 39, mental health care user and advocate, support group facilitator
40. Respondent 40, provincial programme manager for mental health
41. Respondent 41, representative, Society of Psychiatrists
42. Respondent 42, national policy maker, Department of Housing
43. Respondent 43, provincial programme manager for mental health
44. Respondent 44, director, mental health NGO
45. Respondent 45, traditional healer
46. Respondent 46, manager, mental health NGO, Jewish community
47. Respondent 47, NGO, supports users/families with Schizophrenia & Bipolar Disorder
48. Respondent 48, mental health care user and support group facilitator

49. Respondent 49, programme manager for an NGO, people with Intellectual Disability
50. Respondent 50, representative, Psychological Association of South Africa
51. Respondent 51, religious leader, Muslim Judicial Council
52. Respondent 52, provincial programme manager for mental health
53. Respondent 53, provincial Director General
54. Respondent 54, representative, South African Council of Churches
55. Respondent 55, mental health user and advocacy group member
56. Respondent 56, policy maker, Department of Correctional Services
57. Respondent 57, mental health care user and mental health advocate
58. Respondent 58, child and adolescent psychiatrist
59. Respondent 59, statutory board, Health Professions Council of South Africa
60. Respondent 60, elder, Christian Zionist Church of South Africa
61. Respondent 61, policy maker, Department of Justice and Constitutional Development
62. Respondent 62, mental health care user and mental health user advocate
63. Respondent 63, health advisor, South African office of an international donor agency
64. Respondent 64, former policy maker, Department of Health

2.3.2.2 District level

One district and sub-district site in a rural area was chosen as a representative case study. The target district has high levels of poverty and unemployment. Many households lack basic amenities such as water and electricity. There is a lack of proper infrastructure in some areas. The population is 503 760 and the district covers 12 819 km^2. Due to the large area, it is divided up into five local authority areas (sub-districts). One of these sub-districts was the study site.

The sub-district research site has a population of 168 508 and covers an area of 1417 km^2. The sub-district selected is part of the worldwide INDEPTH network and is a Demographic Surveillance Site (DSS) which continuously provides demographic and health information.

In total 35 semi-structured interviews and 12 focus group interviews were held with various stakeholders within the targeted district and sub-district. A schematic depiction of the stakeholders interviewed at this level is provided in Figure 3.

Figure 3. Stakeholders interviewed at the District level
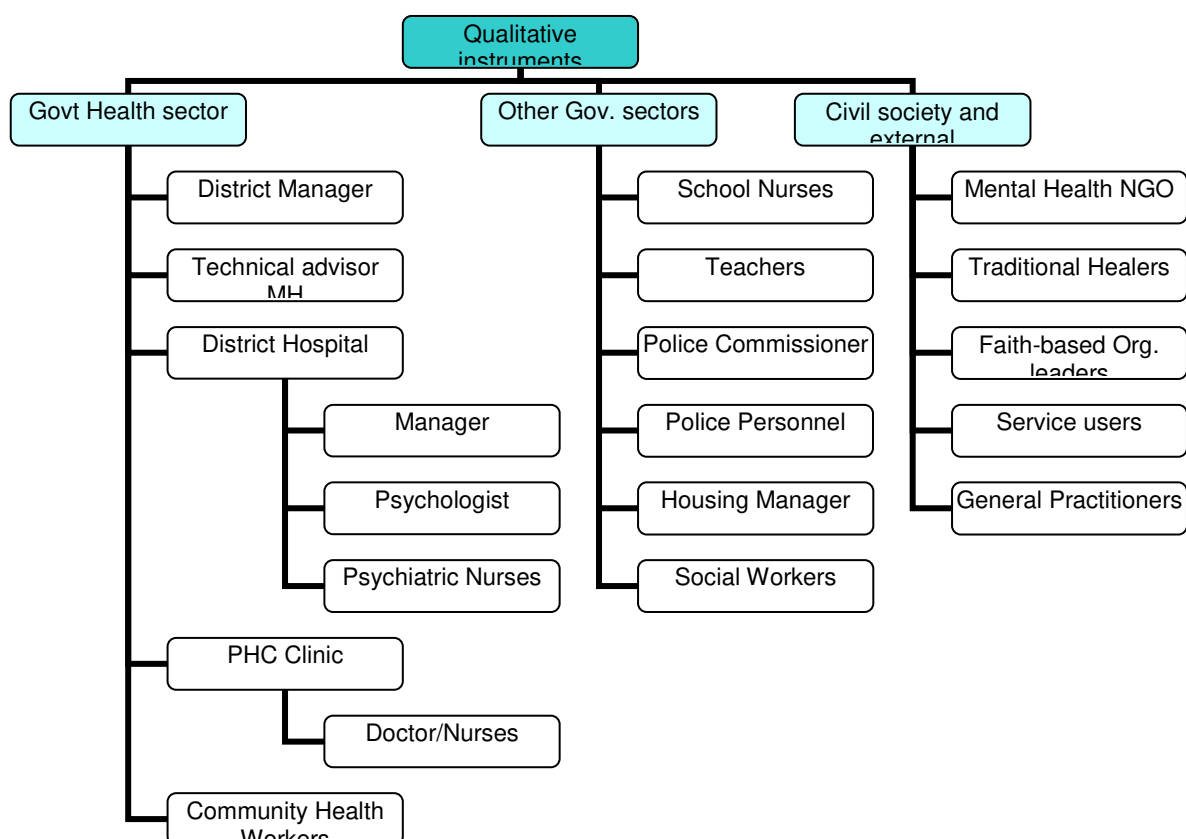
Actual respondents interviewed within the above framework are set out below.

Participants	Reference Code
1. District Management	SA/D/MHCO/SSI/001
2. District Management	SA/D/HMAN/SSI/001
3. Hospital Management	SA/D/HOSP/SSI/001
4. Mental Health Practitioner	SA/D/PSYC/SSI/001
5. Psychiatric Nurses	SA/D/PSYN/FGD/001
6. Social Worker - Hospital	SA/D/SOWO/SSI/002
7. Social Worker - Social Development	SA/D/SOWO/SSI/001
8. Community Health Workers	SA/D/CHWS/FGD/001
9. Police Management	SA/D/PCOM/SSI/001
10. Police Personnel	SA/D/POLP/FGD/002
11. Housing Management	SA/D/HOUS/SSI/001
12. Clinic Nurses 1	SA/D/PHCN/FGD/001
13. Clinic Nurses 2	SA/D/PHCN/FGD/002
14. Clinic Nurses 3	SA/D/PHCN/FGD/003
15. Clinic Nurse 1	SA/D/PHCN/SSI/001
16. Clinic Nurses 2	SA/D/PHCN/FGD/002
17. Clinic Nurses 3	SA/D/PHCN/FGD/003
18. Clinic Nurse 1	SA/D/PHCN/SSI/001
19. Clinic Nurse 2	SA/D/PHCN/SSI/002

Participants	Reference Code
20. Clinic Doctor	SA/D/PHCD/SSI/001
21. Teachers - Primary School	SA/D/TEAC/FGD/002
22. Teachers - Primary School	SA/D/TEAC/FGD/003
23. Teachers - High School	SA/D/TEAC/FGD/004
24. Teachers - High School	SA/D/TEAC/FGD/001
25. School for Handicapped	SA/D/TEAC/SSI/001
26. School Nurse	SA/D/SCON/SSI/001
27. Non-Governmental Organisation	SA/D/NGMH/SSI/001
28. General Practitioner 1	SA/D/GPPP/SSI/001
29. General Practitioner 2	SA/D/GPPP/SSI/002
30. Religious Leader 1	SA/D/PSLF/SSI/001
31. Religious Leader 2	SA/D/PSLF/SSI/002
32. Traditional Healers	SA/D/TRAD/FGD/001
33. Traditional Healers	SA/D/TRAD/FGD/002
34. Traditional Healers	SA/D/TRAD/FGD/003
35. Traditional Healer	SA/D/TRAD/SSI/001
36. Traditional Healer	SA/D/TRAD/SSI/002
37. Service User	SA/D/USER/SSI/001
38. Service User	SA/D/USER/SSI/002
39. Service User	SA/D/USER/SSI/003
40. Service User	SA/D/USER/SSI/004
41. Service User	SA/D/USER/SSI/005
42. Service User	SA/D/USER/SSI/006
43. Service User	SA/D/USER/SSI/007
44. Service User	SA/D/USER/SSI/008
45. Service User	SA/D/USER/SSI/009
46. Service User	SA/D/USER/SSI/010
47. Service User	SA/D/USER/SSI/011
48. Service User	SA/D/USER/SSI/012
49. Service User	SA/D/USER/SSI/013
50. Service User	SA/D/USER/SSI/014
51. Service User	SA/D/USER/SSI/015

2.3.3 Analysis

Interviews were recorded with the permission of respondents and transcribed verbatim. The transcripts were then analysed using NVivo 7 qualitative data analysis software. A framework analysis approach was adopted (Ritchie & Spencer, 1994), in which certain themes were agreed upon by investigators from all four study countries. These themes were based on the objectives of the study (as set out in the introduction). From these objectives, sub-themes were suggested by partners, and reviewed by all partners through a process of iteration, until a single framework was agreed upon that could be used by all four study countries. Where specific themes emerged from the interviews that were not included in the generic cross-country framework, these were added to the coding frame, to adapt the analysis to issues specific to South Africa. Transcripts were multi-coded on the basis of these themes, with additional themes added to the coding framework as determined by the data.

The coding framework adopted for the national/provincial and district levels is set out in Annex 2.

2.4 WHO Mental Health Policy and Legislation Checklists

The WHO Checklist for Mental Health Policy and Plans and the WHO Checklist for Mental Health Legislation are designed to assess the content and the process of developing mental health legislation, policy and plans according to a number of criteria (See Annex 3).

2.4.1 WHO Mental Health Policy and Plan Checklist

The following individuals were contacted to request completion of the policy and plan checklist:

- o Chief Director Policy and Planning, National Department of Health.
- o Cluster Manager/Chief Director for Non- communicable Diseases, National Department of Health.
- o National Director: Mental Health and Substance abuse.
- o Former National Director: Mental Health and Substance Abuse (involved in drafting 1997 Policy Guidelines).

Respondents from the Department of Health were of the opinion that the 1997 Mental Health Policy Guidelines document (Department of Health, 1997a) did not constitute formal policy as it did not follow more recently adopted policy development protocols and was not published for dissemination. A draft mental health policy is currently being developed by the national Department of Health. In the absence of a current policy, the checklist was completed for the 1997 Mental Health Policy Guidelines document by the Cape Town MHaPP team, comprised of Professor Alan Flisher, Dr Crick Lund, Ms Beauty Mlanjeni, Ms Ritz Kakuma and Ms Sharon Kleintjes. The checklist completed by the MHaPP team was reviewed by former National Director: Mental Health and Substance Abuse. All comments were integrated into one draft document, and circulated to the WHO review team for final comments.

The checklist analysis of the 1997 document was undertaken for two reasons:

- o The 1997 Policy Guidelines document has been used by provincial mental health programme managers to initiate work in key areas of the mental health programme within the provinces, and at national level, to initiate the development of norms, standards and targeted policy guidelines in areas such as child and adolescent mental health, psychosocial rehabilitation, and substance abuse (see results of interviews, below). It has therefore had an important impact on the mental health policy and service environment in South Africa, in spite of uncertainty about its status.
- o An analysis of the 1997 Policy Guidelines document could generate lessons that may be useful for future mental health policy development.

As there is no national mental health plan, the plan checklist could not be completed.

2.4.2 WHO Mental Health Legislation Checklist

The following individuals independently completed the legislation checklist:

- o National Director: Mental Health and Substance abuse.
- o Deputy Director: Mental Health and Substance abuse.
- o Former National Director: Mental Health and Substance Abuse (involved in drafting the Mental Health Care Act and coordinating the consultation process and adoption of the legislation).
- o A leading forensic psychiatry expert who provided extensive consultant support to the development of the legislation.

The independent ratings were collated into one schedule. Raters were interviewed telephonically or face to face to address differences between raters, to complete omissions in the ratings, and to document views on what additional work was needed, with the aim of arriving at a consensus rating as well to clarify the research officer's understanding of raters' perspectives and suggestions. The consensus document was again circulated to the above participants for final verification.

In addition, the following individuals were included in a second round of the review of the legislation checklists, with comments and changes invited to the compiled consensus document:

- o National Executive Director of the SA Federation for Mental Health (SAFMH), the largest mental health NGO in South Africa.
- o A mental health care user, and Chairperson of the Consumer Advocacy Movement (CAM), a user led movement launched in Gauteng Province.

Additional input and feedback was received to the consensus document by the respondents.

The Cluster Manager/Chief Director for Non-communicable Diseases, National Department of Health was unable to complete the checklist because of her busy schedule. The legal department of the Department of Health was contacted but they were unable to provide an individual who could participate in the review during the time allocated for this task.

2.5 Document analysis

Document analysis was conducted in two broad forms:

- o Formal analysis was conducted of key policy and legislation documents, using the WHO Mental Health Policy and Plan Checklist and the WHO Mental Health Legislation Checklist (see above).

o Background literature relevant to mental health policy development and implementation in South Africa was compiled and reviewed to provide a theoretical and contextual understanding of the key issues for this study.

2.6 Research ethics

Research ethics permission to conduct this study was obtained from the Research Ethics Committee of the Faculty of Health Sciences, University of Cape Town; the Research Ethics Committee of the Faculty of Humanities, Development and Social Sciences, University of KwaZulu-Natal; and the Research Ethics Committee of the national Department of Health. Permission to gather data from provincial health services was obtained from the Heads of the 9 provincial Health Departments. Permission to gather data from the 17 Mental Health Societies was obtained from the South African Federation for Mental Health. Permission to gather data from the district site was obtained from the Department of Health at District level, the Africa Centre and their Community Advisory Board.

Respondents in the semi-structured interviews and focus group discussions gave informed consent to participate in the study (copies of the consent form are provided in the SSI outlines in Annex 1). The identities of interviewees have been kept confidential and all identifying data have been removed from data used in the study.

Summary: Methodology

- A conceptual framework for understanding mental health policy development and implementation was formulated by the research team to guide methods, data sources selected, and analysis of mental health policy development and implementation in South Africa.
- Quantitative data for the 2005 calendar year was collected on the mental health system in South Africa using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2. Descriptive statistical analyses of relevant items were conducted. Nationally aggregated responses to items were then entered into the WHO AIMS narrative template.
- Semi-structured interviews and focus group discussions were conducted between 1 August 2006 and 31 March 2007 to understand the processes, underlying issues and interactions between key stakeholders in mental health policy development and implementation. At the national and provincial level, a total of 64 purposefully selected stakeholders were interviewed. At sub-district level, 35 semi-structured interviews and 12 focus group discussions were conducted. Interviews were recorded with the permission of respondents and transcribed verbatim. A framework analysis approach was used to develop a coding frame for analysis of the transcripts.
- The WHO Checklist for Mental Health Policy and Plans and the WHO Checklist for Mental Health Legislation were used to assess the content

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and the process of developing mental health legislation, policy and plans according to a number of criteria (See Annex 3).

- Research ethics permission to conduct this study was obtained from the Research Ethics Committee of the Faculty of Health Sciences, University of Cape Town; the Research Ethics Committee of the Faculty of Humanities, Development and Social Sciences, University of KwaZulu-Natal; and the Research Ethics Committee of the national Department of Health.

3. Results

This chapter begins with the context and general situation regarding mental health in South Africa. The general policy-making process in South Africa is then described, followed by an account of the process of mental health policy and legislation development and the current status of mental health policy and legislation. This includes a review of the content of current mental health policy and law. The extent of current mental health policy implementation is then described, with an account of current mental health service provision at national, provincial and district levels. The chapter then concludes with an outline of key mental health service provision issues and research.

3.1 Context

This section presents the findings of the study regarding the broad context of the mental health system in South Africa. In the interviews, respondents were asked to give their opinion on the broad context within which mental health may be situated in the country and the major development priorities and challenges that we face. The contextual issues most frequently raised were:

- The political environment
- Poverty
- Unemployment and job creation
- Social supports, in particular social assistance
- HIV/AIDS
- Crime and violence

3.1.1 The political environment

3.1.1.1 Policy implementation challenges

Viewed from a political perspective, respondents were generally positive about the new democracy which has emerged following the first democratic election in 1994. The new vision for development and service provision to those who had been disadvantaged and discriminated against under the Apartheid system was not disputed, and the fundamental provisions of the constitution, and its Bill of Rights, with its focus of working toward equality was lauded by several respondents. There was an agreement that good work has been done to develop legislation and policy to support the underlying values of the constitution, with some respondents specifically mentioning the importance of including a legislative and policy focus on a redress agenda. The underlying belief in the need to protect human rights, promote economic upliftment of the nation, and ensure access to services to meet basic needs were echoed in the views of many respondents.

The key area of concern and in some cases, active dissatisfaction, was the perceived failure of government to move to effective implementation of the legislation and policies that are in place. Some respondents acknowledged

that the democracy was in its early stages and implementation in its infancy, but along with others, expressed an urgent need for government to move toward translating policy into practice.

> *The problem I think we have is we, even though we're 12 years into our new democracy, we're really, we're sitting with the baggage of more than 40 years of discrimination, which you obviously can't eradicate in 12 years. It often takes decades. What we are finding from a service delivery perspective…is that in terms of implementation, that is where the biggest gap is. The gap between the wonderful legislation, bill of rights and then the gap that we find when it comes to implementation, the resourcing, the providing, the infrastructure for people to access services. That is either seriously lacking, or is in fact, absent. The further you move into the rural areas and more isolated communities, the less you actually find in terms of what is required to bring about that redress agenda.(Respondent 53, Provincial Director General).*

3.1.1.2 Human resource challenges

The key issue for attention in supporting sound implementation of policies was the provision of sufficient resources to implement the policies, and in particular, human resources.

> *The major constraints right now- and I think some of these things have been spelt out in policy- but some of the major constraints right now facing the health system, besides the resources which is finance and all that and materials, I think is the human resources factor. Because say for instance you envisage that in your health policy you can have well-functioning school health programmes so that you identify learners with problems early, …but if you do not have sufficient competence and sufficient staff to do that, that policy on paper will not be implemented and I think this is the major challenge right now. (Respondent 28, national policy maker, Department of Health)*

With regard to the health sector, some respondents noted the need for leadership of the health portfolio of the country and concern was expressed about the government not prioritising the health needs of the population.

> *R: …….first of all we were subjected to the (previous health minister) who was useless and knew nothing about health…and then we get (current health minister) who is even worse and absolutely disgraces us not only at home but abroad, and he keeps her in that position…they're actually making it hell for the public, and they're not providing the service and I think they're making it hell for the person, who shouldn't be in that position. (Respondent 47, NGO supporting users and families with Schizophrenia and Bipolar Disorder)*

Government legislative and policy commitment to disability was also recognized, but again, with respect to implementation, it was felt that mental

disability was still a neglected area of attention. Respondents felt that political support for the prioritization of mental health was needed.

> *R: You know, what concerns me is that the momentum has slowed down and that possibly we've regressed a bit. The momentum is not quite there; we need a stimulus to get it going again. I: Do you have any suggestions? Minister XX…he has a tremendously soft spot for Psychiatry. Now, he can't go and pump lots of money into it, but boy, it's made an attitudinal change. It's such a pleasure. He had a press conference one year after the Act to discuss progress and to – it was a political move – and to introduce the mental health review board to the press, right?...But he has learnt the Act off by heart, he knows and he asks us…and he goes through this. And the press are there. So what happens? Of ten reporters and press requested to come, two arrive, right? Of the two – and they were given all the handouts – one writes a beautiful article and one writes something insipid... You've got to have managerial and political will; otherwise it's not going to work (Respondent 29, academic and mental health practitioner)*

3.1.1.3 Rural development

Several respondents, including those from NGOs, statutory councils, researchers and rural based programme managers, supported government policy on promoting rural development, yet again emphasing the need to support the implementation of this policy with sustainable solutions.

Commenting on the "scarcity of rural resources":

I: With regard to scarcity of rural resources, what did you have in mind? R: You're looking at employment opportunities, opportunities for education, for higher education, for further education and training. Many of the rural areas have primary schools and not even high schools, in some cases. Families have to send their children out to urban relatives so that they can go to school. That profile is changing, but even though they may have general education opportunities in terms of high school – it's still limited, very limited. Subjects are very limited. I: So you feel that the other issues you highlighted as development priorities are particularly felt in the rural areas? R: Oh, most definitely. And then added to that are employment opportunities, access to services, infrastructure, housing, access to water – those things are realities for people in rural areas. I'm not saying all rural areas don't have access, but it is a big challenge. Also, the other big challenge, in terms of their geographical location, a lot of the rural areas are situated very far away from infrastructural support. So if they need to get access to services, they have to spend a lot of money for those services – those kinds of challenges are big ones. Also, for the country itself it is a very big challenge to set up these services in rural areas; because, very often the skilled people – even the ones who are skilled from that community – will migrate to urban areas because of the lack of rural employment opportunities. It becomes a vicious cycle (Respondent 26, representative, South African Nursing Council)

Commenting on community development in rural areas:

R: Provide the necessary resources in the rural areas. For schooling, work, employment, transportation, you know? And also facilities to use your money to buy the basic groceries, you don't have to travel fifty kilometres to go and do shopping. I: So, you're really meaning bringing development to our rural areas?. R: Bringing development closer to the people where it's needed most. I mean closer to the rural people, developing, bringing the infrastructure; …and I think some of the rural people...if they are given the kind of facilities, or maybe a semblance of those facilities that are in the big urban areas, they are willing to remain where they are. (Respondent 59, Statutory Board, Health Professions Council of South Africa)

Commenting on attracting and retaining human resources in rural areas:

R: They say let's take people in the rural areas and train them, I suppose they are more likely to get back to their communities. That's not the case. People in the rural areas come to town, they want to stay in town. Oh, it, that is difficult to achieve. You just need dedicated people. I think the Government has gone a long way towards easing this problem by introducing the rural allowance. I think people will go anywhere for money. The young people will go there, collect as much money as they can in a short time as possible and then come back to the urban areas and then when they retire, people retire to the rural areas. I think the financial incentive is important and of course, we must take those services to the rural areas like good schools, electricity, running water, etc. (Respondent 15, Head of Clinical Service and Department of Psychiatry in one province)

Commenting on the impact of rural undevelopment on health service delivery:

I: What would you say are the key challenges that you guys are dealing with in managing health care in the (predominantly rural province)?R: Okay, the fact that there are many clinics in rural areas where there are no telephone lines – we sometimes have a problem with clean water, electricity, even transport. Transport is a big problem, in all the top districts. There's a large number of vehicles you know, not roadworthied, and then a lack of staff. I mean the demands of the primary health care nurse are increasing but the number of staff are decreasing, and the posts are not being filled – simply because there are no applicants. So I think those three things: a lack of facilities or resources at clinic level – especially in the rural areas, a transport problem, and a lack of personnel. I think those three might be the main issues. (Respondent 32, provincial programme manager for mental health)

3.1.1.4 The role of local government and civil society

With the shift to implementation of policy, several respondents noted that the level of government which most urgently requires role clarification and capacitation is that of local government.

> *R: …we need to try and translate the existing policies, make sure that people who implement them know what they are and what they say….Then I think the second thing is to look at what are the constraining factors in the interface between the national framework, provincial and local government…and then target those things that have a high impact......But the third thing …is missed opportunities at local government level. Because the focus has been at the top and mid-level, I think we left it too long to focus on local government. (*Respondent 28, national policy maker, Department of Health)

Along with local government, respondents stated that implementation should be supported by attending to rebuilding a level of participation of civil society in nation-building that was seen before 1994. This meant strengthening community participation through community structures and NGOs to drive initiatives to meet local needs, including needs of people with mental health problems.

> *I: Who should create awareness about mental health as a priority? R: One, the first is those that are being affected. I: The people with the mental health problems? R: Yes, because they know their needs, and they are able to you know lay the foundation, to say: "For you to advance our cause; this is what we require at first". The second is the community organizations or the NGOs, because they are in the community and they are an entry-point, you know. And much of government policies have been influenced by what is coming from the community. Third then it will be the government department. The government department will need a lead, and they might choose Health. Each department develops policy that comes, that is informed by NGOs, that is informed by the persons with mental illness. And how does the department support the work of those NGOs? It could be through funding, it could be through various support, you know.*
> (Respondent 42, national policy maker, Department of Housing)

> R: There *are some partnerships already between State Department of Health, for example, and NGO's, but the partnership also has to be with the communities. In the communities you will find that they may have poverty, but they've got social capital. I: And explain that term? R: Social capital is basically looking at what exists within our nation, what exists within communities. It may be knowledge, it may be expertise, it may be traditional cultural know-how…I: Are you saying there's not enough Government investment in community participation in mental and other health programme development? R: Ja, absolutely…Often they're needing other support which they don't have the capital to provide, which is the infrastructural support. Or the specialist support when it comes to let's say, psychiatric nurses or psychiatrists. That, that I believe, the State needs to provide. And then I think also the*

development of community-based resources, civil society, as in NGO's, have been there, have always been there, and the big concern we have in the sector is, unless we form strategic partnerships, that's the State department, ourselves, with communities and business, again, it's not going to work, for health, or for mental health specifically. (Respondent 16, director, provincial mental health NGO)

R: I still am worried about Government commitment. I:To the issue of mental health? R: Yes, they might say, "Look we have a policy", you know? Or, "We have a legislation, what's your problem?"… I think what Government has not done effectively in my view, is that, you know, Government necessarily would not be able to implement some of these policies themselves, or see the realisation of what these policies are purporting if they are not using the NGO or their disability sector in this way to actually make sure that the implementation is realised. So there needs to be, especially in creating meaningful partnerships also supporting financially, those organisations. (Respondent 13, leader, national disability organisation).

3.1.2 Poverty

Poverty was identified as the primary development challenge for South Africa, the alleviation of which would have an impact on all other development priorities identified by the respondents.

R: Well in terms of the development challenges, I think the eradication of poverty must be top of the list; secondly, we must also facilitate more equity in relation to access to resources, including income. Of course to do all that, we need social policies…and economic policies for equity… On the policy matters, it is clear that our economic policy currently is not giving access to people on an equitable basis. We have a market-driven economy which means that if you have access, you can do very well, in business circumstances, but if you've been marginalized for a long time, it will be very difficult for you to get into the mainstream of the economy. Our, the government's plan to do that was to figure out how to get more people into the second economy and then to get more from the second into the first economy… The first economy is your big business, formal sector; the second economy is the informal sector. (Respondent 25, National policy-maker, Department of Health)

I : And the key development priorities for the country? R: I think it's around economic development which means bringing everybody into the mainstream so that they benefit from the economy, closing up the gap between the haves and have-nots because if that doesn't close you'll perpetually have social, health and those kind of problems. But certainly those things, growing the economy, reducing poverty, I think also touch on things like how you improve your education system, how you improve your health system so that as you intervene economically, you also intervene at a social level, providing a safety net for people who are in poverty, dealing with people who are socially orphans in our

country and vulnerable groups in general so that those people can be given a chance to move out of that poverty cycle and if it's possible and those who cannot move out of it, the system should be able to provide them with the basic services such as water, housing, access to electricity, access to education, those kind of services. (Respondent 28, National policy maker, Department of Health)

I: Could you give some idea of what you feel are the main social and development priorities in your province, at this stage?. R: Job creation is definitely one. Alleviation of poverty. That is, I think, the two main ones, because it's mainly rural areas in our province; it's not really urban or sub-urban. So I think those two are the main ones. (Respondent 32, provincial programme manager for mental health)

I: Are you saying that your whole strategy for sustainable human settlement development is aimed at poverty alleviation? R: It's, yes, you can…there's a number of objectives; one of it is poverty alleviation. The second one is…job creation. The third one is ensuring that property can be accessed by all, as an asset of wealth creation and empowerment. It also looks at liberating growth in the economy; key is also combating crime, promoting social cohesion and improving quality of life for the poor (Respondent 42, Department of Housing).

You cannot deal with economic issues without addressing social issues, so they also cut across labour, they cut across health, Department of Health; they cut across Trade and Industry and all that. For us to actually run, or provide a comprehensive service to persons with disabilities, we need an integrated service delivery mechanism. We need to develop that and that can only be done with the co-ordination or collaboration from key departments (Respondent 9, policy maker, Department of Social Development).

I: What are the main factors? R: Clearly poverty and that's a key focus for (names donor agency). The other one that I would particularly pick out is health systems because that's where…. I mean partly my specialist interest but it's also in mental health. If one looks at the development of services, it's not clear where mental health fits, certainly in South African government's policy portfolio. And it's interesting having seen some of the hospitals wards in the (names province) that the level of care for severe psychosis is positively Victorian… (Respondent 63, health advisor, South African office of an international donor agency).

3.1.3 Unemployment and job creation

As can be seen from these quotations, unemployment, and its corollary, job creation, was identified as the most important poverty alleviation strategy for the population in general.

Within the current situation of pervasive poverty, some respondents based within the disability sector, the NGO sector and mental health care users felt that people with disabilities, including those with mental disability, struggle to gain entry to employment opportunties despite specific provisions in legislation to prioritise the inclusion of disabled people in the workforce. When people with disabilities are included, they often find the job environment inadequately equipped to respond to their specific needs.

> *Regarding current employment practices: Very ruthless. I mean, they don't care. If they go and employ disabled people they would do it in a piecemeal fashion or that kind of a token thing. I: So, although we have legislation that speaks of inclusion, the 2% target etc, on the ground you're finding this is not being done? R: They find ways of circumventing the law or maybe, that's why I'm saying , you know, the problem it's a poverty trap, I must tell you honestly. Unfortunately you have a group of people who are marginalised , are in an almost permanent poverty trap and that causes exclusion. And I don't know, I mean, as a society, really, we have a problem. People get jobs and they're out in six months. Even in government….(names his/her organisation) keeps on fighting with all the departments to say look keep people in jobs, you know, retain people in jobs.* (Respondent 8, policy maker, disabilities).

Within the disability sector, respondents felt that for people with mental disability, opportunities to gain entry or retain job security was even more difficult to secure than most.

> *R: I find that people want to employ you in a lesser status or you are willing to work for less money because you're just happy to find work. Very rarely you will earn more but generally the tendency is for less. I: And why is that? R: First, like I said, the person takes time to develop maybe their best abilities which means then it's fair that you get paid according to work delivered and then develop the employee. The other side, there is stigma and discrimination… we generally don't get work, you send in your CV, you don't even get- people who accept your CV- you don't even get a return back because then they can say they didn't receive it, and you find a lot of frustration to get employed if your are honest about your condition which means you have declared your condition.* (Respondent 37, mental health care user and mental health user advocate).

> *R: You must put bread on the table for your kids. When you go to somebody or to that firm or somewhere needing employment, maybe you are given forms there to fill in with 'Have you ever had any mental illnesses?' and then once you say yes you have had- or the other 'have you ever attended a psychiatrist?'- say 'yes' you won't get that job because those people think that you are really mad so there's nothing better you can do...I: You don't get the job? R: They are afraid to employ you, maybe you are going to go mad…or wherever. And then you don't have any money. You go to the government and ask for a*

*grant or something to…and then you are examined and examined and examined and…they say 'No you are fit enough you can go back and work'. Now you are stuck in the middle, nobody wants you. You really do feel deserted, you feel… you feel helpless. (*Respondent 55, mental health user and advocacy group member).

*I: So with regard to employment Mr... ...this is something that people had voiced as a problem for them? R: Ja, .that they can't get employment and if they ever mention ...that they have mental problems then they definitely don't get jobs. I: Mmm. Have people come up with any ideas around how we could resolve this problem of not getting employed because of their mental health condition? R: Ja...I think it's just a case of educating the employers somehow and ...although it's...there's sort of...there's all these laws regards disabilities, they don't ...they don't practically find that there's any that they're able to access jobs and such things. I: The laws are in place but they are not being implemented with regard to people with mental disabilities? R: Ja...I would say that (*Respondent 57, mental health care user and mental health advocate)

3.1.4 Social assistance

The care dependency grant is provided for the care of a child requiring fulltime care due to a mental or physical disability or medical illness, while the disability grant provides temporary or permanent support to a person unable to perform income-generating work due to a medical illness (including mental illness).

Some respondents felt that not only do the high levels of poverty place an enormous pressure on the existing social assistance provisions of the state, but people without alternative sources of income may be reluctant to relinquish these benefits. With wellness will come a return to impoverishment, posing a threat to their ability to focus on recovery. A grant may be the only source of family income, with the loss of the grant negatively impacting on the value and status of grant recipient.

*R:..and poverty that is so high that Social Assistance has become the answer to all… even those that are employed who don't have employment benefits like disability benefits and old age grant and all those things. So when... a person employed in an informal sector, including domestic service, either gets old or has an injury, their first port of call is our Social Assistance….anybody who falls from the gaps of unemployment and poverty end up depending on Social Assistance… We have another challenge also of disability especially on disability grants.The challenge is do we have an exit strategy? Because people just come in, and they never get out. I: Because as you mentioned before, there isn't that other employment network that they can get into? R: Ja. (*Respondent 21, national policy maker, Department of Social Development)

R: And I think that there's no question in my mind, from work that others and I have done, that often the grant is very helpful and the lives of people with mental illness or other chronic illnesses and disabilities and so on. But the help is almost never for what the grant's intended for. It is to help the family survive and that was never, that's never the aim of a disability grant. (Respondent 11, mental health researcher and academic).

I: So because… we currently have an unemployment problem with job generation being a problem we finding that our disabled people are holding on to the security of a disability grant? R: Unfortunately they get trapped in that thing, you know…(later).. the unfortunate situation is that it's a method of survival. Now what we're trying to do is to sort of make sure that the job market, the labour market is open enough. Open enough to accommodate people with disabilities and make them feel secure. (Respondent 08, policy maker, disabilities).

It was agreed nevertheless that social assistance is an essential aid during the recovery process, an aid which might be inaccessible to people with mental disability because of the hidden nature of the disability.

R: But what I can tell you from work that I've done is that it is commonly reported that the people who make decisions around grants know nothing around mental illness….(later)… the kind of level of expertise that you need to be able to have to make these kind of decisions about whether somebody should get a grant or not…It's quite subtle. …And one of the things that we wanted to capture was amotivational syndrome you know… or the kind of thing that happens when you're very depressed and you can't get yourself moving…For you and me, we can see it's part of the illness not to be able to motivate yourself. Every group that we worked with saw this in entirely moral terms…We're talking about lazy people. And these included health professionals…So I think that's a major access thing, that it's invisible and stigmatised and so on. And some things, like if you're frankly psychotic and really crazy it's fine, but it's like you know most people aren't, most people with mental health problems aren't like that. (Respondent 11, mental health researcher and academic)

3.1.5 The impact of HIV/AIDS

HIV/AIDS was identified as the top priority on the health agenda by one fifth of respondents , and its significant impact on health and development in the country was noted by many other respondents.

I think in general the perception is that community care, community support rather than community care is strong in Sub-Saharan Africa but if you look at the impact of HIV, clearly thats eroding that capacity to deliver support. I think that again that then comes back to poverty, increasing urbanisation, difficulties with recruiting staff (Respondent 63, health advisor, South African office of an international donor agency).

Concern, however, was expressed about the degree to which resources are allocated to HIV/AIDS relative to other health priorities, including mental health.

> *R: For now, at this point in time, the main concern that we face is HIV/AIDS because everybody's scared of that, even the church is concerned about that, but I think as we learn about this AIDS thing we realise that it's not just a virus, it's a whole lot of other things that effect people: poverty, malnutrition and unemployment. And the church being part of the community is touched by that everyday. The church people live through that everyday, and you look at that, you live that, you hear that… (Respondent 60, Elder, Christian Zionist Church of South Africa)*

> *I: : So when you were speaking of poverty and unemployment were you meaning as it relates to HIV/AIDS, that HIV/AIDS is making people poorer, malnourished and unemployed? R: No, it's the other way round. Even if people have HIV/AIDS but if people are employed then they can handle it better. I: So you were speaking generally about people being impoverished, malnourished and underemployed and then saying that this in itself affects people who have HIV/AIDS-related problems? R: Ja (Respondent 54, representative, South African Council of Churches).*

Some respondents who discussed the impact of HIV felt that there was a neglect of the greater mental health burden associated with the HIV/AIDS pandemic.

> *I: Mental health and HIV Aids – do you have anything to say about that? R: It's huge. Its huge. From the minute you're diagnosed, mental health becomes a huge issue because, I hate to say this, but the sisters at the clinics, when they give the news, eventually it just become something that they do, there's no more feeling attached to that, the debriefing is definitely not done in a lengthy enough way and in a comprehensive enough way. So these patients then leave, not understanding the fact that they shouldn't sleep around now because they would be contagious to everybody and that if they are depressed these are the resources that they can use and that type of thing. By the time we get these people they've been rejected by family…and this whole stigma attached to the illness. So, yes, we have facilities where one of the first priorities is that we would sort out their mental state as they arrive because their mental state is very important to their health. If they are despondent and depressed they are going to be ill, so it's all related. We've had three suicide attempts here because they just feel they can't bear the thought of their illness. Then we have a huge problem with Aids-related dementia and we have nowhere to go with those people. So that is huge. We do try and help wherever we can, but we're not geared for that and there are many people walking around who have Aids-related dementia who are totally shunned and kicked out of their homes and living in bushes and things like that and*

we absorb a lot of those people. S: To your Centre? R: Yes into our Centre. (Respondent 36, mental health care user and mental health advocate)

The mental wellbeing of children and adolescents infected and affected by HIV/AIDS was also highlighted by the 2 respondents quoted below, as an area of concern which required input from the mental health field.

> *I: And the other issue that is strongly leaping up with the HIV/AIDS pandemic is the issue of child-headed households …R: My point of view is it impacts negatively on the development of the children. Children need to be without the kind of responsibilities that they are experiencing at a very early age. They need to play, they need to have a carefree life, and when they get to adolescence they've got their own issues in adolescence; the changing of their bodies, the hormonal changes, the issues of employment opportunities, the issues of their identity; they shouldn't be riddled with issues of parenthood, you know, what are my siblings going to eat, what is going to happen and that type of thing. I: And mental health professionals, is there a role for them in terms of advising ministries and government regarding this? R:…if you look at what happened during the times of war in Europe, surrogate parenting was there. People were given surrogate parents, and I think we should be looking into surrogate parents; have an experimental design group of children with surrogate parents and those without surrogate parents, what happens, what are the differences there? Instead of just promoting a policy.* (Respondent 59, Statutory Board, Health Professions Council of South Africa)

> *R: One of the big issues is child-headed families. I: Yes. Could you say what you think about this? R: I know that there have been initiatives to support those families but even that is not appropriate for a fourteen year-old to be looking after his or her siblings… It is unfair on the child who's heading the household and equally unfair on the children that are being cared for. I: But people are saying that traditional approaches such as taking the children into care, placing them in foster care, developing SOS villages etc that we don't have the money, the capacity. There are too many children for these approaches and the children are caring for each other anyway in these households so why don't we just go with that approach. Your comments regarding this? R: If we do continue with an approach like that, there have to be adults who are supporting those children on a regular basis...Those fourteen and fifteen year-olds have their own developing to do and they need somebody to care for them, they can't spend all of their time caring for others. (*Respondent 58, child and adolescent psychiatrist)

A few respondents, including a policy maker, NGO directors and two mental health care users, suggested that the mental health fraternity could learn lessons from the advocacy work done in the HIV/AIDS field to reduce stigma and engage political and resource investment in improving the mental health status of the country.

R: what I see if you look at HIV/AIDS, how far they have come and they haven't been in existence for so long and they manage to be accepted anywhere, you know, find jobs no problem, housing , you name it. I: What do you think's made the difference for people with HIV/AIDS that they're kind of more accepted into the general community and opportunities in the community? R: Definitely, government support first of all, campaigning, putting money into this campaign of HIV/AIDS and also Mandela being kind of an ambassador to this cause. Now for mental illness we go back to ancient years and still we don't really get much further the way we should. (Respondent 35, mental health care user and mental health user advocate)

3.1.6 Crime and violence

Several respondents raised concern about the high levels of crime and violence in South Africa.

*R: Well, I identify the enemies of South Africa are…right now, of the democracy, is our violent crime…I think it is out of control. If crime was not out of control, then there would be a lot of anticipation and a lot of pre-emptive arrests for a lot of the crimes happening. For instance, I consider terrorism, urban terrorism – that people can blow up, with explosives, an ATM, the automatic teller machine…That is pure urban terrorism. That people can paralyze the public transportation system in Johannesburg, so that the bus drivers aren't free to drive because they get shot – that is terrorism. And it is the economy that is suffering, and more so, it is the poorest people – who depend on the buses and who depend on the ATMs and so on – who suffer. So…I can't find another worthy example of terrorism right now, but that is – to me – the enemy of the state. (*Respondent 41, representative, Society of Psychiatrists).

R: What I've dealt with is that…I have found that many of these cases of children being abused are within families. I: Okay, so that is a key challenge that we have with regard to child abuse?R: I really think so, you know. I: And gender-based violence, Dr? R: Gender-based violence we've found within schools, and once again, my opinion is that it really comes from the family, and it's exacerbated within the school setting. You know it's violence in terms of…I really think there's still this notion of, the girl child for instance is – and I don't know if I can use this word, I don't know if it's the correct one – is to a certain extent inferior to the boy child. And it's still that power role that…or that power that plays a specific role in gender-based violence. (Respondent 30, policy maker, Department of Education).

Again, the role of government in implementing policies was highlighted as an important ingredient in the strategy to reduce crime. It was felt that political promises which exceed capacity to deliver, and an emphasis on rights without a concomitant emphasis on citizen obligations to participate in community and nation building, could contribute to high expectations and attitudes of

entitlement which might exacerbate crime and violence as people's frustrations at non-delivery of these expectations rise.

> *R:…if you create unnecessary expectations you're not going to meet them and then people will riot. Because you promised them bread, you promised them cake and you're now giving them brown bread, whereas brown bread is actually very good but not good enough. So you've got to make sure that you make people realise that these things take time. I: Who should play the primary role in that reorientation of …R: It's the leadership, it's the politicians. Anybody that is in a leadership position must propagate that, but the politicians also you know, even if they are looking for a tick for a cause they mustn't promise people the things that they will not be able to deliver. If you tell people that you will build them houses in the next five years and you are unable to build those houses, what then happens? You've seen it in the Cape. I mean people were bulldozing and getting into those houses that were standing idle, simply because I mean people had unreasonable expectations that by such and such a time they'll all be having free houses, free electricity, free water, free everything. I mean that culture of entitlement. And if you create those expectations, I mean people will then riot because they feel that they expectations are not being addressed but I mean if we all go out and say these things take time. I mean we're talking about a nation, it takes time, so you can't do it over night. (Respondent 17, Statutory Council, Health Professions Council of South Africa)*

Two respondents also commented on the negative impact of the pervasive nature of the crime and violence in the country on citizens' mental well-being and on the development of a positive and empowered national psyche.

> *R: The crime…is something that obviously has increased mental health concerns in the province…You know, as a Society, we don't work too much with, kind of, trauma debriefing you know. But from what you hear in communities, people are pretty stressed out. I: Why? R: From their own experiences, from the experiences of others. So I mean, that clearly does not make for a society that is mentally okay or able to kind of move on to levels of mental health that are accepted. (Respondent 31, director, provincial mental health NGO).*

> *I: Say something more about that what you meant? And this for people with mental disabilities? R: With mental disabilities, but it's true for everybody, for the whole …but if you are a vulnerable person and you have to be able to get to work and you can't be sure that you are not going to be robbed, you're going to be pushed out of a taxi, you're going to be pushed off a train etc. etc. and those things, your family might be particularly worried about. Like, I mean, if I were a carer or somebody with a mental illness that's what I would be concerned about…Again one doesn't know this for sure but are you as a person with psychiatric disability more likely to be a victim of crime than other people? You know, say you have an anxiety disorder and you're a very frightened person and you could actually do your work, but if you think about what it*

would mean to get from your house in Khayelitsha to the city in Cape Town….(Respondent 11, mental health researcher and academic).

Summary: Contextual Issues Impacting on Mental Health in SA

According to respondents the most frequently raised contextual issues impacting on mental health were:

- **The political environment:** Respondents were generally positive about the new democracy which emerged after the first democratic election in 1994, agreed that good work has been done to develop legislation and policy to support the underlying values of the constitution, and expressed an urgent need for government to move toward translating policy to practice. The key issues to support implementation of policies was the provision of sufficient resources to implement the policies, promotion of rural development, and improved involvement and capacitation of local government, NGOs and community structures to drive initiatives to meet local needs.
- **Poverty** was identified as the primary development challenge for South Africa, the alleviation of which would have an impact on all other development priorities identified by the respondents.
- **Unemployment and job creation** was identified as the most important poverty alleviation strategy for the population in general. People with disabilities, including those with mental disability, struggle to gain entry to employment opportunties despite specific provisions in legislation to prioritise the inclusion of disabled people in the workforce.
- **Social supports, in particular social assistance**: High levels of poverty place an enormous pressure on the existing social assistance provisions of the state. Social assistance remains an essential aid during the recovery process, an aid which might be inaccessible to people with mental disability because of the hidden nature of the disability.
- **HIV/AIDS** was identified as the top priority on the health agenda: There is a neglect of the greater mental health burden associated with the HIV/AIDS pandemic, including the mental well-being of children and adolescents infected and affected by HIV/AIDS. It was suggested that mental health could learn lessons from the advocacy work done in the HIV/AIDS field to reduce stigma and engage political and resource investment in improving the mental health.
- **Crime and violence**: Respondents commented on the negative impact of the pervasive nature of the crime and violence on citizens' mental well-being and emphasised the policy implementation role of government to deliver on the basic needs of the nation, as a strategy to reduce high levels of crime.

3.2 Mental health situation

3.2.1 Public attitudes to mental health

Respondents felt that despite evidence of the burden of mental disorders and the availability of modern treatments for mental disorders, public attitudes toward these conditions remained negative. These attitudes are brought into the public service sector as well, as evidenced by uninformed and discriminatory practices toward people with mental health problems.

There were a number of issues that respondents identified as upholding a fearful and negative public image of mental disorders and people who suffer from these conditions. These included lack of factual information, the continued spread of fearful and discriminatory information within the public domain, misinformation and sensationalism in the media, inadequately available treatment services to facilitate stabilization, and the lack of family and community supports to sustain treatment effects and promote recovery.

> *R: You know, the stigma will always be there, which brings me to the issue of discrimination of people with mental illness or mental disabilities. I think it's a really big issue. If you look at how much resources have been poured into discrimination against HIV positive people, mental health doesn't come anywhere there, you know? And discrimination of mentally ill people has been with us before the advent of HIV/AIDS. And I think, what is happening with mental health, people who are mentally ill, I think we don't have people who can mobilise the community to say let's mobilise the community, let's mobilise the government and what have you, to bring better resources for mentally ill people to...to pour in money for us to work on issues of educational campaign against discrimination for the mentally ill. It's not there, you know? I: And, why is it not there? R: Mental health problems and people with mental health problems have been seen as a nuisance, have been seen in the past as people to be locked in state institution, people not to be seen, you know, and not to be heard, you understand? I: And would you say this has changed significantly? R: It hasn't changed significantly. The policy has changed but the attitudes of people haven't changed.* (Respondent 59, Statutory Board, Health Professions Council of South Africa).

> *I: Anything else you feel is needed so people (with mental health problems) can get the same respect as other people, or do you think they now have that respect? R: Um, ja. I do think that people do understand it more…I just think that there should maybe, be success stories exposed in the media, then people will understand. I: Advocacy and exposure in the media might be useful? R: Yes definitely…To give a true reflection of what happened or what symptoms people live with, like, you know, not just the bad stories; the success stories as well and things, you know, the realistic view um, ja.* (Respondent 01, mental health care user and mental health care user advocate)

3.2.2 Low priority given to mental health

Approximately 50% (31) of all respondents specifically mentioned that mental health remained a low priority, despite a progressive and supportive policy framework for mental health, and the formal identification of mental health as a priority health programme:

> *It is worth mentioning perhaps that interestingly (names donor agency) and the (donor country) ministry of health have a memorandum of understanding to provide health care support to the HR function in the South African Department of Health and I am not aware of mental health ever really surfacing. It's a very limited MOU but it's never really came up in discussions with your high commissioner or in terms of the MOU from the (donor country) following that up* (Respondent 63, health advisor, South African office of an international donor agency).

> *I: So when they are talking about priorities, the politicians in your province, what are the main things that they are talking about that need attention? R: Definitely AIDS and poverty and housing and job creation, but I very seldom hear anything about mental health. I: And within those priorities that you mention, HIV/AIDS, the housing, the unemployment, the poverty etc is mental health mentioned when they mention those priorities? R: Not often. I: So it's really not on the regional agenda at this point? R: Not often.* (Respondent 36, mental health care user and mental health advocate)

The result is that mental health is not at the forefront of policy development and implementation in the health, education and social development sector, and there is little integration of mental health onto the agendas of other key sectors.

> *I: And you say there's difficulty shifting resources? R: I think part of it is that it's hard to say exactly where it lies but if you look at mental health in relation to the other programs, priorities, I mean we are not up there as the first priority and as often you hear the HOD saying if I have to choose between somebody who needs to be resuscitated and the mental health client and I need resuscitation equipment, then obviously that is going to be the priority because I need to save lives. Now I think the good will is there to shift the services but the funding is the problem. The funding that even if it has increased it has gone to that other priority area which needs it probably more than mental health. So I think that the budget cycle has again, in terms of mental health, put in a certain amount of policy options, and again it was said that it's probably not going to materialise because of the other priority areas.* (Respondent 05, provincial programme manager for mental health)

The main barriers to improved prioritization of mental health in the country were identified as:

- lack of political support for the prioritization of mental health on the public agenda,
- competition for resources with other more prioritized public concerns, and
- the continued "invisibility" of mental disorders relative to physical health problems, of people with mental and intellectual disability relative to people with other disabilities.

Contrary to these opinions, officials in the national Department of Health argue that mental health has been prioritised since 1994. They point out that since democratic elections, mental health has been clustered under priority health programmes, together with maternal and child health, and HIV/AIDS. From 2005 it was included under health programmes, under the Non-Communicable Diseases cluster, together with other chronic diseases.

These officials argue that mental health is a policy priority but does not always translate into budgets and services at provincial and district level. They therefore argue that the key barrier lies with policy implementation at the provincial level, and varying priorities given to mental health among provincial and district level decision-makers.

3.2.3 Poverty and mental health

Twenty percent of respondents, drawn from across several respondent groups, identified poverty as a central issue for mental well-being. Respondents commented on the way in which poverty erodes the mental wellbeing of the national psyche, reducing the available energies within communities to contribute to nation-building, and influencing the proliferation of socially disruptive and disintegrating behaviour, such as those linked to the violence and crime in the country. Poverty also limits the amount of social and economic resources that struggling families and communities can invest in supporting people with mental disability as their energies are diverted to issues of daily survival.

> I… those with physical or mental health problems, you feel that they will experience them a little bit harder? R: Yes, it will be in terms of everything. It will be in terms of food, transport, hospital, if the health infrastructure in that area for the normal people is not sufficient. Automatically my thinking is that it will be poor for the mentally ill people also, or the disabled people.. (Respondent 60, Elder, Christian Zionist Church of South Africa)

People with mental disability may be impoverished by the exclusionary impact of stigma, and the obstacles that prevent them from gaining access to the already scarce resources in poor communities or to re-accessing family community and work privileges disrupted by mental ill-health, and still enjoyed by their peers.

> R Many times people don't see a direct link between poverty and mental illness, but if you have worked in the field and you see the

impact that just the ordinary clients sit and worry about, where the next plate of food comes from. And if you address unemployment, you're half-way through the battle because automatically you can then, once that has been taken care of, you can then look at other issues that affect the lives of that person, for example, you know, what it means to have a healthy lifestyle etc. etc. But you cannot even begin to address that if somebody doesn't have food on their table. I: So the first line of intervention is really getting people out of their situation of poverty and this you feel will already have a positive impact on mental health status. R: Yes (representative, South African Council for Social Service Professions).

I: Is the social and economic situation of the province bringing any special problems or difficulties for the delivery of Health Services in your province? R Yes, because that is one of the causes of mental illness. Poverty and unemployment can lead to mental illness because if somebody has nothing to eat and so on, that can affect that person. (Respondent 52, provincial programme manager for mental health)

Several respondents felt that mental health concerns are generally poorly integrated into the policies of other sectors, and the link between poverty and mental health is little known and poorly understood. This results in a lack of inclusion of people with mental disability in poverty alleviation initiatives, even where this is articulated for people with other disabilities.

I: Do you think that policy should address the needs of people with mental disabilities around obtaining food and basic services such water, electricity, rent? R: Yes, definitely yes. I've given that a lot of thought as well. I: Could you tell me what your views are about that. What kind of help do people need with electricity, water and rent? R: Ag, I don't say get it for free. Get discount you know, discounted, sliding scale, whatever. My experience is that they used to get 50 units electricity free, now we suddenly don't get that kind of thing. Not free, but incentives and, you know. Or subsidies for it so we're too proud to pay for services as well, but will get discounts and stuff you know. I: And things such as basic food, do you think that people with mental disabilities can manage that on their own or is help needed there as well? R: One is not subsidised with food to the family or these houses, or whatever. Disability grants can never, never cover that on your own, food and clothing and whatever. I: So you find that the current rate of disability grant is not covering people's basic needs? R: No. (Respondent 01, mental health care user and mental health user advocate).

The following areas of action were identified by respondents to address the poverty/mental health link:

- The link between poverty and mental health is not sufficiently understood and articulated in policies and programmes. There is a

need to raise awareness of mental health in poverty alleviation programmes.

R: Well always, you know, we're talking about HIV and poverty, for example – that kind of connection you know, has made headlines. Mental health and poverty hasn't. And that's what we need to focus on, because once mental health you know, mental health obviously hasn't been a priority – in our government's list of priorities, mental health is not number one and yet that should be, because that can affect a range of other things. So where I make the connection is the comparison to HIV and poverty, we need to have that similar kind of status, and then we can help mental health. I: And earlier you said that should be not only around people who already have the disorders, but also in terms of preventing mental ill-health amongst the well. R: That's right. (Respondent 59, Statutory Board, Health Professions Council of South Africa)

- Inclusion of mental health in the policies and programmes directed at addressing poverty alleviation would best be addressed through an intersectoral approach, with the needs of people with mental disability included as a crosscutting issue in programmes directed at community upliftment.

I think within government they've got what is called social clusters. You see you have to link your agriculture, you have to link your social and welfare, you got to link your education, you've got to link your health, you know all these things, I mean add together, and move together, I mean you can not do just one otherwise you know you are more curative in health then you'll be more curative than also being preventative (Respondent 17, Statutory Board, Health Professions Council of South Africa).

I: Are there any agricultural programmes to generate income for people with disability in your province and people with mental disability or not yet? R: Not only for people with mental disabilities. There are programmes, agricultural programmes for everybody. I: And are the mental patients also included in that or not yet…? R: Depending on the locality and the availability of that programme in the area. I: Ok. So they may be included in such programmes but it's because it's aimed at their community, not because they necessarily are mentally ill. R: Ja, they are not only meant for mentally ill people. (Respondent 52, Provincial mental health programme manager).

- Evidence-based support to departments who wish to expand their provisions to include people with mental disabilities as potential beneficiaries.

Regarding access to housing subsidies: *R: Yes, if the person meets the criteria, than the person can qualify – if it's in line with the criteria, the person can qualify. I: And if the person meets the criteria and they have a mental health problem? Is that going to be a problem in terms of giving*

*them that subsidy, at this stage, or will they still be eligible? R: I think it would be said they are not eligible. It would fall to, they would be deferred to the Social Housing… institutional housing one (*meaning: subsidy*). Because one of it is the issue of contracting – that is the key issue there*. (Respondent 42, national policy maker, Department of Housing).

3.2.4 Stigma in mental health

3.2.4.1 Current status of stigma

There was consistent opinion across all participants that stigma towards people with mental illnesses is still something that is highly problematic. Respondents reported that they felt that there were, or had, in the case of mental health care users, experienced various misconceptions about individuals with mental health conditions, which include beliefs that they are weak, lazy, mad, insane, not capable of doing anything, that they cannot think, or that there is something wrong with them. There are generalizations that they are violent or aggressive, with unpredictable behaviours, and that they should be locked away or medicated for the rest of their lives.

The negative consequences of such inaccurate beliefs is that individuals who have been labelled as having, or having had, mental health conditions are feared, ridiculed, or exploited. Many individuals have also been neglected, isolated, rejected by family and peers, abused, or excluded from social engagement and basic rights. In some instances, they are mocked because mental illnesses are not considered "*a serious group of illnesses*" (Respondent 47, NGO supporting users and families with Schizophrenia and Bipolar Disorder).

> *People see it as a weakness, and not as an illness. They see it as the person not being able to cope and not as a disease."* (Respondent 48, mental health care user and support group facilitator).

> *I'm still being stigmatized. People are still telling me that I'm insane, that I'm mad; that I have a disease. […] I'm the one who's the problem because this is the way society has been organized. People have these labels and now I'm fighting against those labels and therefore there's something wrong with me… (*Respondent 62, mental health care user and mental health user advocate*)

> *You hear people talk about how they are afraid of working with a person with a mental illness because you never know if they are just going to flip off. (Respondent 21, national policy maker, Department of Social Development)*

> *Like Primary Care Practitioners are nervous about treating people with mental illness. […] because they don't know enough. They also, there are prejudices about mental illness. (*Respondent 12, former provincial programme manager for mental health)

There are mentally ill people within the villages that are so poverty-stricken […] and they, of course, get the thin edge of the wedge because they're not participating in tilling the fields, looking after the goats and the cows and things like that and so this is a real dilemma, you know and they're very often just locked up in a hut at the back of the village and very often neglected, because there's a lot of ignorance about mental health as well (Respondent 19, Statutory Board, Health Professions Council of South Africa)

Exposure to such discriminatory behaviours can begin very early in childhood and adolescence.

There are some very hidden messages within school environments […] there are many messages that teachers often inadvertently send to learners, that they don't belong there, they are not welcome. It's like constantly telling children that they are badly behaved, and not having people at school where children could go who feel they don't have a grip on things, you know and those are the things where you don't need professionals you need a supportive school environment […] I don't think that our teachers are inclined enough to do a more fine grained analysis you know, of what the real needs of the child are, and they also tend to label a child, I think that people who have psychiatric problems are the worst labelled of all because people have no skills to deal with it and they would just shun such children and I think it's a huge big problem. And one's heart bleeds for children like that who get side-tracked because of that. (Respondent 02, national policy maker, Department of Education)

*There are parents who come here with their adult children who are nowhere near acceptance of this terrible pain that they have to bear, they just are not at a point where they are able to see their child as someone with a disability and mourn the loss of the child they didn't have, and move on and turn their life into as positive a life as possible. (*Respondent 46, manager, mental health NGO, Jewish Community*)*

The resulting problems of discrimination and human rights violations include loss of, or inability to obtain employment, inability to access social security, poor access to health care, receipt of poor quality health care, and loss of housing.

In some areas they are accepted but there is still a stigma, because I said, even in general hospitals if a person arrives there and says "I was once admitted in a psychiatric hospital" they take that person as mentally ill, even if he just goes to the hospital for a physical ill problem. And even in communities he cannot be angry like me. I am accepted if I'm angry with somebody, but immediately that person is angry with somebody they will say that the person is [sick]" (Respondent 52, provincial programme manager for mental health)

But the way medical practitioners are working with mental, mentally disabled people, it's unacceptable. The way they prescribe medicines. I mean, you can't keep a person on a prescription for so many months without even doing the re-evaluation and reassessment. […] I mean, I can tell you that you still have people in mental institutions who are chained. (Respondent 8, policy maker, disabilities)

There is so much research that makes it very clear; higher incidence of mental illnesses and their impact in relation to the GDP etc. of the country. And it seems to me astonishing that so little attention is given to ensuring that there are adequate facilities for the treatment of mental illnesses. (Respondent 3, research director, working for a Health Research Organisation in SA)

Furthermore, there is the presence of stigma within disabilities and within mental illnesses themselves. Mental disability is at the bottom of the disability group, and individuals with psychotic conditions are stigmatized by those with neurotic conditions.

We are more marginalised than the average disability. If you have to level it, the bottom of the rung would be people with intellectual disabilities, if they are neglected or thrown away. But psychosocial disability has a stigma attached to it also, so people will shun you like the lepers used to be shunned. So it's not easy to gain support if people see that you are physically looking in good shape, you know. 'There's nothing wrong with you…I don't know what's wrong with you (Respondent 34, mental health care user and mental health user advocate).

*… it's very frightening if you're suffering form a neurosis and you end up in a hospital environment where there's schizophrenia and, you know, long-term mental illness, really is seriously frightening for the person. […] I was put in a hospital setting when I suffered from Panic Disorder and Depression and I was put in a ward with people going through alcohol withdrawal, people with really bad psychiatric problems – real mental illnesses, more on a psychosis kind of thing, like schizophrenia – and I found it very frightening because I thought I was going to end up like them; I didn't see my condition as being separated from them, in that I was suffering from a neurosis and not a psychosis, being that my problem was treatable, but a lot of these involved long-term medication, medication for life, and I just found it tremendously upsetting being mixed with a whole variety of people who were suffering from different conditions. […] and I found that that is the first question you ask is, am I going to end up in a mental hospital? Because […] you think you're never going to recover and never get better and you're going to spend your life behind bars in a mental institution. (*Respondent 48, mental health care user and support group facilitator).*

Such stigmatizing attitudes have led to individuals with a mental health condition hesitating or deciding not to seek treatment and thereby worsening their condition.

> *People are maybe uncomfortable saying: 'I have depression' and they leave things up until they get out of hand where there could have been an earlier intervention.* (Respondent 61, policy maker, Department of Justice and Constitutional Development)

> *I think very often people are very loathe to go and consult anyone if they are not feeling emotionally comfortable and again if they …so that would be to get even diagnosed, but having been diagnosed, then there is enormous difficulty in continuing with treatment because they're too frightened to tell their employer that they need to go to a clinic for that and etc. etc. So I think that it's all very closely linked. (*academic and mental health advocate)

The stigmatizing attitudes and the associated mistreatment can become internalized by the individual, such that they become hopeless.

> *They have swallowed their status and their labelling hook, line and sinker but in essence what's happening is that people are becoming hopeless. They've lost hope, they have lost any sense of having capability and skill and talent and a contribution to make. It's happening to the vast majority of people. They then become just your average disabled person who is a drain on society. (Respondent 34,* mental health care user and mental health user advocate*)*

> *If you are diagnosed with a serious mental illness then that's it. And I think very often the person does land up functioning less and less well because they have not received, a, the medication but b, the social support in the community that would allow them to function reasonably well. (Respondent 7,* lecturer, involved in the mental health NGO sector and mental health movement*)*

3.2.4.2 Impact on policy development and implementation

Respondents consistently reported that mental health issues are still very low or non-existent in the list of priorities in Government, particularly outside of the Health Department.

> *I was in the Health Department and I've spoken earlier about how we're trying to look at integrated approaches but all the mental health input, impact, policy and all that is in the Health Department. That's where it is. The rest of the departments don't worry about it. When we worry about it is when something happens to a staff member and we bring in EAP, Employee Assistance Programmes. Then a mental health element will kick in but it is seen more as part of the EAP or the medical aid or the doctors or the hospital. It is not seen, in other words, what I'm*

trying to say and that is maybe the challenge that you need to bring to us, I'm not seeing us encouraging good mental health practice in the workplace to ensure that staff have, not just social wellbeing, but also mental wellbeing. […] as soon as somebody talks about disability then we think about the lifts and the ramps and the toilets. That's what we think about firstly. Mental disability doesn't feature. (Respondent 53, Provincial Director General)

I don't think our system has really ever dealt effectively enough with psychiatric disorders. I just think it's not being acknowledged in education yet, it's something that we need to deal with more attentively. (Respondent 2, Policy Maker, Department of Education)

Apart from human resource constraints, stigma by health professionals also seems to be playing a role in deterring the process of implementation of the Mental Health Act. There is still the fear of the potential violent behaviour of patients, there is lack of experience, and the sense of having this 'imposed' onto them.

*Now we have a challenge of people being so scared of this 72-hour Assessment and when they, when you talk about 72-hour Assessment, the worse that they think about is the violent patient and not having capacity to, ja, the district hospital has been so small to accommodate these people. […] It's currently not working that well. Although they have tried to market it, but then the people in the periphery, they're still not using it. The system that they want to do, is just to refer the patient. The observation now of the Psychiatrist is that people lack capacity – number one – don't know what to do. Number two, they are not interested, they just fear. They've got this fear of the psychiatry patient and they're not even interested in, they just want to get rid of the patient to another level. So there's this 24-hour service which has been introduced where a doctor can call and manage the patient over the telephone with a Psychiatrist and then if that fails, then the person has to be transferred, but in some cases, they just transfer without calling or, trying to manage the patient there. (*Respondent 14, provincial programme manager for mental health)

We hope those attitudes can be addressed with training, but where you find that even that training cannot take place, people choose to attend or not to attend that type of training, then you really have to battle in terms of accessing them to address things… People feel they cannot attend to mental health, mentally ill people, in a general setting – they need to be separated altogether from the general setup [because] number one, they are dangerous; they are destructive to property. My feeling's that it's because people do not have the necessary skills to handle them. And the necessary understanding of mental health issues…and a feeling that certain things are being imposed. The other issue is the history that we

are coming from, that we did not address. If you remember very well, working in a mental health environment was by choice. And then when the new Act came into being, and certain categories of people were included as practitioners and so on – they feel they were never consulted. And then up to this stage, they feel they have got a choice, to participate in the care of people with mental illness, or not…and once you have those people really not buying into the whole thing, you may as well forget it…Because they are the key people, you know, in terms of diagnosis, assessment, diagnosis and prescription. Nurses may treat and understand and do whatever, but they do not have the necessary capacity [to] come up with an ultimate diagnose and prescribe treatment. (Respondent 43, provincial Programme manager for mental health)

With regards to the attitudes by practitioners, one policy maker reported:

overall it's good, but there are those professionals that we still find do not feel it's sort of their job... but I think again, it's, it's because they are not comfortable in dealing with the client. But if, as they gain the skills in dealing...with them, I think that that kind of attitude will definitely change. But overall, I must say that I think that, ja, the attitude is quite good. (Respondent 23, national policy maker, Department of Health)

3.2.4.3 Reducing stigma

There were mixed responses when respondents were asked whether they felt that the situation with regard to the stigma at the policy, service provision, and community level has improved or remained the same over the years. There was agreement among all respondents that there is work that is still necessary in addressing this key issue.

There was a very general trend of people in Government, NGOs and academic positions feeling that there has been little change, particularly among the policy makers and service providers.

Stigma hasn't changed significantly … the policy has changed but the attitudes of people haven't changed (Respondent 59, Statutory Board, Health Professions Council of South Africa).

There's no doubt mental health is still stigmatised both in urban and rural areas (Respondent 44, National Mental Health NGO).

I don't think it's moved from the 60's at all (Respondent 47, NGO supporting users and families with Schizophrenia and Bipolar Disorder)).

I think it's very sad actually in that in this day and age I don't I think we've progressed very far in terms of stigma, I mean we still have newspapers talking about 'crazy man does this', you know. We still

talk very glibly and take those words very out of context. I think that the, that people with mental illnesses still are considered if somebody's depressed it's very much "pull yourself together". I'm talking about your more common mental illnesses and then when we're talking serious mental illnesses I think there's still a perception if somebody is diagnosed with schizophrenia or bi-polar or schizo-affective or whatever then they are quite unable to function in society which is not true. (Respondent 7, academic and mental health advocate)

It's very bad. Very bad. I mean you still get people who are called mad and crazy and psychotic, you know. (Respondent 8, policy maker, disabilities)

The stigmatization issue is a real crisis and sadly, we have an attitude of, a holier than thou attitude at times, in which we do not want to acknowledge the recovery of those who were sick and who were not well. We must be able to give opportunity…(Respondent 51, Religious leader, Muslim Judicial Council)

nobody talks about it and if you have a family member that is mad or has a mental problem it's almost as if; "We've got a mad person in our house and we can't talk about it" and people still don't talk about it. (Respondent 54, representative , South African Council of Churches)

However, there were also respondents who felt that there have been positive shifts with regards to attitudes and awareness, particularly in the general community.

I must say that a lot has changed over the past few years. People are becoming more aware of mental illnesses and mental health. You know, they're really becoming different groups, different...even the community and things like that. But like I say, they must...there's still a lot of work to be done. (Respondent 20, provincial programme manager for mental health)

I think there was a lot of improvement in terms of perceiving mental health differently. In the sense that any one of us can become a potential person with mental problems but I also think that we should do a little bit more marketing and a little bit more PR. Specifically if you look at the clientele that we're servicing, deep rural areas, the level of the clients that we serve. I think there's a certain category or understanding of mental health, know how to deal with it but you still have a certain category of our population that needs a lot of education. (Respondent 10, representative, South African Council for Social Service Professions)

I think people are coming out of the closet more. I think that that has helped. I think people with disabilities generally and intellectual

disability and mental illness it was very hidden away. I think people are getting braver to come forward. (Respondent 49, programme manager for an NGO supporting people with Intellectual Disability)

I think that there is a shift, even though it may be marginal […] I think that the mental illness and mental health issues are being spoken about more often than in the past, you know, like in the media, issues being included in soap operas, TV documentaries, radio programmes, I think all those things do raise awareness and do shift attitudes. […] I do think that some of the consumer advocacy groups have been quite successful in working in schools, working in communities like for example the South African Depression and Anxiety Group. So, you know, I do think that there is a shift. But I still think there is a lot of stigma and prejudice, [and] I think that there probably still is quite a lot of stigma around people with serious mental illness at work (Respondent 12, former provincial programme manager for mental health)

*Definitely there's still a stigma attached to mental illness; I've found that in the 15 years since I've suffered from it there's definitely been more understanding and I think it's come about through more publicity, but there definitely is a stigma attached to it. (*Respondent 48, mental health care user and support group facilitator)

3.2.4.4 Strategies to address stigma

Respondents felt that the key strategy for addressing stigma and mental health is education and awareness-raising through various mediums such as public campaigns, identification of champions or role models, workshops at various settings, media, and information packages. There was consistent reporting of the importance of starting early. Education and awareness needs to be done at a young age. As one of the mental health care users reported:

I think if school children could understand it, I think it would make a huge difference for when they reach adulthood. (Respondent 48, mental health care user and support group facilitator).

At the policy level, various suggestions were made. These include the need to work with other Departments, such as social development, education, police, and correctional services, to include mental health into their agendas.

"we have to make use of the other departments as well, like police, for instance, which is very supportive in broadening our programme and get involved to also, to inform the public" (Respondent 23, national policy maker, Department of Health).

… once we change that attitude of medical professionals then you can go into the society […] And I think one of the things that we all have to understand is that mental illness can happen to anybody[,...] we have to start working, I think it has to start at policy level. It starts there

where the policy changes will accommodate this group of people. Secondly there has to be some practical steps taken to change the attitude of professionals. I'm talking about health professionals, I'm talking about the people in the justice system. (Respondent 8, policy maker, disabilities)

*Social workers can play a pivotal role in de-stigmatising that by becoming an agent for change. To start changing the mindset of our communities to understand that the illness can get better and for also people to understand that you're not dying when you are diagnosed. (*Respondent 10, representative, South African Council for Social Service Professions)

From an advocacy point of view maybe you need to advocate much more strongly in business and do a lot of our advocacy really in areas where money matters because then we need — it is no good mental health people just doing the advocacy — we need people much more powerful than us to pick up the advocacy and push policy makers. (Respondent 3, research director, working for a Health Research Organisation in SA)

I haven't observed any discrimination by [warders, the people that are managing the prisoners], they are really supportive… But I think we still need to educate our warders because you might find that it's only this warder and others are not aware of that, or they are aware and they're neglecting it, so that we can contribute to the healthcare rendered to these offenders. Also the offenders…to teach them about mental health issues I think it will help. And also to promote…not to promote…to teach them about the rights of people with mental illness, although they may not differ that much from the rights of the other ill people but just to sensitize them and make them aware that mentally ill people are people like us, they need to be cared for, they need to be protected…and also the mentally ill people, I think we also need to teach them not to have pity on themselves because when you start withdrawing or feeling pity about yourself, people take advantage of you…those are the things I can think of for now. (Respondent 56, Policy Maker, Correctional Services)

Respondents indicated that the Mental Health Act needs to be promoted to address de-stigmatization. Suggestions were also made about the need to bring the legislation in line with the UN Convention and the Bill of Rights (Respondent 34, User). The communities and Government need to be mobilized around de-stigmatization and education campaigns for de-stigmatization and the promotion of mental health. Other legislations such as the Employment Equity Act were also identified as another tool to prevent discrimination because of a mental illness (Respondent 12 Academic – Psychiatry).

The participation of mental health care users was reported as a critical component in giving them a voice and educating policy makers through

experience that users are capable of participating in policy processes and providing them with better insights as to the needs of the mentally ill population.

Furthermore, personal contact or exposure was seen as a way to sensitize people at all levels to the fact that not all mentally ill individuals were violent, and that they were just like everyone else.

> *The more you deal with certain mental health care users, the more you come to know that it's not everyone that would be or can turn aggressive. […] It's about exposure* (Respondent 8, policy maker, disabilities)

> *The most important way to overcome stigma is to include children in the local neighbourhood schools. I think by getting to know children and making it, and driving successful inclusion for them a lot of the stigma and labelling and fears are broken down. We have had experience of children really, where schools were well-prepared, teachers were equipped and supported by some form of support service you know, you could break through those kind of labels, and the children were actually accepted within the school. The second thing is I think we need to have more support staff that can help teachers and so the whole issue of how we use support staff in South Africa is crucial.* (Respondent 02, policy maker, Department of Education)

> *I think we need to start it in schools, I think in our events being thought about and all that sort of thing in primary school people need to be brought up with a much better understanding of mental illnesses.* (Respondent 3, research director, working for a Health Research Organisation in SA) 1

Media was identified as a critical component to educating and increasing awareness. These included the news, television shows (including talk shows and TV drama), radio shows, and newspapers. Other suggestions included the performing arts, the use of international days such as World Mental Health Day, Mental Health Awareness month, and so on.

> *The media is terribly important […] It really is. Pamphlets, radio, of course, particularly for the rural areas which is the major form of education generally of the public (*Respondent 19, Statutory Board, Health Professions Council of South Africa)

> *I now have a character in a daily drama on SABC who is deaf. Because I spoke to this gentleman I saw a need and you will see others will pick it up as part of dealing with these issues within the drama context. How many people watch drama? And it's a drama in one of the African languages, in Venda.* (Respondent 61, policy maker, Department of Justice and Constitutional Development)

We don't write enough for the media. It's a big, big hole. So what happens is that the media write on it. They send a journalist to cover a lady murdering another lady but they don't send journalists to hear a good news story or something of a group of people saying: this is how we want to change. (Respondent 47, NGO supporting users and families with Schizophrenia and Bipolar Disorder)

*There's definitely more work needed – far more education needed and, you know, understanding […] I think the media plays a huge part in that. You know, talk shows like 3 Talk, you know if they could…I know they've had quite a few talks on it; Carte Blanche, you know, things that people watch; you know, magazine articles…definitely things like that. So I think the media has a huge part to play in de-stigmatizing mental health. (*Respondent 48, mental health care user and support group facilitator)

As also indicated in the previous section, mental health care user involvement was viewed as a critical component.

You never have a meeting or you never embark on these promotional kind of launches or whatever, if you don't have the people with disabilities with you and let them, actually, run the show… you empower them to market their own skills and their own abilities […] I mean, it's a life experience that they can share and people respond far better to those kind of information than when I would go there and said, you know, if you feel like this, you should go for help or whatever (Respondent 23,national policy maker, Department of Health).

But then they can tell us how they are being treated you know, and educate us […] Through that you would get immediately what their needs are and you know what then you develop (Respondent 42, national policy maker, Department of Housing).

Who best to ask than the patients themselves, but those who have recovered. You obviously…we need to engage with those patients who perhaps have gone through a process of recovery, and who have now brought back to or helped or assisted to what we have indicated earlier on with the entire procedures and so forth, and they are now back on track, and they can perhaps reflect and focus much better than I could, perhaps, or anybody else for that matter. And so their personal experiences must be able to be tapped in, it must be able to help and assist to formulate an understanding of mental disorder, mental illness, and it must be able to help and to contribute towards the formulation of the broader base of stakeholders that formulate or then influence policy. (Respondent 51, Religious leader, Muslim Judicial Council) 1

3.2.5 Participation of mental health care users in policy making

3.2.5.1 Support for mental health care user participation

Very few respondents spontaneously raised the issue of user participation in policy development and implementation, but, when asked, most respondents across respondent groups felt that the inclusion of user perspectives in policy processes would improve policy development and provide policy implementers with information which could enhance the direction and quality of mental health programmes provided by the state. No respondents rejected this idea, but few respondents for whom this was a novel concept, had not formed an opinion on this issue, or where it was a familiar issue, agreed that participation was possible, but would need significant support from providers or other supporters, particularly for people with severe mental disability, or with intellectual disability.

> *R: I think that users are very disempowered and there should be…we don't have advocacy in the same way that you have (those)who have been in the system or who have been users and who now take up the cudgels. We don't have that kind of luxury which applies often in the West. So the user now moves on and we then are left with using the name of users and when you interact with users and they really sick, they're not in a position to talk about their service provision in a fashion that would make sense and would lead to their fuller appreciation and their empowerment. I: And recovered users, users during the well period? R: Recovered users, yes, that's why I think we're short of advocates, of people who take up the issues together with previous users and people who are in positions of power, both economic, political and social, and who have loved ones or people close to them who are users. So we haven't worked out that interface.* (Respondent 50, representative, Psychological Association of South Africa)

> *I: And do you think it's important for people like yourself, running this kind of group, for people who have had mental health problems to have a voice with policy makers around the issues? R: I think so because now, as I'm talking now, some of the facts I'm saying here are not documented anywhere. I: Yes it's true. R: I'm so exposed to the people on the ground, and then the politician doesn't know, can't get the facts, and I'm the one who experiences this and the facts, I might highlight it to the policy makers, it might not be documented in any paper…. So I'm making a very much important source of information that is nowhere to be found and it's looking from an experience myself and then the experience in talking to people and the contact with people and working with doctors and working with psychiatrists and psychologists. I: So with all the experience that you have now, you are speaking, and you are helping to educate people that are providing services, like GP's and doctors and nurses and psychiatrists, the family members of people, but the policy makers, so far you have not been successful to carry your message to them? R: I have never been successful in meeting them. I: But am I understanding from you that you think it's important to have that voice with them? R: It can make a*

*difference. (*Respondent 39, mental health care user, support group facilitator and mental health advocate)

The view of users most often brought to the minds of the public and professionals is that of a sick individual poorly equipped to participate in public life. Respondents stated that exposure to competent users through their involvement in policy development and advocacy initiatives would promote de-stigmatisation of this service group.

> *R: But I think there is some kind of a myth, right, I think this is why the Mental Health Federation is developing a kind of amplified information brochures and things like this.   They begin to educate the public about what is the phenomenon called 'mental health' and so that because there is this myth and fear that this is another breed of people and therefore we will help them. (*Respondent 13, leader, national disability organisation)

The psychosocial difficulties which can follow mental ill-health can deeply impact on a person's confidence and belief in his or her abilities to take up their social roles, particularly in the face of the current pessimistic public view of mental disorders. User respondents noted that their participation in decision-making, including policy development and input to the provision of services, is an essential aid to their recovery and social reintegration.

> *Unfortunately the condition of our users in this country aren't that very motivated and don't want to take on challenges like this to start a user movement run independently. I don't want to philosophise about the reasons why this is happening but I think possibly people have to be told that they must believe in themselves and I think it's a loss of belief in people's own ability to do stuff for themselves and therefore my philosophy, my direction has gone towards the idea of self-help and we must have, working towards the idea of independence and self-help, maintain that we will be helping ourselves. My idea is not to want to have a dissident organisation which is out to oppose the medical establishment of psychiatry as such; that shouldn't really be the focus, but essentially the idea is to prove – not to prove to anyone but to ourselves – that user-run initiatives can happen, it can work, it can make a difference and can work independently.* (Respondent 34, mental health care user and mental health user advocate)

Several areas were highlighted which would benefit from user involvement, including user participation in:

- public awareness, destigmatisation and other advocacy programmes;
- professional training programmes, to balance the negative impact of providers' exposure to users almost exclusively during periods of illness, and rarely as people engaged in the usual activities of daily family, work and social life;
- policy development;
- service development and monitoring; and

- service provision, in particular peer support programmes, and self-help projects.

3.2.5.2 The development of a mental health care user lobby

Currently there are three provincial advocacy groups affiliated to the provincial structures of the SA Federation for Mental Health, as well as a few independently organized user groups in some of the provinces. These aside, other peer support groups primarily focus on support around psycho-education and management of illness and associated psycho-social difficulties. These support groups have been set up mainly by the Mental Health Societies of the SA Federation for Mental Health, the South African Depression and Anxiety Support Group and, in a few provinces, by the state mental health services. Respondents felt that these support groups are cost-effective and beneficial for user recovery and favoured the development of these groups throughout the country. Not all users attending support groups will want to participate in policy development and advocacy, but respondents noted that support groups could provide a platform from which to identify interested people, consult with users regarding their needs, inform users of policy developments which impact on services they use, obtain input to new policy developments, and build a local, provincial and national mental health user based lobby.

The development of an independent mental health user lobby within the broader disability lobby was supported by respondents, although it was felt by most respondents who commented on this issue, that "start up" support for the development of the lobby would be needed, both in terms of technical and financial resources. The SA Federation for Mental Health was the most frequently mentioned organization which respondents felt could facilitate the development of such a national lobby for users.

> *R: I think you know if you look at within the Federation, we're getting somewhere. Not there yet and not for a while, but we're on that road, yes. I: On the road to national representation, or at least getting user voices on board? R: Voices on board and even at a provincial…well, regional provincial level. And that's going to take some time. I: What do you think should be the next few steps just to take us a little bit further along that road? R: Again, I think the Federation definitely needs to drive it, I think the Federation needs to expect each region to at least have an elected …well, at least a provincial elected representation. And that they have to see a national launch in sight. . (Respondent 31, director, provincial mental health NGO).*

> *R: The SA Federation is in very good position because it's the largest and most trusted by government but I think the SA Federation must allow people to be quite diverse. I: So you're saying that the SA Federation could play the role of assisting with the facilitation of discussions around the setting up of such a forum? R: That will be fine that they can bring that forum together with all these organisations …bringing in all the service users…once it becomes a forum they know*

there's a central identity they can move to, although they have their own diverse needs and own ways. I: So just to be clear that I understand you correctly, there's a need for an independent, nationally identified service user forum with national, provincial and local component? R: There's a need for service user representation and other organisations doing it too, I think it should be a joint operation. Not just service users but also other organisations because other organisations actually provide support to service users…(Respondent 37, mental health care user and mental health user advocate)

A few user respondents cautioned that NGO support, while welcome, should not replace the development of independent user action and direction over time:

R: How is it that South Africa can't make possible, which some African countries has made possible, to start a user organisation?...I've studied different models and I see in the UK where you have a large but disjointed user/survivor/ex-user movement. They also have a similar structure to the South African Federation called MIND…I: An NGO that's primarily service-driven and run by professionals? R: Yes. It's called MIND but they have a large user structure affiliated within MIND which is independent of mind also, which is called MINDLINK… when it comes to the identity of the DPO (disabled people's organisation) representing, nationally, people with psychosocial disabilities or user survivors, it is an independent entity…In South Africa, the South African Federation for Mental Health has always functioned as an equal, as the DPO for mental health users…That's a problem; it has to come from a genuinely legitimate DPO which is established for that purpose of being the voice of the users…I: And we don't have that in our country? R: We don't. Who is the true voice? I: So in the South African situation we've got the SA Federation…and they've got a lot of clout and then you've got a few consumers on the Board but you're saying that there isn't a consumer body that's springing out of that or that is separate to that? R: They're not going independent. They are still very dependent. (Respondent 34, mental health care user and mental health advocate).

3.2.6 Support for Families

Respondents stated that the policy of deinstitutionalization, intended to support user access to services and continued integration into community life, has at this point in service development primarily resulted in "de-hospitalisation": a cost-saving exercise without the simultaneous development of the necessary community based supports to assist users and their support system to cope with psychosocial disabilities within a community setting. Consequences of poorly planned deinstitutionalisation were identified as: frequent relapses – and consequently frequent readmissions to over-burdened services – family strain, and decreased support of users. These resulted in mental health service users being exposed to violence, abuse and neglect, impoverishment and adverse living conditions. The issue of support

to families was a discussion strand within the overall issue of increased reliance on community care without increased development of supports, which spontaneously emerged as an area of concern for respondents.

Respondents felt that a targeted programme for family support to user recovery was necessary within the overall development of mental health supports. Mention was also made of the limitations of an individual approach to supporting users, and the need to consider widening the scope of benefits accrued to users, to include a family and community perspective.

> *If you take one individual that is disabled be it physically or mentally, you can support that person but my feeling is that person belongs somewhere in a family and that family belongs somewhere in a community. It's a network. When we give disabled people support we should not only be physically helping them with wheelchairs and food and a nice building, there's emotional side there's mental support…these people need love and even if you love them…we have people who work in hospitals who happen to be sisters, nurses, doctors giving these people love but where is their family because everybody belongs somewhere. That person needs to know I belong to this family. That person needs the love of a family.* (Respondent 60, Elder, Christian Zionist Church of South Africa*)*

> *We don't undermine the mental illness in our community, we accept them as you know human beings, like people that have HIV and AIDS, we live with them we eat with them and we counsel them we tell them that no it's not the end of the line, it's not the end of everything, you can live longer as long as you get something that can build your immune system and so on, especially because on behalf of the mental illness people we cannot talk they will not listen to you it's like you know it will be a story. You rather talk to their parents or their sisters or their brothers. So what I can say generally is that we live with them, we accept them as our brothers our sisters our family, we don't undermine them.* (Respondent 45, traditional healer).

At the same time, some respondents stated that the balance of providing individual or family-community based solutions to user supports needs careful deliberation as implementation of one at the expense of the other can have unintended effects on the wellbeing of users.

> *I: What would you say is the role of the disability grant in such a poverty-stricken environment like yours? R: I think in this place it's a life-saver. It keeps more people alive than the one it is given to. The disadvantage of this is that the one it's given to is being most of the time abused because of it. I: What happens there? R: They will be very nice towards the patient while there's money and they will look after them but just after the money is finished, there's a lot of physical abuse again. I: Yes, so every month when the money comes in things go well? R: For two weeks, fine and then after that it's a nightmare again*

and they don't have the self-esteem or the ability to fight for themselves. (Respondent 24, director, provincial mental health NGO)

Summary: Mental Health Situation in South Africa

Low priority of mental health: Public attitudes toward mental health conditions remain generally negative, and despite a progressive and supportive policy framework for mental health, mental health remains a low priority on the public sector agenda.

Poverty and mental health: Poverty erodes mental wellbeing, and limits the amount of social and economic investment that struggling families and communities can invest in supporting people with mental disability as their energies are diverted to issues of daily survival. Mental health concerns are generally poorly integrated into the policies of other sectors, and the link between poverty and mental is poorly understood. This results in a lack of inclusion of people with mental disability in poverty alleviation initiatives, even where this is articulated for people with other disabilities.

Stigma in mental health: Participants agreed that stigma towards people with mental illnesses is still prevalent. Stigma contributes to loss of, or inability to obtain employment, inability to access social security, poor access to health care, receipt of poor quality health care, and loss of housing. Stigma also contributes to the low priority of mental health on the government agenda. Respondents felt that the key strategy for addressing stigma and mental health is education and awareness-raising, as early as possible, through mediums such as public campaigns, identification of champions or role models, workshops at various settings, media, and information packages. At the policy level, lobbying for including of mental health into departmental agendas is needed.

Mental health care users: The participation of mental health care users in this lobby is critical to educate policy makers and to provide them with better insights into mental health care user needs. The development of an independent mental health user lobby within the broader disability lobby is needed to support user participation.

Family support: The impact of deinstitutionalization, and increased reliance on community care without increased development of supports, spontaneously emerged as an area of concern for respondents. Respondents felt that a targeted programme for family support to user recovery was necessary within the overall development of mental health supports.

3.3 General policy making processes in South Africa

Having documented respondents' views on the context of mental health policy and the general situation regarding mental health in South Africa, the report now turns its attention to general policy making processes in this country. This forms an important contextual backdrop to the findings regarding current mental health policy development and implementation. The findings in this

section are taken from a brief review on the general policy literature in South Africa, to provide an understanding of general policy making processes in this country. The focus in this section is on policy making procedures that are officially said to be in place. The reality of whether these are in fact adhered to is discussed in relation to the issue of mental health in the sections that follow, through the findings on mental health policy making processes from interviews, WHO Checklists and the WHO AIMS data.

3.3.1 Policy making in South Africa post-1994

After the 1994 democratic elections South Africa was a state in transition. New processes of policy-making evolved continually in most policy domains (Booysen & Erasmus, 2001). The main focus of the new ANC led government was to abolish all the apartheid policies and develop new policies that would meet the needs of previously disadvantaged groups. It was through these new processes of policy-making that an incisive turnaround of pre-1994 social and political policies of exclusion and differentiation was attempted (Booysen & Erasmus, 2001). In essence the main focus of the new government was the restructuring of policy-making processes.

This restructuring was continued by President Thabo Mbeki when he took office in 1999 and decided to restructure the presidency. One of the main acts of restructuring was the clustering of government departments and Cabinet members into committees around five key policy clusters. The restructuring of the presidency was aimed at providing better service delivery to South Africans and ensuring that these departments worked together cohesively.

The five key policy clusters are:

1. *Economic Affairs-* consisting of Cabinet portfolios of Finance, Trade, Labour and Water Affairs.
2. *Social Services-* including the Departments of Health, Education, Housing and Social Development.
3. *International Relations-* consisting of Foreign Affairs and Defence.
4. *Intergovernmental Relations-* including the Provincial and Local Government.
5. *Criminal Justice-* consisting of Safety and Security; Justice, and Correctional services.

The most powerful policy-generating clusters in South African politics centre on top government, in particular, the Cabinet and the Presidency. The Policy Coordination and Advisory Service (PCAS) was added as a significant component of the core policy cluster to monitor the progress of policies being implemented and also to make suggestions around certain policies being developed to the presidency.

3.3.2 Stages of the policy-making process in South African Government

The policy-making process in South Africa follows the same basic phases that can be found in many other generic policy-making process models. The more general steps to policy making include the following phases: *problem identification, agenda setting, policy deliberation, policy adoption and finally policy implementation*. The process does not necessarily follow a linear progression from articulation of a need to the eventual adoption of policy. In fact policy-making may be viewed as an ongoing, interactive process (Booysen & Erasmus, 2001).

In South Africa, policy-making normally adheres to the following general stages:

1. Firstly a need is identified for a new policy or to revise existing policy. This is done by government or at the request of stakeholders. These people are identified as policy actors and usually drive the policy initiatives.

2. Departments are expected to draft the policy and to consult relevant stakeholders.

3. Departments are expected to revise the draft based on the inputs from stakeholders.

4. Once consultation is completed and the draft has been approved by the stakeholders, departments take the proposed policy to the relevant clusters. To illustrate: if the Department of Health has drafted a mental health policy and consulted all relevant stakeholders on the draft, the Minister of Health will then present that draft policy document to the Social Service cluster. The ministers from each of the departments will give their input on the draft mental health policy around areas that might overlap with policies that they already have in place, or on shared responsibilities within the policy that is being developed. They will also argue for or against the policy.

5. Once revisions are made based on the inputs from clusters, the document is then submitted to Cabinet for consideration. Cabinet with its links to the presidency is a core agency in policy-making and implementation. The Cabinet office has three sections: research, operations, and a Secretariat which oversees and coordinates policy across ministries and departments. Many of the core activities of Cabinet secretariat concern policy-making, policy adoption and policy implementation.

6. Cabinet endorses the draft policy and it then becomes effective or changes are recommended before the documents come back to the cycle again for endorsement (Sourced from the Office of the Presidency, 2007).

With regards to legislation, the same process applies except that the State Law Advisors review the draft legislation to ensure that proposals are in line

with the legal framework and provisions of South African law, and that after Cabinet endorsement, the proposed legislation moves to parliament where it is treated as a Bill until such time that it is adopted and later signed into law by the President.

3.3.3 Documentary stages of policy development

In South Africa policy is not just about identifying a problem and adopting a policy but the process itself also involves a sequence of documentary stages (Booysens & Erasmus, 2001). These documents may originate as position papers and discussion documents. This documentary process in policy development helps to track the status of the policy within the government bureaucratic structures. For example the process may begin with a discussion document, followed by a Green Paper, a White paper, draft legislation and then final legislation. Both the White paper and the draft legislation are monitored and approved by Cabinet before they advance to the stages of draft or final legislation.

3.3.4 Insiders and Outsiders in the policy making process in South Africa

In South Africa there are broadly two groups of people that are involved in policy-making process. The first group is referred to as the "insiders" in government. The insiders are institutions that are directly linked with the process of policy-making. These insider institutions have a great deal of power to influence policy development and change. In summary these institutions are:

- National Government Departments
- Provincial Government Departments
- PCAS structures
- Cabinet and Cabinet Committees
- Parliamentary committees, eg portfolio committees
- National Assembly
- National Council of Provinces
- Provincial and Local government institutions
- Constitutional court
- Intergovernmental institutions and meetings eg, MINMEC (Meeting of the national Minister and provincial ministers, now known as the National Health Council)

The outsiders are usually referred to as "civil society". They are individuals or institutions that serve as a link to wider society on government policy-making processes. The strategies usually employed to get the involvement and participation of civil society in the policy-making process is through the following:

- Public hearings of parliamentary portfolio committees
- National conferences for public participation

- Community forums for policy fine-tuning
- Commissioning research to NGOs and research institutions
- Using specialists and experts from academic sector
- Special meetings with and briefings of private sector institutions
- Meetings with lobbyists.

Summary: General policy making processes in South Africa

- In South Africa the National Departments are grouped under five key policy making clusters consisting of: Economic Affairs, Social Services, International Relations, Intergovernmental relations and Criminal Justice.
- The general policy-making process in South Africa adheres to the following phases: problem identification, agenda setting, policy deliberation, policy adoption and finally policy implementation.
- Cabinet is responsible for the endorsement of the draft policy document and makes it effective, once it has gone through all the policy-making phases.
- The process of policy-making in South Africa also involves different documentary stages: a White paper, draft legislation and then final legislation.
- Some of the institutions directly involved in policy making process are: National government department, provincial government, cabinet and cabinet committees etc.
- Civil society's participation in policy making process is incorporated through some of the following strategies: Public hearings of parliamentary portfolio committees, National conferences for public participation, Community forums for policy fine-tuning.

3.4 Process of mental health policy and law development

3.4.1 Mental health policy development

3.4.1.1 Stages of mental health policy development in the Department of Health

Across all stakeholder groups consulted within the health sector, other than those at chief director level, respondents had some difficulty articulating a clear understanding of the formal departmental processes to follow in developing a mental health policy, and how they might participate in this process.   Respondent 23, a health policy maker in the Department of Health outlined the following process for policy development which is followed by policy developers in the Department of Health:
- Identification of the need for and purpose of the policy.
- Identification and tasking of the relevant section and official(s) within the department to drive the development of the policy.

- Setting up a working group to compile the policy, and informing provincial coordinators for mental health of the new policy development process. Provincial coordinators are central role-players in the policy development process within the provinces, and are responsible for implementation of the policy once it is approved.
- Scoping of the policy : Literature search on the policy issue and review of similar policies in other countries.
- Development of a draft document by the working group.
- Consultation with representatives of the discipline(s) and other stakeholders involved in the policy area. This will be done via one or more workshops. The workshops are used to generate stakeholders' perspectives to incorporate into a revised draft policy document, and to clearly identify and agree on the roles which stakeholders may play in effecting the policy once it is implemented.
- The draft policy is then circulated to a broader range of stakeholders throughout the country for further comment and development. Again, workshops may be used, as well as electronic and other forms of communication. At this stage, provincial coordinators play an important role in coordinating input to and consultation with stakeholders at provincial and district level. This stage of policy development might involve more than one round of consultation, and will continue until saturation is reached, and no new perspectives are generated.
- The policy is finalized, costed and submitted for approval within the department. At national level costing of the policy is intended to provide a general overview of the expected implementation costs to the country.

The approval process within the Department of Health then involves the following steps:

- The document is presented to health management, which includes Directors, Chief Directors, the Deputy-Director General for Health and the Director General for Health.
- Recommendations for redrafting or amendments to the policy is effected by the drafting team and followed up. Depending on the nature of the amendments to the document, a second presentation may be required at this level.
- Once approved at management level the document is presented to senior management, comprising the Chief-Directors, the Deputy-Director General for Health and the Head of Department.
- Approved at this level, the document will be submitted to National Technical Committee comprised of provincial Heads of Health, the Deputy Director General and Director General for Health.
- The heads of the provincial health departments are given three months for formal consultation with provincial stakeholders. Written comment on the policy is submitted to the national office and the policy document is revised, where necessary.

- This revised draft is submitted to the National Health Council (NHC), comprised of the provincial MECs for Health and the National Minister of Health.
- If the policy differs significantly from current policy, or has implications for other sectors, it is then referred to the Social Services Cluster, for approval at cabinet level (see above). If it is not a significant departure from current policy, then the NHC has the authority to approve the policy.
- Once approved by the NHC, the document becomes a formal policy.
- The new policy is then formally distributed to the provinces by the national directorate responsible for the policy.
- The national directorate responsible for the policy then:
    - sets national indicators and implementation targets to effect the policy and supports provinces to develop an implementation plan in line with these targets, and the needs and resources available at provincial level.
    - budgets for and facilitates provincial training in the policy
    - provides technical assistance in the implementation of the policy, developing relevant protocols to support implementation
    - provide ongoing monitoring and support to implementation.
- The provincial office for mental health is then responsible for implementation of the policy. Provinces will then:
    - draft an implementation plan,
    - prepare detailed costing of the plan
    - submit the plan and budget through provincial management channels for approval.

Availability of resources at national and provincial level will influence the timeframes and process for development of the policy at national level, and the achievement of targets by provinces.

3.4.1.2 Current status of mental health policy in South Africa

South Africa's first post-apartheid mental health policy guidelines were approved in 1997. This policy took the form of a document titled "National health policy guidelines for improved mental health in South Africa" (Department of Health, 1997a). In that year, a chapter on mental health was also included in the Department of Health's "White Paper for the transformation of the health system in South Africa" (Department of Health, 1997b). These policy documents were associated with a range of major political reforms that followed the first democratic elections in South Africa in 1994, which marked the end of the apartheid era.

The mental health policy guidelines document was drafted by the National Director for Mental Health in the Department of Health, with the encouragement of the National Minister of Health. The policy guidelines were informed by the provisions of the White Paper on Health, desk research into existing mental health policies in selected countries, consultation with stakeholders in South Africa, as well as visits to other countries (Chile, Cuba and Zimbabwe) to understand their mental health policies and services.

Consultation processes for the mental health policy guidelines in fact preceded the transition to the "new" South Africa in 1994. During this time there were many consultative meetings among mental health stakeholders, but also within the African National Congress (Freeman & Pillay, 1997). The recommendations of the WHO were also highly influential[1].

Policy issues that required urgent guidance, such as integration of mental health into general health care, were given more detailed coverage in the policy guidelines document than less urgent issues. In general, however, the 1997 policy guidelines were drafted as an overview document, with the intention of having more indepth consultations with stakeholders with expertise in these areas, to draft more detailed policies for specialized policy isssues highlighted by the overview document. Examples of this are the Child and Adolescent Mental Health Policy Guidelines, and the Psycho-social Rehabilitation Policy Guidelines. The other priority policy guideline which has been in progress for many years is the Substance Abuse Policy Guideline, which has not yet been completed.

The 1997 policy guidelines are therefore most accurately read in conjuction with specific policy guidelines listed above, and the White Paper on Health (1997). No official plan accompanied the policy, but national targets with indicators were set to guide the realization of selected priorities such as integrated mental health care and deinstitutionalization, and national and provincial operational plans were developed internally to guide implementation of the policy.

The Policy Guidelines were presented to the Meeting of the Health Minister and the 9 provincial Members of Executive Councils (MINMEC) in 1997. MINMEC (now called the National Health Council) is the highest decision-making body for health in South Africa, and all potential health policies need approval from this body before implementation can take place within the provinces. Approval of the policy guidelines was granted by MINMEC in 1997.

Although the 1997 policy guideline was approved for implementation by MINMEC, due to capacity constraints within the national office, it was neither formally published nor widely circulated throughout the country, nor were the specific policy guidelines all completed or followed by the development of implementation guidelines. There were some expectations by the national office that provinces, as the level responsible for implementation of mental health services, would take up this role, particularly as the policy was approved by MINMEC following consultation with the provinces.

Following approval of the policy guideline by MINMEC, the shift to implementation is two-fold. Firstly each provincial Minister of Health and head of provincial department is meant to take the decisions of MINMEC back to their province and oversee its implementation. Secondly, the national level

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[1] Information in this section on the development of the policy guidelines is based on written feedback obtained from Professor Melvyn Freeman, who in his former capacity as the National Director Mental Health and Substance Abuse, drafted the 1997 policy guidelines, and the Mental Health Care Act, no 17 of 2002

takes these decisions to quarterly meetings of provincial mental health co-ordinators to discuss, monitor and support implementation.

Those current provincial coordinators who were in their posts in 1997 noted during their semi-structured interviews, that they remembered receiving the Policy Guidelines of 1997 at a quarterly interprovincial mental health meeting with the National Directorate for Mental Health. According to interviewees, the 1997 national mental health Policy Guideline was subsequently used by provincial mental health programme managers to initiate work in key areas of the mental health programme within the provinces, and at national level, to initiate the development of norms, standards and targeted policy guidelines in areas such as child and adolescent mental health, psychosocial rehabilitation, and substance abuse. Although they used this document to guide their work in developing mental health services in their provinces, none were sure that the document had been officially approved as national policy.

> *And then we've used the policy from the National. We were in process, actually we are in process of developing but because the National isn't, as you know, the National's one isn't...isn't approved with...I: Sorry, are you referring to the policy document that was developed by Mel Freeman in 1997? R: That's right. I: Ok, so you've been using that? R: We've been using that and we've being using the White Paper...*
> (Respondent 20, provincial programme manager for mental health)

There are a number of possible reasons for the lack of widespread uptake of the 1997 policy guidelines:

- There was low priority given to mental health by provincial leadership and decision-makers responsible for provincial implementation plans, compared to other implementation priorities, despite national acceptance of the policy.
- Provincial mental health coordinators had limited bargaining power to promote the prioritisation and resourcing of mental health services. They were often in junior management positions without adequate access to such decision-making positions.
- Capacity for policy development in the mental health sector has been limited in the last few years:
    - There has been a loss of experienced policy makers and advocates within the national mental health directorate, with a lengthy period of time (2004 to 2007) taken to replenish these lost skills by appointment of suitable policy makers to the vacant positions.
    - There has been a paucity of senior posts to attract adequate skills and to position programme managers strategically within the Departmental hierarchy to allow for effective impact on policy development and resourced implementation.
    - There has been inadequate attention to skills development in policy making and implementation for new and existing national and provincial mental health coordinators.

- The change over in national leadership structures has been accompanied by new leadership being insufficiently informed of previous developments.
- There has been insufficient use of formal national-provincial dissemination /communication channels to promote the policy guidelines.
- There has been insufficient lobbying and technical support from the national office for the implementation of the policy in the provinces.
- There has been insufficient development of activism within communities and the mental health and disability movement to lobby for implementation of the provisions of mental health policy.

Currently the Cluster for Non-communicable Diseases, within the National Health Department, and specifically the National Directorate: Mental Health and Substance Abuse, located in this Cluster is in the process of drafting a National Mental Health Care Policy for South Africa and assisting in the implementation of the Mental health legislation, as directed by senior management. This new draft policy is regarded as the first national mental health policy for the country by the current national mental health officials[2]. The first draft of this policy was compiled as a desktop activity within the Cluster, and circulated for input to mental health stakeholders in the country in April 2006. The Cape Town based team of the MHaPP submitted input to this process in June 2006, along with colleagues from the Human Sciences Research Council (HSRC).

A second round of consultations with provincial coordinators has concluded and the inputs from these consultations are being incorporated into the April 2006 draft document under the direction of the new national director. This will be followed by broader consultation with stakeholders. According to the Department of Health, timeframes will shortly be set for these activities.

In the absence of national policy, two provinces (Free State and North West) have developed their own provincial mental health policies, using the new Mental Health Care Act (2002) as a guide. According to the national Directorate, Eastern Cape, Western Cape and Gauteng also used the 1997 policy guidelines to develop their own provincial mental health policies.

To shed some light on the official status of the 1997 Guidelines, the Cape Town office of the MHaPP is in the process of trying to obtain copies of the MINMEC minutes for the year 1997 from the Secretariat for the National Health Council (previously the Health MinMec). These are restricted minutes and permission for access is being sought from the Ministry for Health.

3.4.1.3 Areas of action for policy development

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[2] Most officials in the national mental health directorate at the time of drafting the 1997 guidelines have left the service. Those remaining were junior officials at the time and not involved with the policy developments or relatively new to the work of the directorate (appointed during the past 4 years) (Personal communication, Professor Freeman).

Respondents to the semi-structured interviews suggested the following strategies to strengthen the development of a national mental health policy:

- Develop one overaching national mental health policy to provide a comprehensive understanding of the range and scope of work to be conducted within the field of mental health. More targeted policies can be developed to support this, as necessary.

  *I: You thought that it would be a good idea to have a guideline and then specific policy. R: A guideline and then more specific policy. Yes. That was why we did the child and adolescent one and the psychosocial rehabilitation one; there was meant to be a substance abuse one, and it was meant to be a sort of a cumulative process; as we needed, we would sort of develop more and more until there was full package. (*Respondent 64, former policy maker, Department of Health)

- The policy should be based on wide and thorough consultation with stakeholders.

  *I: W*ho do you think should be part of that consultation process? R: Right, it should be mental health care users, it should be mental health care practitioners and it should be multi-sectoral, like social work, we also know that the SAPS (South African Police Service) and the Department of Justice are very much involved as far as mental health users are concerned. So it could be, it should be multi-, multi-disciplinary, multi-sectoral, and of course, the Department of Education.* (Respondent 15, Head of Clinical Service and Department of Psychiatry in one province).

- Support should be provided to stakeholders unfamiliar with the policy development process, to equip them to engage meaningfully with the policy consultation process.

  R: But I'm not strong as I said, I know that XXX is very good in terms of law and very strong in terms of policy and legislation and that I think is one of my biggest areas of weakness, in terms of myself and in terms of my skills and I need to work at that more. (Respondent 49, programme manager for an NGO supporting people with Intellectual Disability)

  R: So I can give you a hellava lot of input,but I mean, it might not be relevant, because that was not the way of thinking. I: Yes, so if policy documents come to role players for input, it must be very clear what is expected and what is permissible, you know, what kind of things you can feel free to input. R: I think so. Because otherwise you know, we are not all politicians. Not politicians, but we are not all policy makers. It's not your strength, strong point. (Respondent 24, Director, provincial mental health NGO)

- Meaningful consultation would need to be mindful of the cultural and linguistic diversity of respondents in South Africa.

  I: So in fact you are doing quite a lot of mental health work in your church on an individual basis? R: We didn't seem to have the same understanding of mental health work. I: Are people not using the terms 'mental health' in your church? Would they describe their problems in a different way perhaps? R: Yes. We don't use that term but that's exactly what we do. I: I'm coming from a mental health field, so I tend to use that term, but would you say that in a community setting the more common words that people would be using is what? Emotional problems…how do people describe their condition when they come to you? R: We would use our African language more. (Respondent 60, Elder, Christian Zionist Church of South Africa)

- The policy should be based on sound evidence.

  R: I think before one develops a policy, one would have an analysis of the situation to inform the policy developer, what is there and what needs to be put in place and what needs to be, you know, in that document, what is the main focus. (Respondent 18, provincial programme manager for mental health).

  R The other organisation that we should be using a lot is the World Health Organisation. I think their Mental Health programme also has published a lot of very useful documents around various aspects of the Mental Health services. (Respondent, former provincial programme manager for mental health).

Respondents stated clearly that the incomplete policy issues identified above should be driven by the Mental Health Directorate within the National Department of Health, in collaboration with their provincial counterparts:.

  I: Why would you think that this particular programme is one of those programmes that does need a concerted advocacy and somebody to fly the flag for them? R: You know, mental health is not a...a very, what can I say…sexy programme. And I think the whole history of mental health, not only in South Africa, in the world, is...is one of, ag, you know, diagnose them and leave them there in the institution. See that they've got food and clothes and that they get their treatment. It was, but since we have implemented a Human Rights approach, there is definitely a…a champion needed because it's a whole shift, mindshift that needs to take place. And I would say among, from senior to junior people and for that you definitely need somebody to drive that process. I: And, do you have an opinion around who that somebody should be? R: Well, I think of course, the Director for Mental Health should be that person, and also within the provinces, the programme managers. They…they should be the people that now, as I said, currently, I think we're very lucky to have in most of the province quite good programme managers in that sense. That they understand the shift and that the

shift must take place. So hopefully there will be a major improvement because that will also lead to better understanding of the Mental Health Care Act (Respondent 23, national policy maker Department of Health).

However, concerns were expressed about the need to strengthen and maintain required capacity of the National and Provincial Directorates for Mental Health to effectively carry out their policy development and implementation briefs:

> *R: And, as I said, that's my personal opinion, that was the situation because of the Director's post not being filled, because in the provinces the post levels were quite low, low-level post in…in the hierarchy, so they don't have often the opportunity to also perhaps; it's not that they not willing, but the…the opportunities were just not there.*
> *I: And is this a situation that you feel is improving?R: Yes, no definitely. Definitely it has. I can tell you that the people are included now in meetings, there are directors even appointed in some of the provinces...* (Respondent 23, national policy maker, Department of Health)

> Re the status of policy for mental health *: R: Ja, I think it's quite weak because it's not really at the centre of issues in the country. It's peripheral as far as I'm concerned and it's not a priority…I've engaged with the department on a variety of issues. I know that in terms of applying the Act…in terms of doing that, but when I'm talking about a policy, I'm just talking about a strategic sort of charter that we'd say: this is what we want to do… If you look at that, we're all doing our own thing in different ways. There isn't a very co-ordinated and I think I don't see any kind of leadership that says: this is where we are going.*
> *I: And what do you propose should be done to improve this situation?*
> *R: I think somehow or the other we will need to sort of culminate in some kind of a summit. Where people that are actively involved in the sector could start actually talking and starting to chart a common course.* (Respondent 04, director, mental health NGO)

It was felt that the capacity development needs of this central group within the mental health sector needs to be addressed, and in the shorter term, given the current human resource constraints in the national directorate, and the specialised legal, technical and clinical nature of some of the policy issues, that the Directorate should make use of expertise available countrywide to assist them with the drafting of policies, guidelines and programmes.

3.4.2 Mental health law development

The process of developing the Mental Health Care Act no 17 of 2002 followed the standard process required by all legislation, as outlined above. During the interviews, it was agreed by all respondents who addressed this issue that the Department of Health consulted widely and extensively during the development, finalisation and promulgation of the Mental Health Care Act no

17 of 2002. The process of this consultation is set out in the WHO Mental health legislation checklist (see Annex 3).

There also appeared to be general support for the Mental Health Care Act in parliament. One respondent point out that the promulgation of the Act was one of the fastest in the history of the democratic era parliament, a fact that she interpreted as indicating widespread political support for mental health among parliamentarians.

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Summary: Process of mental health policy and law development

- The official process of mental health policy development does not differ significantly from that of other public policies.
- However, the South African Mental Health Policy Guidelines, approved by MINMEC in 1997, are not regarded by current Department of Health officials as official policy. There is currently no official policy, but the National Directorate: Mental Health and Substance Abuse is in the process of developing a draft policy.
- Many respondents expressed the view that the development of a national mental health policy was an urgent priority, and provided suggestions for how this policy should be developed, namely:
  - Develop one overaching national mental health policy
  - Base the policy on wide consultation with stakeholders.
  - Equip stakeholders unfamiliar with policy development to engage meaningfully with the policy consultation process.
  - Base the policy on sound evidence.
  - Strengthen capacity of the National and Provincial Directorates for Mental Health to effectively carry out their policy brief
  - Review other policies that have a bearing on mental health in SA.
  - Note the principles and directions of the UN Convention on the Rights of Persons with Disabilities, and the National Disability Strategy for South Africa
  - Draft or finalise other specific policies, including the policies on Psychosocial Rehabilitation and on Substance abuse

- The Mental Health Care Act 2002 was developed through an extensive consultation process and appears to be widely supported by the respondents interviewed, particularly for its human rights orientation and promotion of community-based mental health care.

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3.5 Content of Mental health policy and law

3.5.1 Content of the 1997 Mental Health Policy Guidelines

The 1997 policy guidelines document includes the following components:

1. developing community mental health services;
2. downsizing large mental hospitals;
3. developing a mental health component in primary health care;
4. human resources, involvement of users and families;
5. advocacy and promotion;
6. human rights protection of users;
7. equity of access to mental health services across different groups;
8. financing;
9. quality improvement; and
10. a monitoring system.

The detailed analysis of the 1997 policy guidelines and recommendations for improvements to future policy are set out in Annex 3.

3.5.2 Appropriateness of current mental health policy

As mentioned, there is currently no official mental health policy in South Africa. Suggestions for areas of policy development made by respondents are set out below in Section 3.5.4.

3.5.3 Links with other relevant policies

Apart from formal mental health policy documents, respondents pointed out that there are a number of other policies that have an important bearing on mental health in South Africa.

3.5.3.1 White paper for the transformation of the Health System in South Africa (1997)

The White Paper on Health (Department of Health, 1997b) is a key policy document which has informed much of the restructuring of health services in South Africa, post-apartheid. Chapter 12 of the White Paper is dedicated to mental health, and sets out the responsibilities for mental health policy development and implementation within the health sector in South Africa through national, provincial, district and community structures.

- **The National Directorate Mental Health and Substance Abuse**

The White Paper on Health proposed the establishment of a Mental Health and Substance Abuse Directorate at the national level. The key function of this Directorate is to plan "comprehensive and community-based mental health and related services (including substance abuse prevention and management) at the national, provincial, district and community levels, and integrated with other health services", with input from relevant roleplayers. This work should facilitate and support the development of preventive and promotive services, decrease reliance on custodial care, and support community involvement.

Box 1 lists the functions of the Directorate specified in the White Paper on Health (Department of Health, 1997b):

Box 1. Functions of the National Directorate for Mental Health and Substance Abuse

- evaluating the prevalence of mental health problems and promoting strategies to address problems identified;
- coordinating the restructuring of mental health services, including the development of norms and standards and integration of mental health services into PHC;
- promoting intersectoral co-ordination and the multidisciplinary team approach;
- developing norms and standards for the education and training of human resources for mental health;
- monitoring research on mental health on a national basis and promoting research in priority areas;
- monitoring and evaluating mental health services nationally and ensuring equity;
- exploring the nature and extent of collaboration with traditional healers;
- reviewing and evaluating legislation relating to mental health and substance abuse to safeguard the human rights of all service users;
- developing and promoting specific programmes addressing substance abuse, child abuse, women abuse and the management of victims of violence, in collaboration with other sectors;
- planning, providing and monitoring forensic psychiatric services;
- planning and promoting specific services for the mentally handicapped in collaboration with the relevant stakeholders and users of the services; and
- planning, developing and promoting specific services for psychogeriatrics to ensure quality of life, in collaboration with other role-players.

- **The provincial health authorities for Mental Health and Substance Abuse**

The White Paper on Health stipulates that provincial health authorities will be responsible for the development, co-ordination, monitoring and evaluation of mental health and substance abuse services at provincial and district level. Unlike at national level, a specific structure responsible for this work is not speficied at provincial level. Box 2 below lists the provincial functions specified in the White Paper on Health (Department of Health, 1997b).

Box 2. Functions of the provincial health authority : Mental Health and Substance Abuse

- Providing a sustainable budget for provincial and district mental health and substance abuse services;

- facilitating intersectoral co-ordination of workers from sectors such as religious, educational, women's, industrial, police, agricultural, youth and sport groups and NGOs;
- ensuring comprehensive integration of mental health and substance abuse services with other health services, to avoid verticalisation of the service; and
- ensuring that mental disability and psychogeriatric services are also included in the health services.

- **The district health authorities for Mental Health and Substance Abuse.**

The White paper on Health provides for district health authorities to focus on the comprehensive integration of mental health services with other services. Box 3 below lists the district level functions of the health authorities specified in the White Paper on Health (Department of Health, 1997b).

Box 3. Functions of the district health authority : Mental Health and Substance Abuse

- undertaking mental health education programmes in communities;
- planning, implementing and co-ordinating mental health and substance abuse prevention, promotion and rehabilitative services, including community-based rehabilitation;
- planning and implementing inpatient and day-patient care for the mentally ill and substance abusers, including 24 hour consultation services for mentally ill patients and victims of substance abuse;
- providing emergency and crisis interventions and counselling;
- providing training for health facility staff;
- establishing and maintaining mental health committees;
- maintaining collaboration with other sectors, private practitioners, traditional healers and NGOs;
- collecting data, and initiating/contracting out research in accordance with local needs, with the support of relevant institutions; and
- developing appropriate indicators for monitoring and evaluation.

- **The role of community structures in Mental Health and Substance Abuse**

The White paper also provides that district health authorities plan district level mental health care services, as well as substance abuse prevention, management and rehabilitation services, with non-governmental and community-based organisations and structures, and role-players from other sectors. Planning should be based on data collected on local conditions, and implementation should promote participation of these local and community

players. Box 4 below lists the activities which the White Paper recommends for action at community level (Department of Health, 1997b).

Box 4. Community-based activities : Mental Health and Substance Abuse

- form community mental health forums to evaluate causative problems within the communities, promote destigmatisation and reduce substance abuse;
- develop programmes to address violence within communities, with an emphasis on children and women;
- provide health education and information on mental health and substance abuse, especially for the youth;
- establish community centres for crisis intervention; and
- develop programmes to educate and support people with mental disability and psychogeriatrics, to improve their quality of life in the community.

3.5.3.2 United Nations Convention on the Rights of Persons with Disabilities

Recently, South Africa became a signatory to the Convention of the Rights of Disabled Persons. Respondents in the disability, mental health user and NGO sectors felt that the Convention presents an enormous opportunity for the mental health movement to forefront the challenges faced by people with mental disability in our country, and to participate in deriving solutions which will improve our human rights standing with respect to people with mental disability. It was felt that development of new legislation and policies and the implementation of existing laws and policies should be guided by the principles and directions contained in the Convention.

3.5.3.3 Integrated National Disability Strategy

The South African government has a national disability strategy which requires every government department to develop a policy which guides that sector to address disability issues in their work. Advocacy for inclusion and technical support to effect provisions which address citizens with mental disability in departmental disability plans is needed.

3.5.4 Areas to be addressed in the new Mental Health Policy

Respondents suggested the following areas to be included in the new national Mental Health Policy:

3.5.4.1 Child and adolescent mental health

A child and adolescent mental health policy guideline has already been developed at national level. Respondents said that technical support is now needed to develop mental health plans and programmes to implement the national guideline. It was felt that the work of developing an updated overarching national mental health policy would be important to help provinces contextualise the implementation of child and adolescent programmes within the overall service platform for mental health. Cognisance would also need to be taken of the national and provincial policies of other health programmes for children and adolescents, such as the policies for the health promotion programme, the reproductive health programme, the child and maternal health programmes, the school health programme, and the rehabilitation programme. Similarly child health related policies and programmes within other sectors would need to be reviewed, and consultation initiated, to align policy provisions which have intersectoral implications.

3.5.4.2 Gender issues

Preliminary discussions to prepare for the drafting of a women's mental health policy was initiated by the National Directorate for Mental Health a few years ago, but capacity constraints curtailed further development of this initiative. Respondents felt that an engendered perspective should be included as a cross-cutting approach to policy development and implementation. This should include:

- Policy and programmes to address the mental health implications of violence toward women.
- Community-based care givers are predominantly women. Little attention has been paid to the emotional, social and economic impact of, and appropriate supports to, women in these care giving roles in any sector, including in the mental health sector.
- Policy guidelines for same and mixed sex facilities for mental health care users. Provision for separate accommodation during treatment programmes for severe illness may be preferred by inpatient users, while users living and working in community-based support facilities may prefer integrated living spaces, for example. There is lack of clarity regarding when separate or integrated facilities are to be provided.

3.5.4.3 Intellectual disability

Intellectual disability, a marginalised issue within the broader mental health sector, was raised mainly by NGO-based respondents working in services for these users.

> *Intellectual disability is always bottom of the list when it comes to people focusing around disability. Part of the issue I think is that the nature of the disability is so hard...and often there's secondary disabilities that go with intellectual disability, so the person is often not always that attractive until it's your child or your family member or you realise that this is actually a person who's trying jolly hard, who just is not being given the rights that they deserve.* (Respondent 49,

programme manager for an NGO supporting people with Intellectual Disability) 1

This sector has lobbied for change around several crucial policy issues related to service development for this group. These include:
- o Inclusion of children with intellectual disability in the education system under the provision of the inclusive policies of Education White Paper 6.
- o Funding for day and residential care for profoundly and severely intellectually disabled adults, where provinces mainly, if at all, fund day and residential care for children and adolescents only.
- o Lobbying for a seamless, intersectoral approach to education, occupational and vocational training and lifelong learning services for this group.

3.5.4.4 HIV/AIDS and Mental Health

Respondents stated that the gap in the current policy framework about the relationship between HIV/AIDS and mental health should be addressed in the new national mental health policy.

3.5.4.5 Poverty and mental health

Respondents emphasised that an inclusive approach should be used, through which people with mental disabilities are beneficiaries of poverty eradication initiatives as much as other vulnerable citizens.

In addition, other key policies, related to mental health were said to require attention.

- **Finalise the policy on Psychosocial Rehabilitation**

The policy on Psychosocial Rehabilitation, currently in its 4th draft (2004) should be finalised as this policy contextualises treatment and supports within a recovery-based perspective, and provides a comprehensive overview of the community-based mental health services needed to promote recovery and social integration of users with psychosocial or mental disability.

- **Finalise the Substance Abuse Policy**

The Draft National Policy on the mental health response to substance abuse prevention and treatment of substance use disorders should be completed.

In addition to these comments from the interviews, the following suggestions were made by respondents to the WHO Policy Checklist for consideration in drafting the new national mental health policy (see Annex 3 for details).

PROCESS OF DEVELOPING AND IMPLEMENTING NEW MENTAL HEALTH POLICY
Evidence-based practice:
• Formal analysis of the mental health policy environment in South Africa should be

used in the process of developing the new mental health policy.
- A review should be undertaken of successful policies developed in other low and middle income countries.
- Current provincial policies and plans should be taken into account to ensure sensitivity to developments at provincial, regional and local levels of services.

Consultation with a range of stakeholders:
- **Inter- and intra-sectoral collaboration**: Collaboration with Social Welfare, Housing, Justice, Education and all other relevant sectors must be considered. For example, further discussion is needed with Social Development, to clearly delineate the scope and nature of their service provision for people with mental and intellectual disability, and people with substance abuse related problems. New discussion is required with (a) Department of Housing regarding the accommodation of people with mental disability in their Special Housing Policy, and with (b) Department of Correctional Services regarding services to people with intellectual and mental illness or disability in the prison system is needed. Technical support to these sectors and other health policy and programmes developers should be provided to assist them to define their role and to integrate mental health into their existing programmes.
- **Consumers:** Work is needed regarding the development of a consumer lobby in South Africa. The new mental health policy should more clearly define this area of development. Human rights perspectives on mental health care user participation and self determination should be articulated in the policy. Direct input from consumers (not only via provider representatives) should obtained (SAFMH-affiliated as well as other smaller independent support groups and advocacy groups should be consulted countrywide). The role and involvement of consumers and their support network in policy development and service evaluation should be set out in the policy.
- **Family lobby** remains small, but there are groups in different provinces which should be consulted as part of the drafting of the new policy.

Implementation support: A formal dissemination process, support to provinces regarding implementation plans and a national monitoring process will be needed. Advisory committees that were set up in some provinces in the 1990s have fallen away in most provinces. Advisory and/or multisectoral coordinating bodies could be a useful consultation and monitoring tool. A process for review of the implementation of the new policy must be built into the policy (eg through reviews of demonstration sites).

CONTENT OF THE NEW MENTAL HEALTH POLICY

As with the 1997 policy, the provisions of White Paper for the transformation of Health, chapter 12, are relevant for the new policy.

Poverty reduction and development focus: The new policy needs to note the context of poverty, the impact of social and economic inequality on mental health in South Africa, and in turn, how mental health problems can lead to, or perpetuate, poverty. The policy should suggest strategies to interface with existing poverty alleviation strategies adopted by government. The importance of mental health for wider development policy must be addressed. Examples include mental health related development considerations with respect to urban regeneration and rural development, access to basic amenities and housing, social supports, social assistance, inclusion in job creation and skills development opportunities, and the inclusion of mental health on the broader disability agenda.

Values and principles stated in the policy should promote:
- *Human rights and social inclusion*: the human rights provisions of the Mental Health Care Act and the provisions of the UN Convention on the Rights of Persons with Disability should be referred to and inform the content of the new policy.
- *Prevention of mental illness, promotion of mental health*: The provisions of the White Paper can be expanded in the new policy. Attention to the promotion of recovery and prevention of disability should be included.

- ***Awareness raising, public education, advocacy and destigmatisation***: The provisions of the White Paper, and the WHO advocacy module should inform this aspect of the policy.
- ***Dehospitalisation, deinstitutionalisation, community care, integration and equity with physical health care***: The policy and plan should clearly state the focus of community services, and use the Mental Health Care Act, 2002 and draft Psychosocial Rehabilitation (PSR) policy guidelines, 2004, to inform this approach.

Areas for action should spell out:
- strategies to promote a balance in the allocation of human and financial resources: The policy directives on financing should be informed by the current financing and human resource policy framework and mechanisms of the Department of Health – additional expertise from the finance and human resource sections should be secured to assist the directorate with this aspect of the policy;
- role and involvement of community structures;
- partnership with private/traditional practitioners;
- dedicated service providers;
- incorporation of training institutions as partners;
- capacity development (training, supervision, etc);
- quality improvement: The policy should commit to developing quality improvement mechanisms (standards for care, accreditation mechanisms) and a process to measure and improve the quality of services; and
- information systems: The policy should commit to developing mental health information systems that can guide decision-making for future policy, planning and service development.

3.5.5 Content of the Mental Health Care Act (2002)

The Mental Health Care Act was enacted in 2002 and promulgated in December 2004. It includes the following areas:

1. access to mental health care including access to the least restrictive care;
2. rights of mental health service consumers, family members, and other care givers;
3. competency, capacity, and guardianship issues for people with mental illness;
4. voluntary and involuntary treatment;
5. accreditation of professionals and facilities;
6. law enforcement and other judicial system issues for people with mental illness;
7. mechanisms to oversee involuntary admission and treatment practices; and
8. mechanisms to implement the provisions of mental health legislation.

Standardised documentation exists for the implementation of all components of the mental health legislation.

Interview respondents were generally positive about the contribution that the Mental Health Care Act can make to protecting human rights and promoting community-based mental health care in South Africa.

An outline of how the Mental Health Care Act meets criteria set out by the World Health Organisation is set out in Annex 3 (WHO Mental Health Legislation Checklist). In general the Act appears to adhere to international human rights principles, as set out in the Checklist. Suggestions for areas of legislative review by respondents to the checklist are set out below in 3.5.5.2.

3.5.5.1 Links with other relevant legislation

There are many laws which have mental health implications. Below are the most frequently noted legislation which respondents felt had an impact on advocacy and promotion of mental disability issues, and service development for mental health.

- The Constitution, in particularly the chapter on human rights, the Bill of Rights and Section 9 of the Constitution, which deals with issues of equality.
- The Promotion of Equality and the Prevention of Unfair Discrimination Act, (The Equality Act)
- The Employment Equity Act, and in particular the provisions for reasonable accommodation for disabled people in the workplace.
- The Children's Act, in particular those aspects related to the mental wellbeing of children and support to intellectually and mentally disabled children.
- The Correctional Services Act, in particular provisions which impact on state patients and mentally ill patients in prisons.

In terms of these laws, the following legislative provisions exist to protect and provide support for service users:

- o Legislative provisions concerning a legal obligation for employers to employ a certain percentage of people with disabilities (including mental disabilities); and
- o Legislative provisions concerning protection from discrimination (dismissal, lower wages) solely on account of mental disorder.

However these provisions are not systematically enforced. At the present time, there is no legislative or financial support for the following:

- o Legislative or financial provisions concerning priority in state housing and subsidized housing schemes for people with severe mental disorders.
- o Legislative or financial provisions concerning protection from discrimination in allocation of housing for people with severe mental disorders.

3.5.5.2 Areas to be addressed in further legislation development

Interview respondents identified the following areas for further attention within the Mental Health Care Act, no 17 of 2002.

3.5.5.2.1 Child and adolescent issues

Child and adolescent specific issues are not adequately and comprehensively elaborated in the new legislation. It was suggested that these gaps be more clearly defined in the mental health regulations.

3.5.5.2.2 Human rights

The strong human rights emphasis of the Act was welcomed, but it was felt that a great deal of work would be needed to translate these principles into implementation strategies which would uphold users', families' and practitioners' human rights.

3.5.5.2.3 Financing of mental health

The Mental Health Care Act holds the state responsible for financing mental health service development "within available resources". This was thought by some respondents to require support from policy and provincial strategic plans and budgets, if it was to be implemented.

> *I: What is your view on how one should deal with issues of financing of mental health?R: The thing is that if you say that something must be legislated, then you've got to make sure that there are sufficient funds for the implementation of that and that's why cabinet would never pass legislation until you had given them an economic rundown of what the whole thing was gonna cost and we did that in the cabinet memo…and I don't think that our parliament would actually accept legislation that said it must be funded this way and that way, I think that that would be seen as a sort of health financing legislation rather than mental health legislation. That's what you would have to do and then fight within departments for your particular budget. But if you say that this must be done and it's agreed by parliament that it must be done then you have got to find the funds to do it. Or it's got to be progressive realisation 'within the resources available' we say somewhere. (*Respondent 64, former policy maker, Department of Health)

However, it was felt by some respondents that continuation of inequitable allocations for mental health relative to other priority programmes was unacceptable. In addition, inadequate financing of service development was regarded as a human rights issue: inadequately funded services may lead to human rights abuses.

> *Well, there are no resources for promotion of the Act, no resources at all. Still the same number of people working in mental health and what have you. You know, what…what pains me is that, remember there was an outbreak of violence in psychiatric institutions...mental health institutions? I: Yes. R: I was one of the team which had to inspect the facilities. You know, mentally ill patients were still sleeping on the floor.. You…you understand? Things that you don't get with medical patients.*

And you were told there were no resources, shortage of resources. And we even went as far as to the Provincial level; how do they plan for mental health? We found that at the Provincial level they plan for HIV/AIDS and they plan for other programmes, TB and what have you, but they don't plan for mental health. (Respondent 59, Statutory Board, Health Professions Council of South Africa)

A recommendation was therefore to conduct a costing exercise for core aspects of the Mental Health Care Act, or to include this in the new Mental Health Policy and in subsequent provincial mental health plans.

Beside attracting internal funding allocations for mental health it was also felt that strategies to secure donor funding for mental health programmes could be explored.

I: What could a possible way for foreign aid support for mental health to be increased? R: Uh two things: One is the extrapolation of data from a variety of countries to be used quite powerfully to promote mental health… in the (names donor country) when money began to shift… towards mental health services…(there was) very little thought given to how one might justify some of those changes in practice. The general perception was 'well we've been under-resourced for so long now it's our turn to take some of the cash from the acute sector.' I think that's the caveat that if money were to flow then understanding the impact of that is going to be particularly important. The second thing would be I think that in…certainly in South Africa there hasn't been a development of…well I'm not aware of the development of similar NGO pressure groups. So things like Survivors Speak Out, and MIND and some of the charitable groups have not pushed the mental health agenda forward, except in post-war situations. (Respondent 63, health advisor, South African office of an international donor agency).

3.5.5.2.4 Safety and protection of users during treatment

The lack of resources, particularly in services that provided involuntary admission, was an area of concern for some respondents. These included poorly staffed services and inadequate treatment facilities, which increased the potential for vulnerable users to be abused by staff, at a time when users may be least able to protect themselves or be viewed as able to give credible account of the violations they have experienced. Some respondents said that a review is needed of the human rights issues related to current practices of involuntary admissions, for example the use of advance directives.

3.5.5.2.5 Guardianship

The protection of the rights of users declared incompetent and unable to consent or provide input to their treatment and other aspects of their lives was raised by several respondents.

*They had a huge argument around that because they felt that they didn't want to compromise on legal capacity…Psychiatric institutions, the problem is that the power and authority that goes in those institutions, the power that the psychiatrist may have to decide the fate of a particular person and that's what these psychiatric users would refer to you know, its one of the problems that they have and why they argue so strongly for legal capacity (*Respondent 6, Director, organisation supporting disability rights, commenting on user input to the finalisation of the United Nations Convention for the Rights of Disabled Persons).

And this is where the UN Convention becomes very important, because it has taken the whole disability rights thing and looked at how modern legal systems work and the big thing happening all over the world is the issue of guardianship where somebody gets disempowered, he's already disempowered by disability and he becomes more disempowered because now it's being said: "You aren't legally competent anymore". I: So the nature of help can also be disabling? R: The nature of help can be disabling, governments can become a big brother society which starts controlling and robbing people of their inherent human right to be in charge of their own destinies...People will quickly have you declared legally incompetent if they say you're crazy…what I've seen when I was doing social work in this country, people's grants were getting abused by their relatives…the grants industries. (Respondent 34, mental health care user and mental health advocate).

3.5.5.2.6 Disability

The Act's current emphasis, as suggested by its name, the Mental Health *Care* Act, is treatment and care orientated. Respondents, primarily those with in the disability and mental health care user sector, voiced a need to integrate a disability perspective into its provisions to highlight the importance of service development to users who experience ongoing psychosocial difficulties as a result of a mental disorder. A disability perspective would also promote the inclusion of these users within the disability sector, and the benefits of the prioritisation of disability rights within South African legislation and policy. It will encourage desigmatisation of mental disability within general society by contextualising users' service provision needs for episodes of illness within the broader context of their roles as citizens, and their rights to enjoy social and economic benefits on par with others in society.

3.5.5.2.7 Intersectoral links

Respondents stated that intersectoral links in legislative provisions should be addressed. These recommendations are set out in more detail in sections 3.5.6 and 3.8.5 (below).

3.5.5.2.8 Areas for legislation development from WHO Checklist

In addition to these comments from the interviews, the following suggestions for a review of the legislation and regulations were made by respondents to the WHO Legislation Checklist (details of which are available in Annex 3).

Definitions	Include definitions for • Intellectual disability, covering all functional categories • Substance use disorders (dual diagnosis should be treated under MHCA) • Mental disability • Spouse, associate and partner • Child, adolescent and geriatric • Informed consent (or consent) in the Act • Unfair discrimination
Minimal conditions in mental health facilities	Regulations are required, especially for general hospital inpatient facilities.
Vocational training, leisure and recreational activities	**Vocational training**: Regulations should specify that vocational rehabilitation and skills development be provided by the Department of Labour. **Leisure and recreational activities:** Regulate for attention of the Department of Sports and Recreation
Involvement of mental health care users in policy, legislation, service planning	Should not be legislated, but can be covered in policy.
Rights of families or other carers	To be addressed in regulations, particularly with current shift to care in the community.
Competence, capacity and guardianship	• Guardianship provisions which address the needs of people with mental health conditions should be integrated into a more comprehensive guardianship Act • Procedure/criteria for determining incapacity/incompetence should be addressed in regulations • Procedures for appointment, duration, duties of a guardian – currently this only covers property issues, and this aspect needs to be elaborated to include other areas.
Voluntary admission and treatment	This should be set out in regulations, and should cover voluntary patients right to: • discharge themselves or refuse treatment • be provided with timely notice of deterioration in their condition which might require involuntary care.
Involuntary admission and treatment	• these criteria should be aligned to criteria closer to those recommended by the WHO. • The timeframes for review board decisions should be reviewed.
Proxy consent for treatment	Should be addressed in the next legislation review
Emergency situations	These criteria should be aligned to criteria closer to those recommended by the WHO
Skills for determinations of mental disorder	The original drafts of the regulations specified skills required, but these were not regulated. This needs to be reviewed
Informed consent for	Specific mention of role of Review Board could be included in section 34 of the regulations

psychosurgery/irreversible treatments on involuntary patients	
Seclusion and restraint	• Periods of seclusion and restraint need revision: new WHO guidelines can be used to assist this. • Structural and human resource requirements that minimize the need to use seclusion and restraints – this needs revision • Include provision for informing users, or periods of seclusion and restraints
Review Boards	Powers and functions are restricted to patients within mental health treatment facilities, and do not include the power to protect the rights of persons with mental disorders in a more general way. Capacity of review boards needs evaluation before considering amendments to their functions. Areas for attention include: • inspections of mental health facilities – there is potential for duplication by the various boards • composition and competencies of the review boards • regulations containing guidelines for powers and functions, and for the reporting obligations of the review boards (Section 66p)
Complaints procedures	There is currently no provision for this aspect. It needs to be addressed in regulations
Interpreters during complaint and appeal proceedings	There is currently no provision for this aspect. It needs to be addressed in regulations
Police responsibilities	Restrictions on the activities of the police. Review of effectiveness of this aspect is needed with implementation.
Housing	Non-discrimination in allocation of housing - Regulations should specify that the Department of Housing should support access to the provision of housing for people with mental disability
Employment	"Reasonable accommodation"- the scope and range of activities for implementation in respect of people with mental disability still needs to be set out in Technical Guidelines
Vocational rehabilitation and other employment programmes	Clarity regarding the provision of this service needs to be addressed by the Department of Health with the Departments of Labour and Social Development. There was strong support for the Department of Labour to take the lead in this provision, and incorporate this into their policies
Protection of minors	The following should be addressed in the regulations: • Involuntary placement of minors in mental health facilities • Provide facilities separated from adults • Provision of age- appropriate services • Consideration of the opinions of minors in treatment decisions • Irreversible treatments for children
Protection of women	The following should be addressed in the regulations: • adequate privacy • separate sleeping facilities from men

3.5.6 Policy and legislation development: recommendations for intersectoral approaches to specific user groups

Respondents identified several groups of service users for whom an intersectoral approach to legislation and policy development would promote comprehensive services. These groups included:

- **Children and adolescents** and people with **Intellectual Disabilities**: Legislation and policies governing mental health related work of the Departments of Health, Education and Social Development were most often mentioned with this group.
- **Substance use disorders:** Departments of Health and Social Development need to coordinate treatment and support services under the Mental Health Care Act and the Substance Abuse Dependency Act, currently under review. A framework to guide these deliberations is provided by the National Drug Master Plan for South Africa.
- **Mentally ill offenders, state patients and children in conflict with the law**: Legislation and policies governing mental health-related work in the Departments of Health, Justice and Constitutional Development and Correctional Services are pertinent here.
- **Workers with mental disorders, and mental and intellectual disabilities**: Employment and income generation was a key poverty elimination strategy mentioned by respondents. Equal access to jobs in the open labour market, inclusion of people with mental disability in income generation projects developed in urban and rural settings, and opportunities for vocational skilling and work rehabilitation requires intersectoral coordination of the legislation and policies which govern employment-related aspects of the work of the Departments of Health, Social Development, Labour and Agriculture.
- **Housing of people with mental and intellectual disabilities**: The Departments of Health and Social development, which traditionally lead the area of residential care for people with mental disability should engage with the department of Housing regarding legislation and policies, in particular their Special Needs Housing Policy, to address the housing needs of people with mental disabilities.
- **Impoverishment and mental disabilities**: Legislation and policies developed in South African are meant to be pro-poor, that is, directed at assisting the poor to access social and economic resources, via targeted benefits and initiatives designed to lift people, families, and communities out of poverty. People with disabilities, including those with mental disabilities, may struggle even more than able citizens to avoid becoming impoverished, and to lift themselves out of poverty. Advocacy for the inclusion of people with mental disability into the pro-poor strategies of all sectors is required.

Summary: Content of mental health policy and law

- The 1997 policy guidelines document includes the following components:
    - developing community mental health services;
    - downsizing large mental hospitals;
    - developing a mental health component in primary health care;

- o human resources;
  - o involvement of users and families;
  - o advocacy and promotion;
  - o human rights protection of service users;
  - o equity of access to mental health services across different groups;
  - o financing;
  - o quality improvement; and
  - o a monitoring system.

- Respondents felt that the following focus areas should be included in the issues addressed by the new mental health policy:
  - o Mental health of children and adolescents;
  - o Gender and mental health;
  - o Intellectual disability;
  - o HIV/AIDS and mental health; and
  - o Poverty and mental health.

The Mental Health Care Act was enacted in 2002 and promulgated in December 2004. It includes the following areas:

1. access to mental health care including access to the least restrictive care;
2. rights of mental health service consumers, family members, and other care givers;
3. competency, capacity, and guardianship issues for people with mental illness;
4. voluntary and involuntary treatment;
5. accreditation of professionals and facilities;
6. law enforcement and other judicial system issues for people with mental illness;
7. mechanisms to oversee involuntary admission and treatment practices; and
8. mechanisms to implement the provisions of mental health legislation.

Standardised documentation exists for the implementation of all components of the mental health legislation.

The following areas were identified for further attention within the Mental Health Care Act, no 17 of 2002 or its regulations:
- Child and adolescent issues;
- Financing of mental health;
- Safety and protection of users during treatment;
- Guardianship;
- Disability; and
- Intersectoral mental health service provisions

3.6 Mental health policy implementation at national and provincial levels

The results reported in this section are taken largely from the survey conducted with the WHO AIMS instrument.

3.6.1 National and provincial structures and plans

As provided for in the White paper on Health, mental health policy implementation in South Africa takes place through national, provincial and district structures. A national mental health authority exists which provides advice to the government on mental health policies and legislation, namely the National Directorate: Mental Health and Substance Abuse, in the Department of Health. The Directorate comprises a Director, 3 Deputy Directors, Assistant Directors and administrative staff.

The national mental health authority provides policy direction to the provincial mental health authorities, who are involved in service planning, service management and coordination, and monitoring and quality assessment of mental health care. The National Directorate: Mental Health and Substance Abuse has an operational plan for its own activities. The implementation of the Mental Health Care Act has now been prioritised within the national Department of Health's strategic plan (2005-2009), and is a primary focus of the activities of the National Directorate.

As directed by the White paper, each province has a structure responsible for mental health and substance. Provinces have either a dedicated Directorate or Subdirectorate in place to attend to mental health. The seniority of the provincial mental health authority posts vary between provinces.

All health services and budgets are devolved to the 9 provinces. There is wide variation between provinces in the budget and resources available for mental health care. Therefore this section of the report includes provincial indicators where these are available. Mental health services are organized in terms of catchment areas in all provinces.

Although the National Directorate has an operational plan, there is no national mental health plan at present. Five of the 9 provinces have provincial mental health plans, some of which are integrated within the general health plan for that province. There is no emergency/disaster preparedness plan for mental health at either the national or provincial level.

A national list of essential medicines (EDL) is in place. These medicines include antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs.

3.6.2 Financing of mental health services

The percentage of government Health Department expenditure devoted to mental health is not known at a national level. Only 3 of the 9 provinces were

able to report on health expenditure on mental health care: Northern Cape spends 1%, Mpumalanga 8% and North West 5% of its health budget on mental health care. The mean for these provinces is 5% (see Graph 1). Many provinces are not able to report on this indicator because budgets for mental health are integrated into general health budgets, particularly at primary care level. In addition to reporting on budgets, reporting on actual expenditure appears to be extremely difficult, as no provinces were able to provide these data.

Only 4 of the 9 provinces were able to report on the proportion of mental health expenditure devoted to mental hospitals. These are set out in Table 1, with the mean for these 4 provinces in Graph 2. It should be noted that these data do not include expenditure on mental health that is integrated into general health care, particularly at primary care level. It is therefore likely that this is an over-estimate of the proportion of the mental health budget devoted to mental hospitals.

Table 1. Proportion of mental health expenditure devoted to mental hospitals

Province	Proportion (%)
Gauteng	67
Mpumalanga	85
North West	99
Northern Cape	94

80% of the population has free access to essential psychotropic medicines (provincial range: 75-83%). For those that pay out of pocket, the cost of generic antipsychotic medication is 24 cents per day (0.7% of the daily minimum wage) and generic antidepressant medication is 15 cents per day (0.5% of the daily minimum wage). There are no social health insurance schemes as government health services are tax-based.

GRAPH 1. HEALTH EXPENDITURE TOWARDS MENTAL HEALTH
(from 3 provinces)

5%

95%

☐ ALL OTHER HEALTH EXPENDITURES

☐ MENTAL HEALTH EXPENDITURES
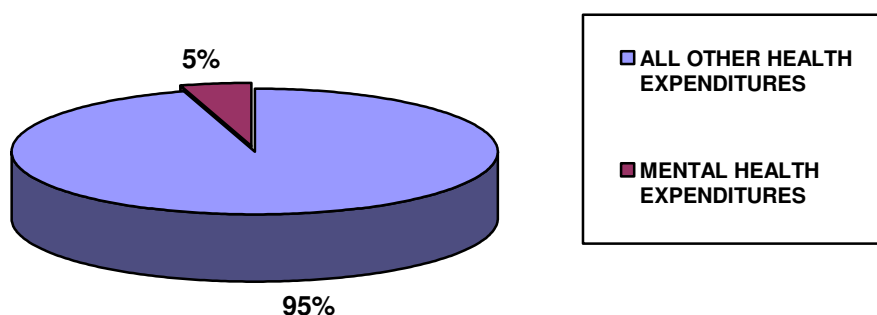
GRAPH 2. MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS (from 4 provinces)

14%

☐ EXPENDITURES FOR MENTAL HOSPITALS

☐ ALL OTHER MENTAL HEALTH EXPENDITURES

86%
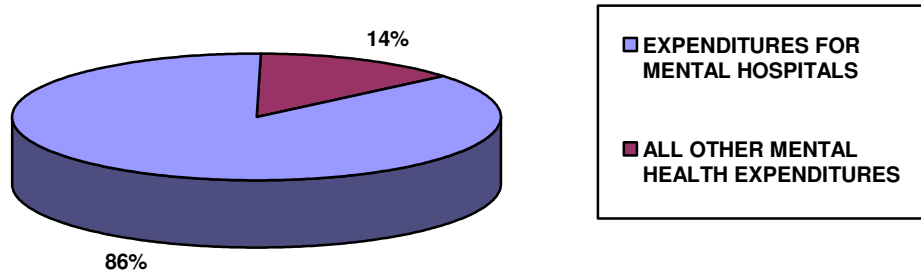
3.6.3 Human rights protection

In keeping with the Mental Health Care Act 2002, Review Boards have been established in each province, with the authority to oversee regular inspections in mental health facilities, review involuntary admission and discharge procedures and review appeals related to these processes. The Review Boards do not have the authority to impose sanctions (e.g., withdraw accreditation, impose penalties, or close facilities that persistently violate human rights). In addition, the parliamentary Human Rights Commission has occasionally reviewed and produced reports on conditions in mental health facilities, and serves an external watchdog function.

52% of mental hospitals had at least one review/inspection of human rights protection of service users in 2005, while 29% of community-based inpatient psychiatric units and community residential facilities had such a review. 78% of mental hospitals and 40% of inpatient psychiatric units and community residential facilities have had at least one day of training on human rights protection of patients in the last two years.

3.6.4 Mental Health Services

3.6.4.1 Mental health outpatient facilities

There are 3,460 outpatient mental health facilities available in the country, of which 1.4% are for children and adolescents only. These facilities treat 1,660 users per 100,000 general population annually. Data on this service utilisation were only available from 4 provinces. These services are run as part of the integrated health service within public health facilities.

Of all users treated in mental health outpatient facilities, the percentages of users who are female or ar children or adolescents are unknown. These data are not routinely collected in any province. Records are also not kept of the diagnoses of users treated in outpatient facilities in South Africa. If these are kept, they are held only in individual case files, but are not used for service planning.

Data on the average number of contacts per user per year was only available from two provinces. In the Western Cape, the average number of contacts per user is 1.7 and in North West it is 12. Data on the percentage of outpatient facilities that provide follow-up care in the community varied between provinces, with some provinces reporting that all outpatient facilities provided this service while other provinces reporting that none did (mean proportion for 7 provinces: 44%). Only 7% of outpatient facilities have mental health mobile teams.

In terms of available interventions, 2 provinces reported that 1-20% of users have received one or more psychosocial interventions in the past year, while another 2 provinces reported that 21-50% of users had received such interventions. The remaining provinces had no record of this item. 88% of mental health outpatient facilities had at last one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or at a near-by pharmacy all year round.

3.6.4.2 Day treatment facilities

There are 80 day treatment facilities available in the country (approximately half of which are provided by the South African Federation for Mental Health (SAFMH). The SAFMH is subsidised by the government for the provision of some of these services. Of these, none are for children and adolescents only. These facilities treat 3.4 users per 100,000 general population.

Of all users treated in day treatment facilities, the SA Federation for Mental Health reports that 41% are female and none are children or adolescents. The Department of Health does not keep statistics regarding gender and age in day treatment facilities. On average, users spend 268 days in day treatment facilities (data available from only 1 Department of Health Day treatment facility and 5 SA Federation for Mental Health facilities).

3.6.4.3 Psychiatric inpatient units in general hospitals

There are 41 psychiatric inpatient units in general hospitals available in the country with a total of 2.8 beds per 100,000 population. 3.8% of these beds in community-based inpatient units are reserved for children and adolescents only. These facilties are provided for and run by the provincial health authorities.

In addition to the psychiatric inpatient units, national Department of Health officials report that 53% of all hospitals (defined as "health establishments" in the Mental Health Care Act) have been listed to provide 72 hour assessments of psychiatric emergencies, in keeping with the provisions of the Act. This includes 131 of 251 district hospitals, 28 of 59 secondary hospitals, and 14 of 33 tertiary hospitals. Frequently service users will be admitted to general wards in these listed facilities if there is no separate psychiatric inpatient unit. However, according to some respondents, while the listing of these health

establishments is laudible, there remain major concerns about the capacity of staff and facilities to provide adequate mental health care in these hospitals. There are also inadequate information systems for monitoring the care provided at 72 hour assessment facilities.

The percentage of admissions to psychiatric inpatient units that are female or children/adolescents is unknown. Records are not kept of the diagnoses of users treated in psychiatric inpatient units in general hospitals in South Africa. If these are kept, they are held only in individual case files, but are not used for service planning. The average length of admission is not routinely recorded and data were therefore not available.

Provinces reported a wide variety of practices regarding the availability of psychosocial interventions in psychiatric inpatient units in general hospitals. One province reported that none were available, 2 provinces reported that a few users (1-20%) received such interventions, and 1 province reported that 80-100% of users received such interventions. 96% of psychiatric inpatient units in general hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility. Therefore, as with other facilities, psychotropic medications are generally more available and more widely used than psychosocial interventions.

3.6.4.4 Community residential facilities

There are 63 community residential facilities available in the country (of which 47% are provided by the SA Federation for Mental Health). These facilities provide a total of 3.6 beds per 100,000 population. The number of these beds that are reserved for children and adolescents is not known.

The number of users in community residential facilities is 2.34 per 100,000 population and the average number of days spent in community residential facilities is unknown, except for 3 mental health societies that reported an average annual length of stay of 364 days. In community residential facilities provided by the SA Federation for Mental Health, 41% of users are female. The Department of Health does not keep a record of gender distribution in these facilities. Neither the SA Federation for Mental Health nor the Department of Health could provide information on the number of children and adolescents in these facilities.

3.6.4.5 Mental hospitals

There are 23 mental hospitals in the country, providing a total of 18 beds per 100,000 population (provincial range: 8-39). 79% of these facilities are organizationally integrated with mental health outpatient facilities. Only 1% of the beds in mental hospitals are reserved for children and adolescents only.

The number of mental hospital beds has decreased by 7.7% in the last five years. There is wide variability between provinces in this regard, with some provinces slightly increasing bed numbers (e.g., Free State: 4%) and some

dramatically decreasing bed numbers (Eastern Cape: -27%, Limpopo: -26%, Western Cape: -21%).

It should be noted that according to Department of Health officials, there are 60 designated psychiatric hospitals or care and rehabilitation centres in the country, a figure which also includes psychiatric units in general hospitals. However, for the purpose of this report, mental hospitals and psychiatric units in general hospitals have been listed and described separately. This is because these facilities provide different forms of care, with psychiatric units in general hospitals being more likely to provide an integrated form of healthcare, and mental hospitals being traditionally associated with long-term custodial forms of care and higher levels of stigmatisation. Furthermore, care and rehabilitation centres traditionally provide care for learning disabilities, which are a different user population and are included under "Forensic and other residential facilities" (below).

According to Department of Health officials, psychiatric hospitals have been included in the national hospital revitalisation programme (with one psychiatric hospital planned to be revitalised every year according to the Department of Health's strategic plan for 2007/8 and 2009/10). According to Department of Health officials, the Minister of Health has accompanied senior mental health staff on visits to psychiatric hospitals, and is supportive of the psychiatric hospital revitalisation programme.

Records are not kept of the diagnoses of users treated in mental hospitals in South Africa. If these are kept, they are held only in individual case files, but are not used for service planning. None of the provinces could provide this data.

The total number of users treated in mental hospitals in two provinces (Western Cape and North West) is 318 per 100,000 population. No other provinces could provide these data. The average number of days spent in mental hospitals in the Western Cape is 32 days. No other provinces could provide these data.

Based on data from 4 provinces (Free State, Mpumalanga, North West and Northern Cape), 40% of users spend less than one year, 4% of users spend 1-4 years, 15% of users spend 5-10 years, and 41% of users spend more than 10 years in mental hospitals. There was wide variability between the provinces in these distributions.

There was also wide variability in the percentage of users in mental hospitals who received one or more psychosocial interventions in the last year. Two provinces (North West and KwaZulu-Natal) reported that 21-50% of users received such interventions, while Mpumalanga reported 1-20% and Gauteng reported 51-80%.

All mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

3.6.4.6 Forensic and other residential facilities

In addition to beds in mental health facilities, there are also 1,676 beds for people with mental disorders in forensic inpatient units and 1,930 beds in other residential facilities, such as detoxification inpatient facilities, and NGO-run homes for people with learning disability or for the destitute.

In forensic inpatient units, based on data from 3 provinces (Free State, KwaZulu-Natal and North West), 9% of users spend less than one year, 25% of users spend 1-4 years, 62% of users spend 5-10 years, and 3% of users spend more than 10 years.

3.6.4.7 Human rights and equity

There were limited data available on human rights. The following are reported from individual provinces, were data were available. Based on data from 3 provinces (Western Cape, Northern Cape and North West) 43% of all admissions to mental hospitals are involuntary. No data were available on the percentage of involuntary admissions to community-based inpatient psychiatric units.

Two provinces (Northern Cape and Eastern Cape) reported that 0-1% of patients were restrained or secluded at least once within the last year in psychiatric inpatient units in general hospitals, and one province (KwaZulu-Natal) reported that 11-20% of patients were restrained or secluded. In mental hospitals, 7 provinces reported that 0-5% of patients were restrained or secluded at least once within the last year.

There were limited data available on equity indicators.The density of psychiatric beds in or around the largest city is 1.2 times greater than the density of beds in the entire country. There was wide variability between provinces in this regard (provincial range: 0.28-4.78).

3.6.4.8 Summary Charts: Mental health services

GRAPH 3. - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES
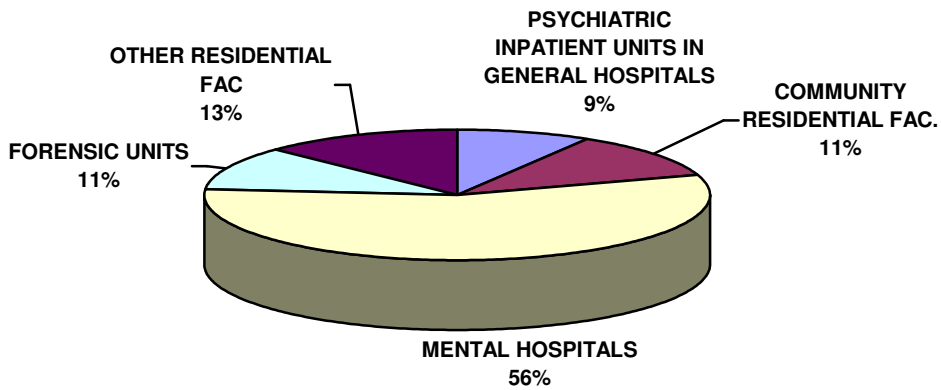
Summary for Graph 3.

The majority of beds in the country are provided in mental hospitals, followed by a relatively even distribution of all other facilities.

GRAPH 4. - PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)
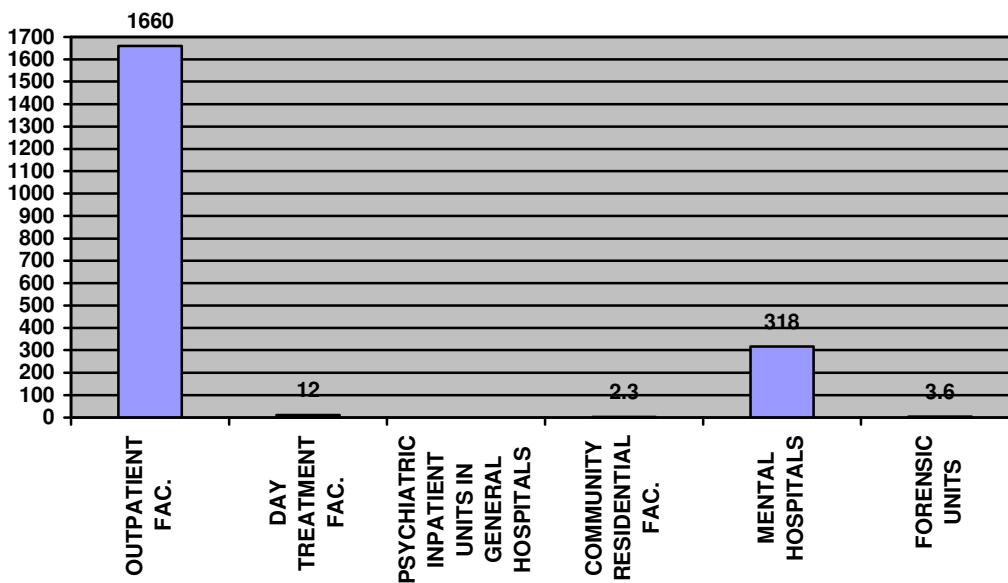
Note: In this graph the rate of admissions in inpatient units is used as a proxy of the rate of users treated in the units. The number of patients in forensic beds on December 31 is used as a proxy for patients treated in forensic units.

Summary of Graph 4.

The majority of the users are treated in outpatient facilities and in mental hospitals, while the rate of users treated in inpatient units, day treatment

facilities and residential facilities is lower. The number of users treated in psychiatric inpatient units in general hospitals is not known.

GRAPH 5. - AVAILABILITY OF PSYCHOTROPIC DRUGS IN MENTAL HEALTH FACILITIES
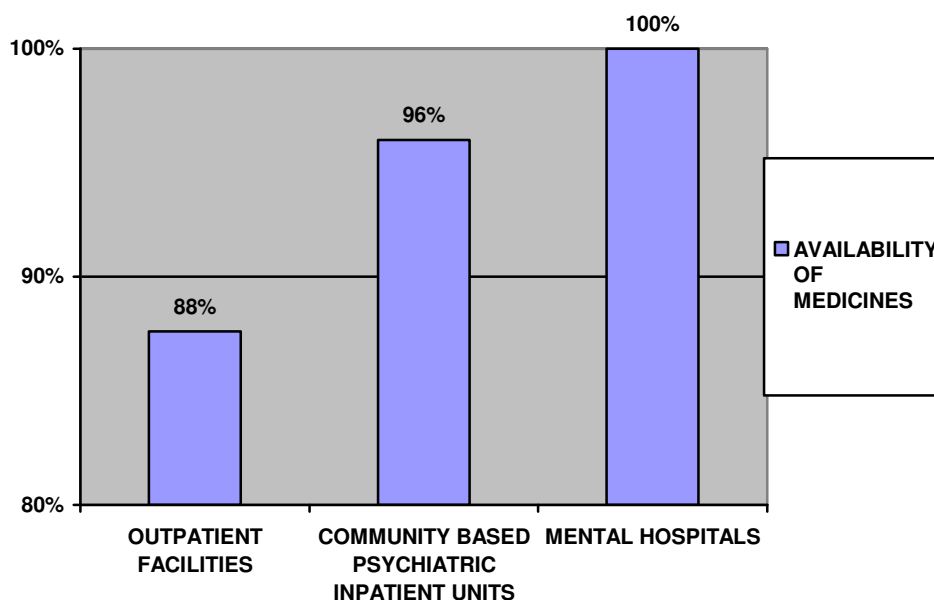
Summary for Graph 5.

Psychotropic drugs are most widely available in mental hospitals, followed by inpatient units, and then outpatient mental health facilities.

3.6.5 Mental Health in Primary Health Care (PHC)

Most provincial services endorse the importance of integrating mental health into PHC, and some training initiatives have been undertaken for PHC nurses. More detail of this is provided in the section on implementation of policy at the micro level (below). The following data provide an overview of mental health in PHC across all the provinces.

3.6.5.1 Training in mental health care for primary care staff

In two provinces (Gauteng and KwaZulu-Natal), a mean of 5.5% of the training for medical doctors is devoted to mental health. According to the South African Nursing Council, 21% of undergraduate nursing is devoted to mental health. No data were available on the percentage of training time devoted to mental health for non-doctor/non-nurse primary health care workers.

In terms of refresher training, no data were available on the percentage of primary health care doctors, nurses or non-doctor/non-nurse primary health care workers who have received at least two days of refresher training in

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mental health. Only in one province (Northern Cape) was it estimated that 80% of nurses had received such training. In another province (KwaZulu-Natal) nurses had received training, but no records were kept of the numbers of nurses who were trained.

3.6.5.2 Service provision in primary mental health care

Both physician-based PHC and non-physician based PHC clinics are present in the country. In terms of physician-based and non-physician-based PHC clinics, there was wide variability between provinces in the availability of assessment and treatment protocols for key mental health conditions (see table). The general trend suggests wider availability of protocols among non-physician-based clinics.

Table 2. Availability of assessment and treatment protocols for key mental health conditions in primary health care clinics

Province	Physician-based PHC clinics: % with protocols	Non-physician-based PHC clinics: % with protocols
Eastern Cape	21-50	51-80
Free State	51-80	51-80
Gauteng	0	1-20
KwaZulu-Natal	51-80	21-50
Limpopo	0	81-100
Mpumalanga	0	0
North West	Unknown	51-80
Northern Cape	0	81-100
Western Cape	1-20	81-100

There is also wide variation between provinces in the percentage of physician-based PHC doctors who make on average at least one referral per month to a mental health professional. In the Eastern Cape, 1-20% of doctors make such referrals, in KwaZulu-Natal, Northern Cape and Free State, 21-50%, and in the Western Cape and Gauteng 81-100%. The remaining provinces did not provide data.

Only four provinces were able to report on the number of non-physician based PHC clinics that make a referral to a higher level of care. Again there was wide variation, with Gauteng reporting 0%, Western Cape 1-20% and Free State and North West 51-80%.

In terms of professional interaction between primary health care staff and other care providers, only Free State and KwaZulu-Natal were able to report that 21-50% and 1-20% of primary care doctors have interacted with a mental health professional at least once in the last year respectively.

In North West, 1-20% of PHC clinics were reported to have had interactions with traditional practitioners and in Gauteng no clinics were reported to have

had such interactions. No other provinces reported on interactions with traditional practitioners at PHC level.

3.6.5.3 Prescription in primary health care

According to the South African Nursing Council, primary health care nurses are allowed to prescribe but with restrictions (e.g., they are not allowed to initiate prescription but are allowed to continue prescription, or they are allowed to prescribe in emergencies only; they are allowed to hand-out medicines but are formally not allowed to prescribe). Primary health care doctors are allowed to prescribe all medications on the essential medicines list.

As for availability of psychotropic medicines, 3 provinces reported that 81-100% of physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) and one province reported that 51-80% of these clinics have such medicines. In non-physician-based clinics, 4 provinces reported 81-100% availability, 3 provinces 51-80%, 1 province 21-50% and 1 province 0%.

3.6.6 Human Resources

3.6.6.1 Number of human resources in mental health care

The total number of human resources working in Department of Health or NGO mental health facilities per 100,000 population is 11.95. The breakdown according to profession is as follows: 0.28 psychiatrists, 0.45 other medical doctors (not specialized in psychiatry), 10.08 nurses, 0.32 psychologists, 0.4 social workers, 0.13 occupational therapists, 0.28 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors). (See Graph 6). Data were not available on the numbers of mental health professionals working in private practice.

Important limitations should be noted with regard to these data:

1. There was wide variability between provinces in the number of nurses per 100,000 population (provincial range: 1.06 to 20.6), which may be partially attributed to differing definitions of nurses between provinces, in spite of the clear definition provided in the instrument. This may reflect a broader trend of inconsistent record keeping and/or information systems across the provinces. For example, although provinces were able to provide the numbers of nurses working in specialist mental health facilities, such as mental hospitals, it was more difficult to provide numbers of nurses providing mental health services within integrated general health facilities.
2. Gauteng was not able to provide data on the number of psychologists, social workers or occupational therapists. As a highly urbanised

province, with a large population, it is likely that there is a higher concentration of these professionals in this province. The resulting underestimation at the national level is therefore likely to be greater than would have been the case had the missing data been from a less urbanized province.

Only KwaZulu-Natal and North West were able to report on the distribution of psychiatrists between government services and private practice. In KwaZulu-Natal, 52% of psychiatrists work in government services and 48% in private practice. In North West, 10% of psychiatrists work in government services. The trend in North West appears to be more consistent with previous studies, which have shown a higher concentration of psychiatrists in private practice than government services (Flisher et al., 1997).

No provinces were able to report on the distribution of psychologists, social workers, nurses and occupational therapists between government-administered mental health facilities and private practice.

Very few provinces were able to identify the service locations of mental health staff. Those that were able to provide this information could only report on the locations of some staff categories in some locations. It is therefore not possible to report on national trends regarding the service locations of the various mental health staff categories.

It is difficult to compare staffing resources between facility types because of missing data. However, where data are available, the trends are that mental hospitals appear to be better staffed than psychiatric inpatient units in general hospitals. For nurses, in Mpumalanga and Free State there are an average of 0.6 nurses per bed in psychiatric inpatient units in general hospitals, in comparison to an average of 1.22 per bed in mental hospitals. For other psychosocial staff (psychologists, social workers and occupational therapists), there are an average of 0.03 per bed for psychiatric inpatient units in general hospitals in Mpumalanga, Free State and Limpopo, and 0.07 per bed in mental hospitals. The exception to this trend is the case of psychiatrists: in KwaZulu-Natal and Free State there are an average of 0.05 psychiatrists per bed in psychiatric inpatient units in general hospitals, in comparison to an average of 0.02 psychiatrists per bed in mental hospitals. (See Graph 7).

The distribution of human resources between urban and rural areas is disproportionate. Based on data from only 2 provinces (Free State and North West), the density of psychiatrists in or around the largest city is 3.6 times greater than the density of psychiatrists in the entire country. The distribution of nurses between urban and rural areas is not known.

**GRAPH 6. - HUMAN RESOURCES IN MENTAL
HEALTH
(rate per 100.000 population)**
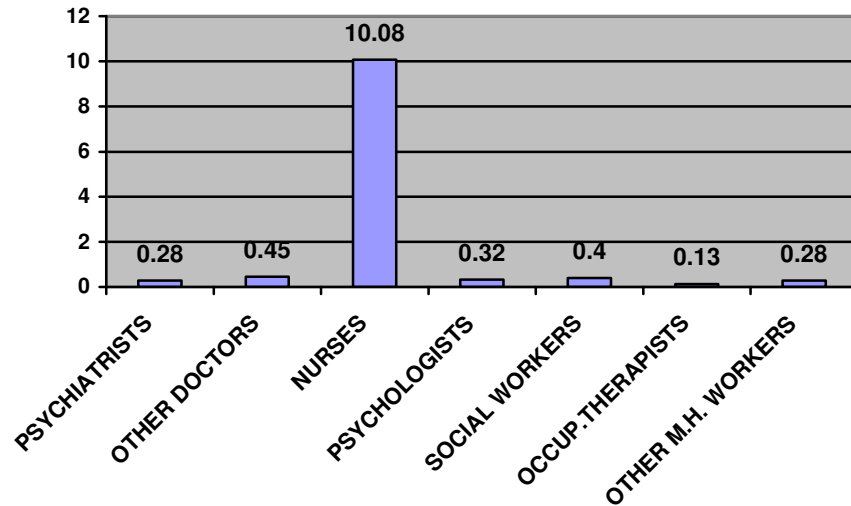
GRAPH 7. - AVERAGE NUMBER OF STAFF PER BED
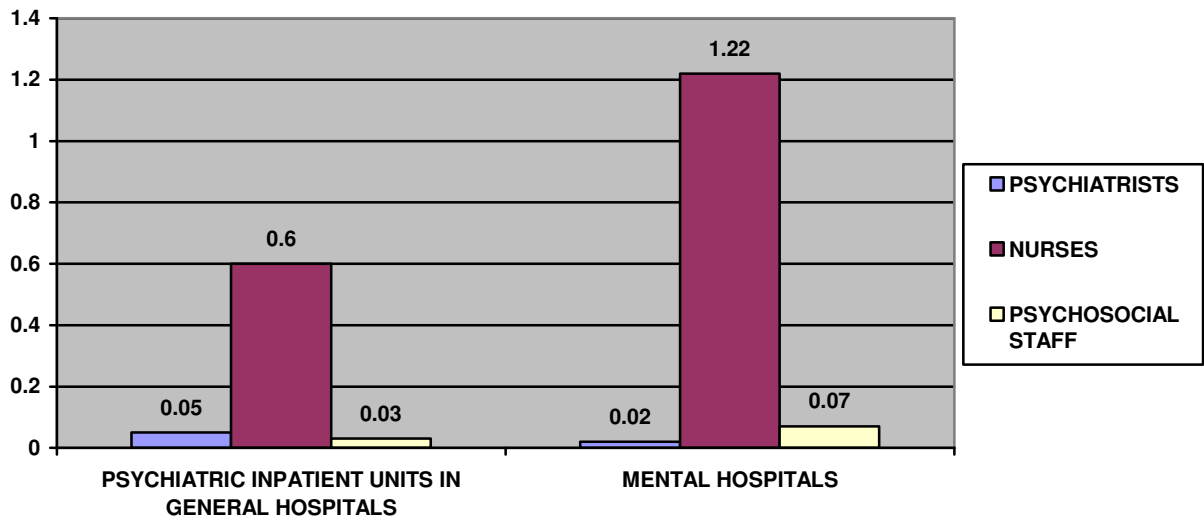
3.6.6.2 Training professionals in mental health

Data on professional training in mental health was only available from KwaZulu-Natal. In that province, the number of professionals graduated last year in academic and educational institutions per 100,000 is as follows: 1.81 medical doctors (not specialized in psychiatry) and 0.04 psychiatrists. No other provinces were able to report on the number of mental health professionals who graduated.

In KwaZulu-Natal and Free State it was reported that 1-20% of psychiatrists emigrate to other countries within five years of the completion of their training.

There was a general lack of data regarding either professional training or continuing professional development after qualification in all provincial Departments of Health. However, the Health Professions Council of South Africa (HPCSA) and the South African Nursing Council were able to provide data on the number of new professional registrations in 2005, according to the following categories (see Graph 8).

GRAPH 8. - NEW PROFESSIONAL REGISTRATIONS IN 2005 (rate per 100.000 population)
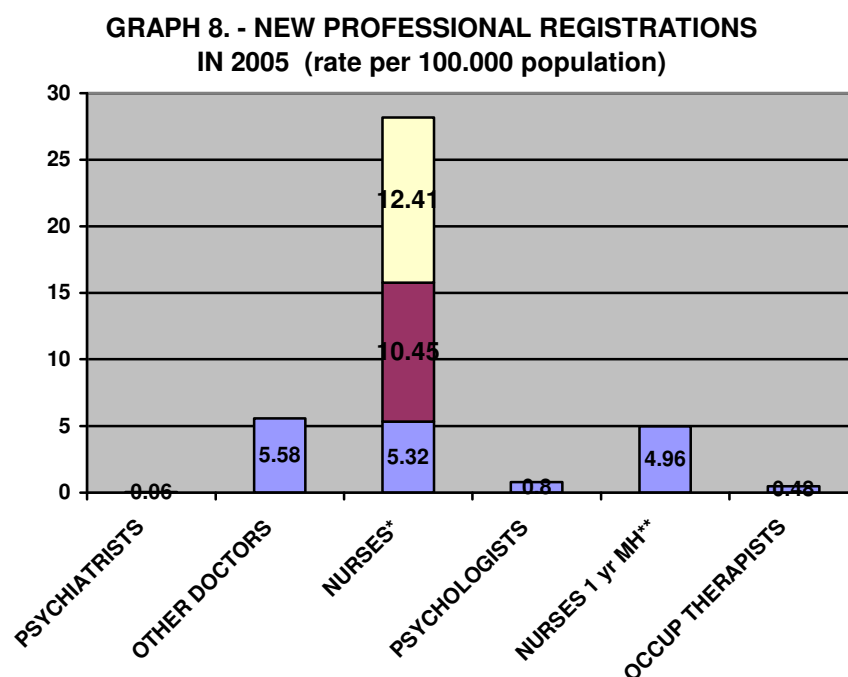
* Nurses include Registered Nurses (5.32), Enrolled Nurses (10.45) and Enrolled Nursing Auxiliary (12.41).
** Nurses 1 yr MH refers to nurses with at least 1 year training in mental health care.

The Health Professions Council have implemented a Continuing Professional Development scheme for medical doctors and psychologists, which covers both private and public sectors. Professionals are required to undertake certain activities each year in order to remain registered with the HPCSA. However, no data are kept regarding the amount of CPD training undertaken each year for all registered professionals, as audits are conducted each year on a group of randomly selected professionals.

3.6.6.3 Consumer and family associations

There is no national mental health consumer association in South Africa. There are 3 provincial consumer associations supported by the Mental Health Societies (South African Federation for Mental Health) in the Eastern Cape (membership unknown), Western Cape (32 members) and Gauteng provinces

(70 members). The SAFMH-supported associations receive some government economic support for consumer associations in the Western Cape and Gauteng provinces. SAFMH-affiliated consumer associations have been involved in the formulation of internal organisational policies as management board members, but have not yet been directly involved in the development of national or provincial mental health policies, plans, or legislation.

Small, independently-run user advocacy groups have been established in the Western Cape and Gauteng provinces, but the membership of these are unknown.

Reliable data on the number of family associations working to support people with mental disability and their support networks were not available. The number of family associations is unknown. The government provides some economic support for family associations only in the Western Cape, Free State and Mpumalanga.

Mental health facilities interact with consumer and family associations in Mpumalanga, Limpopo, Gauteng, North West, Eastern Cape, KwaZulu-Natal and the Western Cape. In addition to consumer and family associations, there are 33 other NGOs in the country involved in individual assistance activities such as counselling, housing, or support groups.

3.6.7 Public education and links with other sectors

3.6.7.1 Public education and awareness campaigns on mental health

There is a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders in South Africa, namely the Department of Health. Advocacy and public awareness programmes are being run by the national Department of Health, but are limited by resources. The Department is assisted by various NGOs, including the South African Federation for Mental Health, the South African Depression and Anxiety Group (SADAG) and other professional, consumer and advocacy bodies.

Government agencies and NGOs have promoted public education and awareness campaigns in the last five years in all provinces. However, only the Western Cape, Free State and Gauteng reported the involvement of professsional associations in these campaigns, and only the Western Cape reported the involvement of private trusts, foundations and international agencies.

These campaigns have targeted the following groups:

- o The general population
- o Children
- o Adolescents
- o Women
- o Trauma survivors
- o Ethnic groups

    o   Other vulnerable or minority groups

In addition, there have been public education and awareness campaigns targeting professional groups in Gauteng and the Western Cape, including:

    o   Health care providers
    o   Complimentary/alternative/traditional healers
    o   Teachers
    o   Social service staff
    o   Leaders and politicians
    o   Other professional groups linked to the health sector.

In the Free State, all these groups have been targeted with the exception of social service staff and politicians. In Mpumalanga, these campaigns have been limited to teachers, politicians and other professional groups linked to the health sector. In North West, campaigns have targeted only health professionals. No other provinces have conducted public education and awareness campaigns for mental health.

3.6.7.2 Links with other sectors

Some important steps have been taken towards inter-sectoral collaboration, particularly at the national level. For example, there is a national forum on forensic psychiatry, to be convened by the Department of Health, with the South African Police Service (SAPS), the Department of Justice and the Department of Correctional Services. Some provinces have also established such inter-sectoral forums for mental health and inter-sectoral collaboration is a standing item on the agenda of the quarterly meetings of the provincial mental health coordinators. However, at the district level, such inter-sectoral collaborations are the exception rather than the rule (see Section on District level, below).

Apart from the Department of Health, other government departments have developed policies regarding mental health. These include the Department of Education and Department of Corrrectional Services. In addition the SA Police Services (SAPS) have developed a "Standing order" which sets out roles and responsibilities for police in relation to mental health. This document was developed with comment from the national Directorate: Mental Health and Substance Abuse in the Department of Health. It is currently in draft form but not yet approved.

There are formal collaborations between the government department responsible for mental health and other departments/agencies at provincial levels, as indicated in the following table.

Table 3. Formal collaborations between mental health and other sectors

Province	PHC	HIV	Rep	Elder	Subst	Chil Pro	Educ	Emp	Hous	Welf	Crim	Child	Other
WC	Y	Y	N	Y	Y	Y	Y	N	N	Y	Y	Y	
KZN	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y

NCAPE	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN
MPUM	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
EC	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FS	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
LIMP	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN
GTNG	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NWP	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	NA

Column titles: Primary health care/ community health; HIV/AIDS;
Reproductive health; The elderly; Substance abuse; Child protection;
Education; Employment; Housing; Welfare; Criminal justice; Child and
adolescent health.
Y = Yes, N = No, NA = Not Applicable, UN = Unknown.

In terms of support for child and adolescent mental health, the percentage of
primary and secondary schools with either a part-time or full-time mental
health professional is unknown. Free State, Gauteng and North West province
indicated that 1-20% of primary and secondary schools have school-based
activities to promote mental health and prevent mental disorders. In the
Western Cape 51-80% of schools have such activities. No other provinces
indicated any school-based promotion or prevention activities.

The percentage of prisoners with psychosis and mental retardation is
unknown. Regarding mental health activities in the criminal justice system,
Gauteng reported that 1-20% of prisons have at least one prisoner per month
in treatment contact with a mental health professional. No other provinces
indicated any mental health interventions in prisons.

As for training, 1-20% of police officers have participated in educational
activities on mental health in the last five years in Gauteng and Free State.
21-50% have participated in such activities in Mpumalanga. No other
provinces reported training activities for police officers. In addition, there were
no educational activities reported with judges and lawyers in any provinces.

In terms of financial support for users, in 4 provinces (Western Cape,
KwaZulu-Natal, Eastern Cape and Gauteng), 1-20% of mental health facilities
have access to programmes outside the mental health facility that provide
outside employment for users with severe mental disorders. In the Free State
21-50% of mental health facilities have access to such programmes. No other
provinces reported such programmes.

The percentage of people who receive social welfare benefits due to a mental
disability is unknown. The Department of Social Development, which
administers social welfare benefits, does not keep records of the distinction
between physical and mental disabilities.

3.6.8 Monitoring and evaluation of services

Of the 9 provinces, 4 indicated that there is no formally defined minimum data
set of items to be collected by mental health facilities (Western Cape,
KwaZulu-Natal, Northern Cape and Mpumalanga). The remaining 5 provinces

reported that a formally defined list of individual data items exists that ought to be collected by all mental health facilities.

As shown in the Table 4, the extent of data collection is variable among mental health facilities and across provinces.

The provincial Health Department receives data from all mental hospitals, all psychiatric inpatient units in general hospitals, and all mental health outpatient facilities, with the exception of the Western Cape, KwaZulu-Natal and Limpopo, which receive data from 67%, 23% and 89% of outpatient facilities, respectively. However, no report was produced on the data transmitted to the government Health Department in any province except North West.

Table 4. Percentage of mental health facilities collecting and compiling data by type of information

Type Of Information Compiled	Mental Hospitals	Inpatient Units	Outpatient Facilities
No. of beds	100%*	100%‡	NA
No. inpatient admissions/users treated in outpatient facilities	100%*	100%‡	100% in 3 provinces§
No. of days spent/user contacts in outpatient facilities.	100%*#	100%‡	100% in 3 provinces§
No. of involuntary admissions	100%*#	100%‡	NA
No. of users restrained	100%	100%‡	NA
Diagnoses	Mixed†	100% in 2 provinces☼	100% in 1 province Ω

* Except Northern Cape
# Except Limpopo
† Only KwaZulu-Natal, Eastern Cape and North West provide all this information. Western Cape provides diagnoses in 1 of 3 mental hospitals. Other provinces provide none.
‡ Only KwaZulu-Natal, Mpumalanga, Eastern Cape, Free State and Gauteng provide all this information. In the Western Cape 17% of facilities provide this information and in other provinces none do.
☼ These provinces are Mpumalanga and the Eastern Cape. No other provinces provide diagnoses.
§ These provinces are Mpumalanga, Eastern Cape and North West. No other provinces provide this information.
Ω Only Mpumalanga reports diagnoses in outpatient facilities.

GRAPH 9. - PERCENTAGES OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH DEPARTMENT
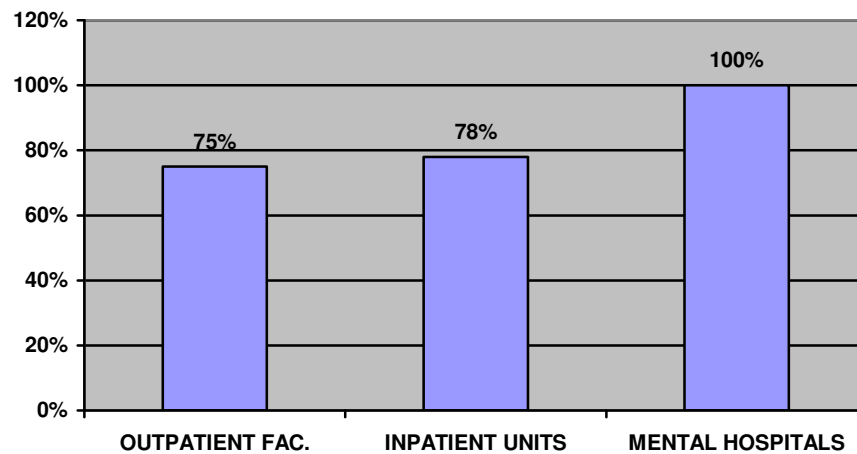
Summary: Mental health policy implementation at national and provincial level: current service resources and provision

- **National and provincial offices for mental health:** Mental health policy implementation in South Africa takes place through national, provincial and district structures.
- **Human rights protection :** Review Boards are established in each province.
- **Financing of mental health services**: The percentage of government Health Department expenditure devoted to mental health is not known at a national level.
- **Mental Health Services** : These comprise
  - 3,460 outpatient mental health facilities, of which 1.4% are for children and adolescents only
  - 80 day treatment facilities available, approximately half of which are provided by the SA Federation for Mental Health. None are provided specifically for children and adolescents.
  - 41 psychiatric inpatient units in general hospitals available in the country with a total of 2.8 beds per 100,000 population. 3.8% of these beds are for children and adolescents only.
  - 63 community residential facilities, of which 47% are provided by the SA Federation for Mental Health. These facilities provide a total of 3.6 beds per 100,000 population. The number of beds reserved for children and adolescents is not known.
  - 23 public mental hospitals, providing 18 beds per 100,000 population (provincial range: 8-39). 79% of these facilities are organizationally integrated with mental health outpatient facilities. Only 1% of these beds are reserved for children and adolescents only. All mental hospitals have at least one psychotropic medicine

of each therapeutic class.

- 1,676 beds for people with mental disorders in forensic inpatient units.
- 1,930 in other residential facilities such as homes for people with learning disability, detoxification inpatient facilities, homes for the destitute, etc.
- **Service access:** The density of psychiatric beds in or around the largest city is 1.2 times greater than in the entire country (provincial range: 0.28-4.78). Most users are treated in outpatient facilities and in mental hospitals. The number of users treated in psychiatric inpatient units in general hospitals is not known. Psychotropic drugs are most widely available in mental hospitals, followed by inpatient units, and then outpatient mental health facilities.
- **Mental Health in Primary Health Care**: Most provincial services endorse the importance of integrating mental health into PHC, and some training initiatives have been undertaken for PHC nurses.

- **Human resources** in mental health care total 11.95 per 100,000 population working in Department of Health mental health facilities or NGOs. Per profession these comprise (per 100,000):
  - 0.28 psychiatrists,
  - 0.45 other medical doctors (not specialized in psychiatry),
  - 10.08 nurses,
  - 0.32 psychologists,
  - 0.4 social workers,
  - 0.13 occupational therapists, and
  - 0.28 other health or mental health workers (including auxiliary staff, non-doctor/non-physician PHC workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors).
  - Data were not available for mental health professionals working in private practice.
- Approximately 100 service users/consumers are members of consumer associations, and an unknown number of family members are members of family associations.
- **Public education and awareness campaigns on mental health**: The Department of Health acts as the coordinating body overseeing public education and awareness campaigns, supported by various NGOs.
- **Monitoring and evaluation of services:**The extent of data collection is variable among mental health facilities and across provinces.

3.7 Mental health policy implementation at district level

The following section provides a detailed description of mental health policy implementation in the rural district site.

3.7.1 Overview of facilities, resources, services provided and service use from WHO AIMS

3.7.1.1 District

Facilities		Staff	
No. of Hospitals	5	Mental Health Technical Advisors	1
Fixed clinics	50	Psychiatrists	0
Mobile clinics for PHC	12	Psychologist (Community Service)	1
Mobile clinics for Mental Health	0	Nurses	51
Dedicated Beds	22	Social Workers	8
Community Residential	0	Occupational Therapists (6 Community Service)	10
Child/Adolescent dedicated	0		

In total, 7,519 mental health service users were treated in the hospitals and clinics in 2005. This means that service users make up 1.5% of the population. There is one dedicated psychiatry bed for every 342 service users and for every 22,909 individuals of the general population. Although there is no psychiatrist based in the district, one is sometimes incorporated into the monthly Red Cross Flying Doctor service. But this is inconsistent and of little help in such a large area.

Protocols for key mental health conditions are generally available in all facilities. There is also psychotropic medication from each therapeutic category (antipsychotic, mood stabilizer, anxiolytic and anti-epileptic) available. The district health service has conducted public education and awareness campaigns on mental health within the last five years. The district mental health office has intersectoral links with a number of government departments. The Department of Health Provincial office is in Pietermaritzburg.

3.7.1.2 Sub-district

Facilities		Staff	
No. of Hospitals	1		
Total beds	296	Psychiatrist	0
Dedicated mental health beds	5	Psychologist (Community Service)	1
Outpatient department (OPD)	1	Community Health Workers	UN
Crisis centre	1	Nurses	UN
Fixed clinics	15	Social Workers	4
Mobile clinics for PHC	UN	Occupational Therapists (6 Community Service)	10
Residential facilities	0		
Child and adolescent	0		

dedicated services

Unfortunately some data from the sub-district were unavailable.

3.7.2 Structure of Services at the District and Sub-district

Mental health services at the district and sub-district level are discussed in terms of its current structure illustrated below:
1) District Health Office
2) District Hospital (in sub-district)
3) Primary Health Care
4) Community - Government
5) Community - Other
6) Service Users
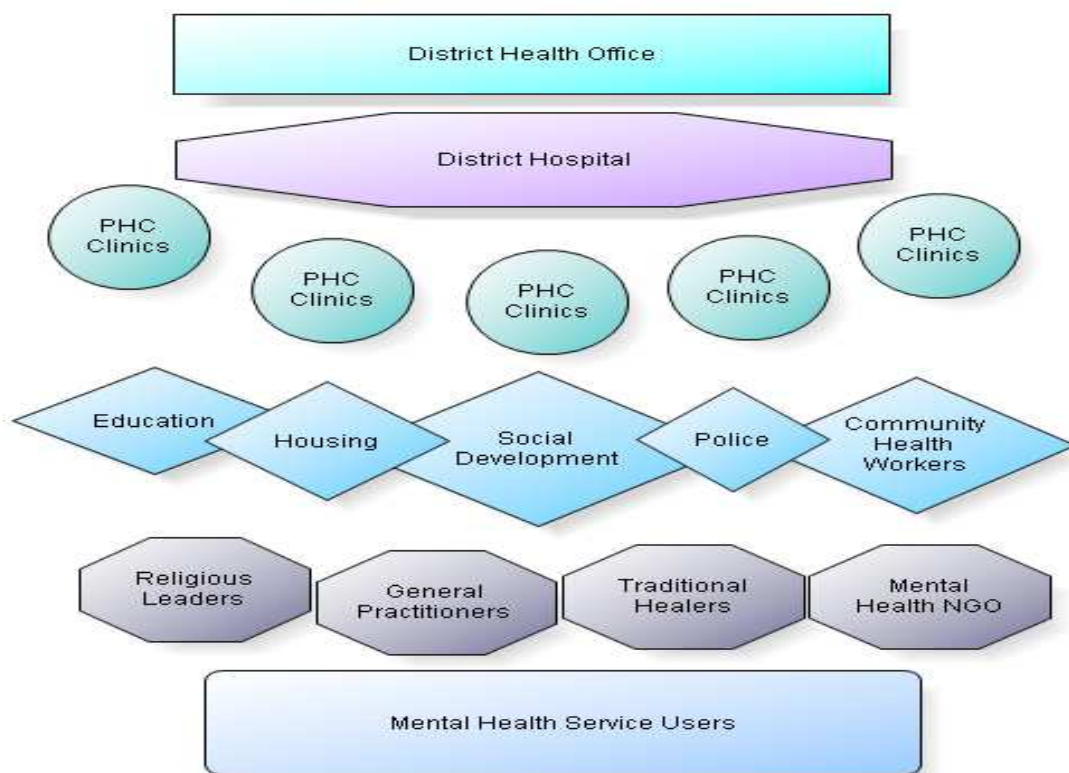
This structure demonstrates the district referral system, and enables a discussion of the mental health resources at each level of service provision.

Summary: Overview of District facilities, resources, services provided and service usage from WHO-AIMS

- **Facilities** – 5 hospitals; 50 fixed clinics; 12 mobile clinics; 22 beds; 0 residential; 0 Child/Adolescent dedicated; Crisis centre; OPD
- **Staff** – 5 Hospital Senior Technical Advisor; 1 Psychologist, No psychiatrist, 51 Nurses; 8 Social Workers; 10 Occupational therapists
- 7,519 mental health service users treated in 2005 (1.5% of population)

- **Beds** - 1 for every 342 service users and every 22909 of general population
- **Protocols** – Generally available
- **Psychotropic medication** - Generally available
- **Structure of services** – District Health Office; Hospital; PHC; Community-Government; Community-Other; Service Users
- Education/awareness campaigns on mental health within the last 5 years

3.7.2.1 District Management

Mental health has not been a priority in the district thus far. The district mental health coordinator is involved in coordinating a number of other programmes in addition to mental health and has been unable to devote her full attention to mental health. In May 2007, she was appointed the new senior technical adviser for mental health, a post dedicated to mental health. However, due to retention and recruitment problems in the rural area at the district level there are a number of unfilled posts for other programmes. As a consequence, the district mental health coordinator must oversee other programmes as well, with the implication that the post is dedicated to mental health in name only.

> "…*there is a lot that is not even happening right now. You find that I have to run there and there and there and yet mental health is having a lot that is not yet being done, especially for the district. I think if I will get enough time to look to mental health services, the district will be proper…"* (District Health Management, MHCO).

The senior technical advisor's role is to:
- coordinate the training of general health staff in mental health,
- provide regular support for the hospitals through information provision and problem-solving,
- draft a mental health delivery plan for clinics and community level for this sub-district, and
- monitor implementation of the Mental Health Care Act and shape best practice.

While a district management committee exists, it is focused on primary health care and not mental health specifically. A district mental health task team includes the mental health coordinator and meets quarterly. At the sub-district level, the team comprises the nursing matron and a psychiatric nurse, who is also the coordinator.

Currently, no multi-sectoral forum exists specifically for mental health but the senior technical adviser would like to form municipality mental health forums in the future and invite the different sectors. There is an annual district level meeting which includes SAPS and the Emergency Medical Response Service (EMRS). This forum has developed an operational plan and a business plan for improvement of services. This is a separate plan which is then integrated

into the broader health plan by the clinical programmes manager. Some of the indicators have been drawn from the provincial level and some reflect district needs.

Reporting and monitoring of services:
- Reports are sent from institutions to the senior technical advisor.
- Reports are sent to the district office to be consolidated.
- Monthly reports go to the Programmes Manager at the district office
- Quarterly reports are sent to the provincial mental health coordinator, who is their strongest regional link to the district. However, the provincial offices are located at a great distance from the district and not always able to provide support to the district.
- The report contains information on patient numbers, challenges to implementation and compliance issues with the Mental Health Care Act.
- A Review Board has been appointed which visits institutions to investigate adequacy of the mental health facilities in providing treatment.

> *The board visits institutions to see how are the facilities like for mental health; are we restraining our mental health people; what is the follow up? You know all those things to make sure they are looked after…*
> (District Health Management, HMAN).

The portion of the district health budget for mental health is extremely small.

> *Oh not even a percent. It's so small, very small. It's nearly nothing.*
> (District Health Management, HMAN).

The budget is R200,000 for mental health as a programme for the district as a whole. This budget is to facilitate training and mental health promotion and prevention programmes. Respondents stated that there is a need for a bigger budget, particularly due to the need for continuous training of nurses and other staff due to high turnover and retention problems. The district health managers are well-versed in the new Mental Health Care Act of 2002, as all of the health districts gave input during the drafting process.

Summary: District Management
- Retention and recruitment problems - new senior technical adviser for mental health cannot dedicate herself to mental health due to lack of resources in other programmes
- Management committee - for primary health care and not mental health specifically. District mental health task team meets quarterly.
- No multisectoral forum for mental health
- Reporting occurs from the institutions to the district health office. Quarterly reports are sent to the provincial mental health coordinator
- A Review Board had been appointed
- Need for bigger budget for ongoing training of health staff

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3.7.2.2 Sub-District Hospital

3.7.2.2.1 Background

Mental health was reported to be a low priority at the hospital and this is reflected in both human resources and infrastructure. In terms of infrastructure, there is no specialist unit or designated area for psychiatric patients and they are kept on the general wards. This makes management of patients difficult because it is inadequate as a facility for psychiatric care.

> *We have a little corner where we have got a few beds that we put in there. But it's not a maximum security; it's not user-friendly to be honest. We hope one day we'll be able to say, even if it's not a ward, but some psychiatric unit in the ward where you can have an area where you can put the patients because it's very difficult to manage the. (*Hospital Management, HOSP)

Currently a new hospital is being built which will have a separate psychiatric unit with two beds each for male and female inpatients.

With regard to human resources, while the hospital has a number of psychiatric nurses, they are rotated through the wards and the outpatient department due to staff shortages. Thus psychiatric patients are cared for by nurses with varying degrees of experience in mental health.

For the past three years, the post of the psychologist has been a community service post which is filled on an annual basis. The rotation of staff results in a number of problems relating to continuity of services.

> *…faced with the challenges that I've mentioned that if there were services that were started by an individual last year there is a possibility that they may collapse somehow and the possibility of patient care not being sustained properly enough. Particularly at the clinics where people there know that the psychologist is coming regularly and if there's a break, if they don't get a new community service psychologist to fill the position, those services then collapse.* (Mental Health Practitioner, PSYC).

However, a permanent psychologist post has recently been established and a community psychologist has been employed on a permanent basis. This will facilitate the building of sustainable and long-term services. It will also ensure that there is a focal person to highlight the importance of mental health and champion it at the hospital.

3.7.2.2.2 Common and Serious Mental Health Problems

3.7.2.2.2.1 Training

Staff training needs vary depending on the extent of exposure to a mental health curriculum in their initial degree. For example, nurses' training varies depending on which nursing courses they completed and the duration since having taken the course.

> *…nowadays, when they are doing a diploma course, they do a four year course, it includes…mental health training. With us, in our own times we used to do a three year course and it was never included so we do it (mental health) as a post-grad course….With the enrolments they only do a two year course and they are not eligible for post-graduate...* (Psychiatric Nurse)

As mentioned, the psychiatric nurses are rotated through general wards and sometimes have no contact with psychiatric patients. Only the OPD Matron works consistently with mental health patients. Thus, most nurses working with psychiatric patients are not psychiatric nurses and may not have any training in psychiatry. Recently this issue was raised as a problem of poor practice and therefore different wards must now have at least one dedicated psychiatric nurse available.

> *…in each ward there is a person who has got the expertise who shares because what needs to happen now...everybody should have some knowledge about the management of mentally ill patients.... we are all as health workers, mental health practitioners, but the trained psychiatric nurses have conducted workshops and the one they had with you so that they could share best practices and keep on going to the wards to suppor. (*Hospital Management, HOSP).

The psychiatric nurses felt that they have sufficient training but need to practice these skills under proper supervision and support, dealing with psychiatric patients rather than general medical patients. While a workshop on mental health was conducted for some of the staff, this seems insufficient as most health personnel still need more training, information, and exposure to mental health.

Because of lack of psychiatrists or doctors trained in psychiatry at the hospital, the psychologist is frequently called upon to suggest psychopharmacological treatments. Psychiatrists in other hospitals are consulted to develop drug treatment programmes. Given that the psychologist is on contract, no long-term training plan exists. However, a limited budget has been allocated for continued professional development (a requirement of the Health Professions Council of South Africa).

3.7.2.2.2.2 Supervision and Support

According to participants the supervision structure for mental health is poor and there is a need for a formal support and supervision structure. Currently the psychologist meets with the two nursing matrons to discuss difficult cases. The psychiatric nurses get some support and supervision from the matrons. In

turn, they provide informal supervision to other nurses dealing with psychiatric patients. However, structured support needs to be improved at all levels:

> ...*those sub-district coordinators are supervised by their immediate nursing managers, so they do get support really. Except…I was having a problem again with (research site hospital), because now each time they employ a person she's not there, she's allocated there, she's not…at the mental health services, she's doing other things, she's in OPD*" District Health Management (MHCO).

A new nursing sister has now been employed to do outreach work, which should leave more time for the sub-district coordinator to provide supervision for the nurses. The hospital has also secured a chief medical officer who worked at a psychiatric hospital during implementation of the Mental Health Care Act and who is assisting the team to accommodate the new processes.

The intern psychologist has no proper supervision at the hospital. While he reports to a line manager, this person is not psychiatrically trained. He therefore relies on the psychologist previously occupying the intern post as well as colleagues at his University for supervision via telephonic discussions. He has now contacted the psychologist at the referral hospitals and they will be meeting monthly to establish discussion forums and case presentations. However, there is a need for a consultant psychiatrist to provide supervision and support to the psychologist.
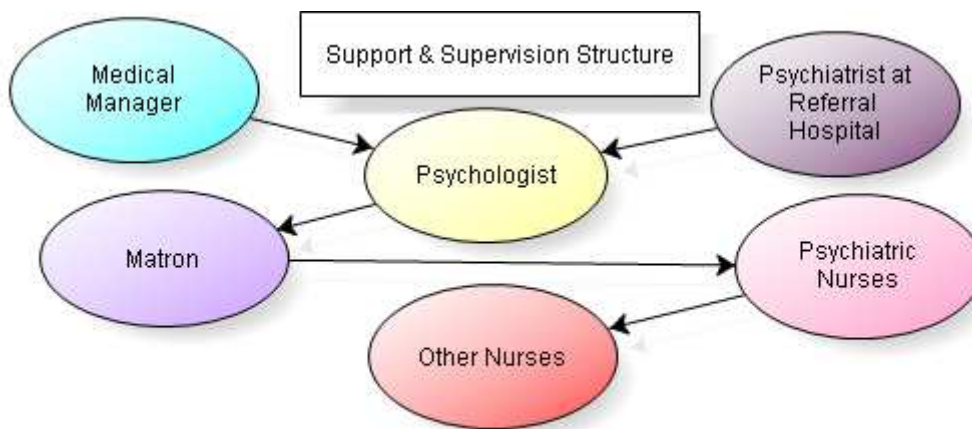
There is a lack of support from management for other initiatives. A number of respondents complained that they did not have enough time or support for community work such as supervising the clinics, psychosocial rehabilitation, home visits or defaulter tracing.

> …*the management, they are the ones who are giving us the light in everything. You can't just jump into something and say okay today I want to do a home visit, next day I want to do defaulter…. much as we can see that this person has long been attending, he hasn't been coming for a long time. We have to find out why are they not coming. How and when are you going to do that when you've got to look at some other things within the institution.* **(**Psychiatric Nurse)

The Technical Advisor for mental health would like to organise and support a team of mental health practitioners to go to the clinics and provide psychosocial rehabilitation, training, and promotion. This team will consist of the doctor, the psychologist, the social worker and the occupational therapist.

There is a report back system in place for both the managers and other staff. For example, the psychologist reports directly to the Medical Manager. However, because he is not a mental health specialist, some issues are reported directly to the district. The hospital also reports to the district and the Review Board, which was established in terms of the Mental Health Care Act:

> *There is a Review Board. The Review Board meet and give permission to have a person institutionalized. And the Review board who does this follow up and see that okay this patient can now be discharged from the institution.*"(Psychiatric Nurse)

3.7.2.2.2.3 Assessment

Patients in the ward are under the care of the psychologist and the doctor. The nurses report to the psychologist the number of mentally ill patients in the ward. He will then conduct ward rounds and, together with the doctor, develop a treatment plan and decided whether or not the patient should be referred. According to the new Mental Health legislation, patients must be transferred to a referral hospital or discharged within the 72 hour observation period. It is difficult to ensure compliance of the 72 hour observation period, especially during weekends when there is minimal mental health staff.

> *…on admission they must be assessed…by the psychologist…If there's an indication that their symptoms can subside within the two days then then we keep them here and we stabilize them here. If there's an indication…the second day or so that their symptoms are not subsiding then a transfer letter must be arranged…psychiatric patients…must remain in the hospital only seventy-two hours and it is either they are continuing their stay for further treatment at (deleted). Or if we can manage to stabilize them within the seventy-two hours* (Mental Health Practitioner, PSYC).

In terms of care for common mental health problems such as depression, it seems that these are sometimes identified by clinic health staff who refer them to the psychiatric nurse or psychologist. They would receive some counselling from the psychologist or a psychiatric nurse:

> *...they do get some counselling. But it depends on how far we go with the problem and if we do identify the cause we deal with the cause and we give the treatment – we prescribe. If the cause is beyond our capabilities I usually transfer them to the psychologist. (*Psychiatric Nurse).

The Social Work Department refers patients to social welfare, makes home visits, and helps with disability grants. Although their resources are stretched due to lack of staff, they try to make home visits with the person and provide appropriate services.

> …make sure that the patient is linked to the local…home-based care-givers….And uh the villagers I tell them to be very responsible for this person to make sure that the treatment is taken correctly; the patient is eating correctly; if there is a problem they should report back to us. (Social Worker)

3.7.2.2.2.4 Referral System

There is a new referral system with referral forms. Health staff write a brief summary of the reasons for referral on the patient's handheld card. Patients either arrive on their own, are referred from the clinics, or are brought by the police. On arrival, they must first go to OPD. There, they will either be treated or given an appointment with a mental health worker. After discharge or for their second appointment, they will be given a review date to see the psychologist for a one month follow-up at the hospital or at the nearest clinic. The person will then collect medication from the clinic every month. Individuals with more serious psychiatric problems are transferred to referral hospitals. After discharge from tertiary care, patients are sent back to the hospital from which they were transferred.

3.7.2.2.2.5 Medication & Tests

There are a number of psychometric tests available, although the psychologist stated that he would like to order more tests. Respondents indicated that they generally have all the necessary psychotropic medication, and have not had an experience where the required medication is unavailable.

> I've not experienced a situation where we've ordered a drug for the patient and they've said that the hospital pharmacy doesn't have. It might be a situation in the clinics sometimes that they run out and then I've just got to do an order from the pharmacy that they deliver those meds you know to the clinics. (Mental Health Practitioner, PSYC).

3.7.2.2.2.6 Language

All of the respondents at the hospital spoke Zulu but some doctors don't speak it and therefore use a translator.

3.7.2.2.2.7 Involuntary Admission and Treatment

Involuntary patients are brought in by relatives, or the police. They are taken to OPD, assessed, and admitted if necessary. This process is very clearly laid out in the Mental Health Care Act. Two practitioners must assess the patient and agree; otherwise a third opinion must be sought. The facility manager must then sign and send the patient. The process aims to protect patients as it

"…*asks you to detail quite clearly the presenting problem you know the patients presentation at that stage and why you think that admission is warranted*" (Mental Health Practitioner, PSYC).

The use of restraints is not encouraged. Instead, they rather sedate heavily and sustain the dose. If it becomes absolutely necessary to restrain a patient then it must be done with a straitjacket. There is a seclusion room at the hospital in H ward where patients are sometimes secluded. The room, however, is situated where it is quite difficult for nurses to observe the patients and this could potentially lead to harmful behaviour.

3.7.2.2.2.8 Disability Grants

The social workers write referrals to the psychologist, and to other relevant referral targets like the District surgeon and the Department of Social Welfare for a disability grant. If users don't have identity documents, they encourage their relatives to apply for one so that they can qualify for the grant. The R830 per month disability grant, however, is considered to be inadequate:

> *Ah it's a very little money…can't survive with that. But I think it is there to meet the family…the families' income, if there is any. But if there is none, it's too little…Because the the family ends up eating this...slicing this little share from the government.* (Social Worker)

3.7.2.2.2.9 Children & Adolescents

There are not many child or adolescent cases. They are not a focus and are only picked up when referred by schools or when they attend the clinic for medical or behavioural problems.

> *There are those who decided okay the child has got a negative behaviour and they came in. Maybe only when it's been picked up by the school and the school writes the family a letter that you know you should take this child to the social worker or to the hospital or doctor or something like that. It's only then they do. Kids are usually neglected. They are only attended to once they become aggressive, destructive.* (Psychiatric Nurse**)**

The treatment strategy is formulated with the referral hospital. If they can't be treated at the hospital they are referred to a dedicated child or adolescent unit. Children with psychiatric problems are admitted to H ward, the same as adults. Most nurses and social workers have some training in dealing with children and adolescents.

3.7.2.2.2.10 Legislation

Knowledge of the Mental Health Care Act varies from person to person but all staff have some knowledge and they have access to copies of the Act. Most of the hospital health staff have had a workshop on the Act and therefore

have some knowledge of the changes that need to be implemented, but they are not up-to-date because there is no focus on psychiatric patients.

Right now there is this and that, and lots of paperwork – medical what what. There is no nurse in that section, you've got to go help out in the other section. There's too much going on. (Psychiatric Nurse)

Summary: Sub-District hospital

- **Facilities** – Currently inadequate but new hospital being built which will have a separate psychiatric unit with two beds each for male and female inpatients.
- **Human Resources** – Short-staffed. Psychiatric nurses are therefore not filling specialist roles and cannot supervise other nurses. The Psychologist post has now been made permanent.
- **Training** - Training needs varied depending on the extent of exposure to a mental health curriculum in their initial degree. But most health workers require more training in mental health.
- **Support and supervision** - Need for a formal structure and a consultant psychiatrist for the district.
- **Language** – Some doctors require a translator
- **Admission & Assessment** - Process as laid out in Mental Health Care Act
- **Involuntary Admission** – Process as laid out in Mental Health Care Act
- **Seclusion** – Room available in H ward
- **Referral System** – New system with referral forms and handheld cards
- **Psychotropic Medication & Psychometric tests** – Available
- **Child and Adolescent** - Not a priority and are only picked up when referred by schools or when they attend a clinic for medical or behavioural problems.

3.7.2.3 Primary Health Care Clinics

3.7.2.3.1 Background

Most of the clinics are small and staffed by nurses. There is one bigger, busier, 24-hour clinic, with four beds, a doctor, and where all nurses, regardless of psychiatric training, see psychiatric patients. Organization of mental health services at the smaller clinics appears to be dependant on availability of resources. Where there is a sister with psychiatric training, patients presenting with mental health problems are referred to her. If they only require follow-up medication however, one of the nurses, regardless of their training or experience, can attend to these patients. There are variations on these practices.

> *…I am the one who has psych so the others…unless they have come to fetch treatment because they already have treatment, unless they have a problem, then they refer to me as a psych nurse.. other sisters see them for issue of treatment if they have no other problem, just for follow-up.* (Respondent 2, Clinic Nurse)

Mental health is a low priority in PMC clinics, as there is a focus on other programmes such as HIV/AIDS and Tuberculosis, rather than mental health,

> *…there is nothing you will hear that much about mental health in this clinic….The one thing...that is given attention is BP, ARV's, you know people who are at the fore. Not mental health….the way I see it, they are not recognised people.* (Resondent 1, Clinic Nurse)

3.7.2.3.2 Common and Serious Mental Health Problems

3.7.2.3.2.1 Facility type and services available

Nurses assess patients and then refer them to the psychologist or the hospital for proper diagnosis. When the person has been given a treatment plan, they will collect their monthly medication from the clinic,

> *When I see them maybe, they have already been seen by the doctor who has diagnosed them as psych cases. Then after that I have to continue with what the doctor has said I have to do. But if I see that a patient walking in through the door…is a psych, immediately I write down and say to the [psychologist] …..he continues from there and diagnoses* (Respondent 1, Clinic Nurse)

If clinic staff refer patients to the hospital, they cannot refer directly to the psychologist, and therefore must go through the medical officer at OPD.

The clinic nurses felt quite strongly that specialization works better. If a nurse is working only with mentally ill patients, they have more time and focus, and therefore better knowledge of patients, including those who default from attendance or medication compliance:

> "… *(patients) need time for you to ask them whether they are taking their medication properly, do they have other problems, what problems are they faced with at home, that can aggravate the situation…I won't have time to ask them all of that in detail because the queue is long outside, somebody calls me while I am still dealing with someone else, the phone rings, you are here to talk to me and if I don't give you some time, you'd be in trouble and would have to make another appointment...*" (Respondent from focus group 3, Clinic Nurse)

However, the one stop shop service provision where all nurses provide mental health care is seemingly the preferred method that is being promoted by the Department of Health, as it tends to promote holistic care and treatment of

patients. This is potentially a problem because it could result in a lack of buy-in of integrated care by service providers.

The psychologist visits most clinics once a month. Some clinics are close together and therefore users from other clinics are sent to the clinic that is being visited by the psychologist. He has a set schedule for the month and tries to see four clinics a week, going out for two days and seeing one clinic in the morning and one in the afternoon. However, it is a battle for him to keep up with the workload.

> *…three hours at my [24 hour] clinic on a Monday and then he has to go to another clinic and there's a queue of ten patients. So I don't know how long he is going to be able to spend with each …. then he has to come back to me here because he can't really change prescriptions without a doctor's advice.* (Clinic Doctor)

Some of the nurses complained that the psychologist is supposed to come once a month but this has not been happening properly. This is due to the inconsistent availability of the psychologist as well as the heavy workload, thereby leading to problems in terms of sustainability and continuity of service.

> *…there are some that have not been seen. Sometimes you "Hey you have not been seen by the psychologist, come back on such a day" and he doesn't come (psychologist). Then we end up with those irregularities.* (Respondent 2, Clinic Nurse)

Access to transport to hospital was mentioned by some respondents as a major problem. Patients can get to hospital either by ambulance, by police van, or by their own transport. However there are issues with each of these. The ambulance is not always available, police are not always very sympathetic, and use of own transport is expensive. Respondents indicated that there is a bus which goes to some clinics twice a week and then transports patients to the hospital but they have to find their own transport back. The nurses would like a properly established protocol on transport.

The 24 hour clinic is open during the weekend and therefore people come from all areas of the district. Most of the serious psychiatric cases seem to arrive over weekends. Since there are only three nurses on duty over weekends psychiatric patients are not kept overnight but are rather transferred to hospital. One of the smaller clinics is also starting to work on Saturdays and Sundays where there will be a Sister at the clinic and another person on stand-by in case of an emergency. If a staff has worked on the weekend, they will have days off during the week. However this is likely to impact negatively on the provision of clinic services.

Analysis of the interviews clearly showed that priority is given to the identification and treatment of more severe mental health problems. For the most part, nurses either do not detect common disorders, or they do not differentiate in their treatment methods between common and serious

problems. Common cases are treated the same as severe cases and referred to the psychologist or hospital, rather than being dealt with by nurses.

Almost all clinics have a visiting doctor weekly or at least monthly but this is for all medical problems, not dedicated to mental health. The nurses refer to the doctor for medication prescription, treatment and review but she does not have enough time for all the patients' needs.

> *…after six months, they have to be reviewed….the problem is that it is not exactly at six months because there is a shortage of doctors. So when the doctor gets to the clinic he does not see all the people we have referred to him. You find that some will sit for more than a year or more than six months without being reviewed.* (Resondent from focus group 1, Clinic Nurse)

Integration of mental health into the work roles of PHC nurses appears to be hampered by a lack of understanding and fear of people with mental health problems, particularly if they are aggressive. The social worker from the Mental Health Society reported that she went with the police the previous week to take a woman to the clinic who had been raped and as a result was having mental health problems. The clinic refused to let her inside for an injection because she was extremely aggressive. They injected her outside the clinic and then she was put back in the police van. This was the second time she had seen nurses refuse to allow a patient into the clinic.

> *Their idea of having a psychiatric clinic is you know these one that every month for their medication, they are complying medication. The non-violent ones…Where you just drug them up and every month they take all the medication and they come back the next time for the injection and the tablet…those are the ones they are prepared to deal with. (Representative,* Non-Governmental Organisation)

3.7.2.3.2.2 Training

The clinic nurses differ in the extent of their mental health training. The psychiatric nurses feel adequately trained, although those who trained a long time ago expressed desires to update their skills. Some nurses have a four-year integrated service qualification which includes primary health care, mental health, community health service and general nursing. Introductory courses on the integration of mental health into primary health care are run at the hospitals to enable clinic staff to manage mental health services but not all the nurses are able to attend the courses. General nurses who attend to mental health service users do not seem to have had any extra training. They indicated that they learned as they went along and would definitely like more training,

> *I think these people will probably benefit from training, in-service training on how to deal with it in that situation. Cos I think they use the EDL guidelines and I think they're strugglin* (Clinic Doctor)

3.7.2.3.2.3 Mental health issues for Women

Nurses have little or no training in issues that affect women and children, such as rape and gender based violence. Instead they refer them to the crisis centre at the hospital or to social workers.

> *I don't remember clearly, there are sessions like that but it's not the same as a person who says "I've just come from there", you see because with abuse, there is physical, sexual….It's not the same you see when you are combining everything that happens in the community, changing modules…it's not the same as when you are working, faced with it* (Respondent 2, Clinic Nurse)

The 24-hour clinic has HIV/AIDS counsellors who can counsel rape survivors if necessary, in addition to their usual function of counselling HIV/AIDS clients.

3.7.2.3.2.4 Support and Supervision

There is not much support or supervision from the hospital for mental health specialists except the psychologist when he comes to the hospital, or the matron who is a psychiatric nurse. The matron's visits are infrequent but service users do communicate with her telephonically if they are having problems. Similarly, they would prefer the psychologist to be more available. Again this goes back to a lack of time for mental health experts to provide support and supervision to other health staff.

3.7.2.3.2.5 Referral

Patients carry handheld cards which must communicate this year's management plan and their next follow-up. They carry it with them, but often don't know their diagnosis,

> *It helps them writing it down, especially if you're ill at the time, and you're in hospital….And language and lots of issues.* (Clinic Doctor)

Obtaining referral information from the hospital was reported to be a problem in general. The clinics are supposed to get information back when they refer to the hospital but this usually does not happen.

3.7.2.3.2.6 Treatment Guidelines

There are treatment guidelines which should be available at every clinic. These include national guidelines such as the "Manual for Severe Psychiatric Conditions". However, nurses were not very familiar with these. The Essential Drug List and the Mental Health Care Act (as well as the regulations) should also be available at every clinic.

3.7.2.3.2.7 Budget

While a limited budget is available, even this is poorly accounted for in terms of mental health spending. The money needs to be spent in a more efficient manner.

> *Like now we haven't received anything but the year is coming to an end, even last year….Even though the money is there. You find that we do not get the things we need. There is a poor process that side. And they do say that no, things did not go well and so forth and so forth. So we end up not knowing whether we should be saying that we do not get things for what reason because even if there is money, we don't get things. (Respondent 2, Clinic Nurse)*

Clinic staff stated that more money should be spent on mental health. This money should be used to provide more specialist support for mental health, as well as more awareness programmes, support groups, and psychosocial rehabilitation programmes.

3.7.2.3.2.8 Language

The doctor comes from the UK and therefore lacks knowledge of the local culture and does not speak the local language. She experiences difficulties using a translator especially in getting a proper mental health history. Her translator is usually a counsellor.

3.7.2.3.2.9 Children & Adolescents

All clinic respondents said they don't treat many cases of children and adolescents with mental health problems. Those that they do see are usually referred via schools rather than by parents. This is probably due to care workers such as school nurses visiting schools. Mostly they assess and then refer to the hospital, psychologist or social worker. The major problems they deal with are sexual abuse, substance abuse and malnutrition.

> *there aren't many but they are there…..a child….that you can see is being abused…they are not open and when you ask the person accompanying them, "where is the child's mother', who do they live with, is the child ever left alone"? You see, and a child who has been abused has that fear….sometimes a parent will come with a child saying that they saw them bleeding…then we check the child and see*. (Respondent 3, Clinic Nurse)

There are no facilities for children and adolescents outside of the hospital and clinics although the department has started piloting youth-friendly clinic services. There is a school for handicapped children near the hospital but it does not focus on psychiatric problems. It has been recognized by the Department of Education. Several respondents stated that there is a need for training in child and adolescent mental healthcare.

Legislation and Policy

The doctor has no knowledge or training in the Mental Health Care Act. Nurses have some knowledge but they are not using it consistently. Most clinic nurses have very little knowledge on the new Mental Health Care Act and there is a definite need for training, even though they are in the process of implementing the requirements.

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Summary: Primary Health Care Clinics

- **Facilities** – Most clinics are small, one bigger 24-hour clinic with 4 beds
- **Human Resources** – Staffed by nurses except for one doctor at 24-hour clinic. In the 24-hour clinic, all nurses see psychiatric patients. Smaller clinics differ according to available resources.
- **Training** - Training needs differ depending on the extent of their mental health training. But most general nurses require more training in mental health.
- **Services** – The psychologist visits most clinics once a month but he battles with the workload. Although nurses felt that specialization works better, one stop shop service provision is being promoted by the Department of Health. Lack of understanding and fear of people with mental health problems, particularly if they are aggressive, are challenges.
- **Common Mental Health Problems** - Identification and treatment of common mental health problems are not prioritized.
- **Support and supervision** – Mental health experts lack time to provide support and supervision.
- **Transport** is a major problem. Nurses want proper protocol on transport.
- **Referral System** – New system with referral forms and handheld cards. Obtaining referral information from the hospital is a problem.
- **Treatment Guidelines** – These were available at clinics but nurses were not very familiar with them.
- **Budget -** money needs to be spent in a more efficient manner to provide more specialist support for mental health, as well as more awareness programmes, support groups, and psychosocial rehabilitation programmes.
- **Children and Adolescents** – They are included as part of general mental health service provision. Not many cases treated in practice, however.

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3.7.2.4 Community

3.7.2.4.1 Facilities

The only facilities for mental health in the district are the clinics and the hospital. There is a desperate need for special shelters, supported employment, support groups, in fact any form of psychosocial rehabilitation in

the area. There are no NGOs in the area; the only NGO that does have some contact with mentally ill patients is about 130 kms away from the sub-district. Chronic mentally ill patients have to be referred to psychiatric institutions. People with mental health problems normally live at home or in the community and their only interaction with medical services is when they collect their monthly medication. As a result it is found that,

> …*a lot of these people who are mentally disturbed, [are] on the streets and they are seen as harmless. They are harmless in fact but you begin to say how long will they be moving on the streets….because the community itself is not that much sensitised, they look at them like that is fine, fine. Because they do no harm to anybody but at the end you see that this person is not well. Maybe a home will do for them. (*District Health Management, HMAN)

3.7.2.4.2 Programmes

There are very few awareness, prevention or promotion activities for mental health in the district. Community education and prevention programmes for issues such as stigma, substance abuse and sexual abuse are desperately needed,

> …*in particular dagga (cannabis) in the area with the older people. Where people take dagga and then they drink and all hell breaks loose. So there is still a lot that needs to be done….serious problem which causes mental illness.* (Hospital Management, HOSP)

The school nurses run awareness days and other projects in schools and the community. They sometimes do joint awareness days with the Health promotion team and the Department of Education. Topics include substance abuse and mental health but there is no sustained programme.

> …*go out to the community to do some talks, like awareness days. They are in the HR's calendar. So we celebrate those days by having some talks to the community. And for two years I've been invited by the school health team and we are going around educating the kids on some issues. But the programmes are there to educate the community….not a continuous thing, it should be a continuous thing.* (Respondent in focus group 1, Clinic Nurse).

One of the churches reported making efforts to host campaigns at least once a year on issues such as HIV/AIDS and drug abuse.

3.7.2.4.3 Poverty

The majority of participants perceived a definite link between poverty and mental health. A deprived socio-economic environment, poor nutrition and high levels of unemployment was believed to cause frustration, anxiety, depression and substance abuse. This is exacerbated by the lack of a proper support system in the community.

…if you do not have the essentials you are bound to be frustrated and you may not provide the support that the family needs. And if it's the whole community, other people are not strong. (Hospital Management, HOSP).

Yes there is because hardships challenge mental health. We see it all the time, if people live in extreme poverty; lacking all the basic things, like water, electricity and food, they start thinking all the time and they lose their minds. (Community Health Worker)

Poverty related factors such as lack of recreational facilities and education were also mentioned as mediating factors. An issue which has already been mentioned is that of transport. People with mental health problems often do not have money for transport to the clinics and hospital so they don't access the services that they need. In addition, most mental health patients are unemployed and lack family support. In some cases, if they do receive a grant, their family takes the money and fails to provide care for them in return.

….they end up not being supported by their family because they've got no money. And if you working…you can get support from the family because they know that at the end of the month there's something that they are going to be given. So they end up neglecting them…
(Respondent 3, Clinic Nurse)

Poverty plays a role in child and adolescent mental health because it is linked to issues such as a lack of food and inadequate clothing, as well as the long distances learners are forced to walk in order to attend school. These factors are likely to impact negatively on school performance, as learners are tired and lack of nutrition affects their growth and concentration.

There are some efforts toward poverty reduction such as the Public Expanded Works Programme but these are predominantly small and unsustainable piecemeal jobs, and they are not aimed at people with mental health problems. There is a desperate need for more employment opportunities or supported work programmes for this target group.

3.7.2.4.4 Gender

The majority of respondents thought that women were more likely to suffer from mental health problems than men because women are the ones most affected by unemployment, poverty and violence; and they have to look after the family,

Poverty hits hard on women….mental illnesses affect women….When a woman has twins and they cry she will feed them, but if one of them continues crying, she will also cry. That is causing a lot of stress. At the same time five children are coming back from school. She still has not found time to cook. Where is the man? Drinking beer with R100 he's

got. When he comes back…they fight, He hits her. (Focus Group 3, Traditional Healer)

Gender predisposes girl children to sexual abuse, particularly in families where the parents have passed away and the children are left with relatives. Since the parents are no longer around, they mostly depend on male relatives which in turn enforces dependence on males and places them in a vulnerable position.

Other respondents felt that men and women were equally affected but that this presented in different ways, for example women suffer more with depression while men tend to abuse substances or have physical symptoms such as erection problems.

> *… women have depression more than men and they present earlier than men and they'll actually come in and want to talk to you. Men don't often want to talk. Men probably use substances more than women to get by, like alcohol and drugs and smoking dagga.* (Clinic Doctor)

The general practitioners mentioned seeing a lot of depression in women, particularly in women whose husbands were taking another wife or were involved with other women.

> *….it's culturally acceptable to take a second and a third and a fourth wife. Whereas from the women's point of view I have to deal with the effects…she'll come and tell me and say, "You know my husband's going to take on his third wife…he's seeing another woman"* (Respondent 1, General Practitioner)

3.7.2.4.5 Stigma

There is a great deal of stigma and discrimination against people with mental health problems in the community. One major reason for this is the community's perception that psychiatric problems cannot be cured. So people with mental health problems are treated differently from other people, even when they are well.

> *A person will stand up, talk in the community meeting and then they will say you know him….he's wasting our time blah blah. And then when you try and find out why were people so angry when that person they will say, "No he's not right upstairs…* (District Health Management, HMAN).

In addition, there is widespread belief in spiritual causes of mental illness can cause stigma because it is believed that you bring it on yourself due to upsetting the ancestors or being bewitched by another person,

> *….we do get that a child was locked in a room and ah you know because the person is mentally ill or tied to a tree….nobody needs to*

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see that this child of mine is then mentally ill….it's something to do with you if you've got a child like that. (Police Management*)*

Stigma is also a widespread problem with government workers such as the police, and even the Health Department. They are often reluctant to provide care for people with mental health problems because they can be aggressive and difficult.

> *…they're often seen as getting in the way or people want to get rid of them rather than actually giving care to the patients. I think it's often because they're a bit unaware of what to do and it's also fear from staff cos they can get quite violent.* (Clinic Doctor)

There is a need for community participation in anti-stigma campaigns and an increase in knowledge about mental illness in order to lessen fear and increase acceptance. Feeling accepted in their families and the community would greatly improve the lives of people with mental health problems.

> *…it should start within the family. It depends on how they perceive it when you have a one-to-one talk with the family. Because you've got to start with the family first, then you go outside to the community. If my neighbour sees that I am handling my mentally ill relative like this they will learn to respect them*. (Psychiatric Nurse)

3.7.2.4.6 Explanations for Mental Health Problems - Community

As shown above, service users and the community often attribute mental health problems to spiritual rather than genetic or psychological causes. There is a widespread belief that mental health problems are caused by witchcraft or the ancestors. So most often, members of the community experiencing mental health problems would first approach a traditional or faith healer, and as a last resort would visit a biomedical health service.

> *With the one I have been seeing, his family told me that his girlfriend brought it onto him. He had many girlfriends and this one steady girlfriend did not agree with that behaviour so she did something to him to make him stop sleeping around...But this thing went to his head instead, that is what the elders say.* (Community Health Worker)

Another cause often cited by the community, which was more environmental in nature, was that of thinking too much or studying too much, leading to mental health problems:

> *….Others, the cause, like this one boy here, but he is grown up, it was due to school, he studies too much. He sat on the books too much….he was unable to give himself time to rest…* (Clinic Nurse)

Other suggestions included dagga, epilepsy, the mother drinking during her pregnancy, and genetic causes. When people approach the health service they often do not connect the physical symptoms they are experiencing such

as headaches or tiredness, with a mental or environmental cause. It is therefore up to the health practitioner to uncover the underlying source of the symptoms.

> *They think that they're sick cos they can't do the things that they used to do. "No I've got a terrible headache Doctor, my headaches…" And they get like cervical neck spasm or they get ulcers….you say but why, is anything worrying you.* (Respondent 1, General Practitioner)

3.7.2.4.7 Explanations for Mental Health Problems - Respondents

Mental health problems were described by resondents as originating from either genetic or social causes. Social factors included domestic violence, crime and poverty as well as drug and sexual abuse. Other causes included low levels of education, family rituals that have not been done for the ancestors, and the stress of living in a community with very high levels of HIV infection. All of these factors can contribute to the onset of mental ill health, according to the respondents.

> *…lot of people unemployed, some get into alcoholism not with the purpose to drink but trying to keep busy because even school children, you find that some of them influence each other, they take drugs….and they drink….Other things have to do with the situations at home…. some homes are run by children. Imagine being a child, coming back from school to look after other children at home* (Clinic Nurse)

> *People are living in fear of HIV; people are in fear of being ill. If a person feels some tiny pain, than they are terrible ill. And it is understandable. They see people falling ill all the time. Parents fall sick and they die of TB and …. people are stressed because people are ill and dying in families and that is causing all the havoc.* (Respondent 2, General Practitioner)

Genetic and biological causes mentioned included chemical imbalances, genetic predisposition and accidents or birth defects.

> *For others it is caused by being beaten too much when they were young and they hurt their head somehow. Some mistakes also happen when people are born and then they become mentally ill as they grow while some will just be born mentally ill without any mistakes having happened* (Community Health Worker)

Summary: Community context

- **Facilities** – There is a desperate need for special shelters, supported employment, support groups, any form of psychosocial rehabilitation.
- **Programmes** – There are very few awareness, prevention or promotion activities for mental health in the district. Community

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education and prevention programmes for issues such as stigma, substance abuse and sexual abuse are desperately needed.

- **Poverty** – There is a definite link between poverty and mental health.
- **Gender** – Women were more likely to suffer from mental health problems because they are the ones most affected by unemployment, poverty and violence; and they have to look after the family. Or men and women equally affected but present in different ways.
- **Stigma** – There is a great deal of stigma against people with mental health problems in the community and even with government workers such as the police, and the Health Department. There is a need for community participation in anti-stigma campaigns.
- **Explanations (Community)** – They often attribute mental health problems to cultural rather than genetic causes.
- **Explanations (Respondents)** – They believed that mental illnesses originate from either genetic or social causes.

3.7.2.5 Involvement of other Government Sectors in Mental Health

3.7.2.5.1 Education

3.7.2.5.1.1 Problems

A variety of issues affecting learner mental health were reported. These ranged from learning difficulties, sexual abuse, substance use, early sexual debut and pregnancy, exposure to dangerous weapons and violence as well as poverty related challenges, such as lack of clothing. HIV/AIDS is also a major problem, and as a result of illness in the family, some children need to be absent in order to look after family members.

3.7.2.5.1.2 Facilities and Services

Five schools were visited - two high schools, two primary and one school for the handicapped. Teachers' level of experience ranged from one to ten years, with the exception of the teacher from the school for the disabled, who only has a matric and has not received any other training.

The school for the disabled is also not yet registered with the Department of Education. It has two classrooms, one for a crèche and one for disabled children. The crèche takes in children from three years to six years, with no identified mental difficulties, and the school takes those from age five to eighteen. Learners' difficulties were said to be that of learning and intellect, such that they were not able to study in mainstream schools. To maintain the school, children pay R150 a month if they are already receiving a grant, while those who are not yet on the grant pay R40. This money goes to the teacher's salary. The activities in which the learners engage are mainly handiwork and gardening and there are no activities tailored to the needs of learners with disabilities.

In general, schools are concerned with curriculum activities and have no arrangements or resources to cater for mental health concerns in learners. Human resources are only in the form of teachers who deliver the academic programmes and try to intervene in learner mental health concerns, in the midst of time constraints and overcrowding in classes. Other resources, such as books are obtained from the Education Department for the registered schools. For the unregistered, learning materials are donated by an outside organization.

There are no facilities catering for child and adolescent mental health in the community, learners can therefore only be referred to clinics and the hospital. There are also no specialized or residential facilities, except for the one formal school for intellectually disabled children. There are however a number of informal schools with accommodation facilities. They are not registered with the Department of Education but as cluster foster homes.

3.7.2.5.1.3 Support

In each of the schools, except the school for the disabled, the school nurses make visits. These visits, however, are infrequent and brief, with no follow-up on problems. Learners are thus advised to visit clinics, hospitals, in which case they are often met with transport difficulties. They are also referred to SAPS for rape cases; however SAPS is reported as invisible in most of the communities. The schools have no formally established links with service providers in the area. The school for the disabled does have links with a social worker who is very busy and visits sporadically. None of the schools had a mental health professional even though respondents stated that it would be ideal to have a person dedicated to learner mental health needs on site, who would be responsible for counselling, follow-up and training teachers on identification of problems and counselling.

3.7.2.5.1.4 Programmes

Teachers reported the absence of school programmes in the past ten years. In some of the schools, not even mental awareness days had been held. In the absence of these, teachers reported making attempts at teaching about issues such as sexual abuse during life orientation classes. But these classes were inadequate to comprehensively cover other important issues relating to mental health.

3.7.2.5.1.5 Challenges

The greatest challenge faced by teachers in working with children with difficulties is that of the silence they are met with in the communities. Community members do not want to talk about issues such as sexual abuse, mainly because of fear.

> ….things are suppressed by the fact that there is violence because most of the time if a person has been raped, they would have been raped at gun point…so the case ends up not being reported. You can't

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say you are going to fight it because they keep quiet about it. They keep quiet about a lot of things…can have programs here in school just for the sake of it but stakeholder involvement matters; you can't work with a secretive community. What are you going to get because when you work you have to get something from the people…you get nothing. (Respondent in focus broup 1, Teacher)

This is exacerbated by the fact that there are no formally established clear channels that teachers can use to refer learners. Furthermore, teachers don't have time to concentrate on learners with learning or other mental health problems at the expense of other learners with no problems. An additional challenge is that most learners live with grandparents, who are not in a position to give much information and help regarding children's difficulties. There were reports of poor parent-teacher relationships because parents are not cooperative. Most only come to the schools when they get called in because of a problem with the learner. Very few are able to acknowledge problems as they feel the child does not have a problem, or they accuse teachers of discriminating against the child. This is worsened by the unavailability of many parents due to death, illness and working far away. Teachers often feel powerless to intervene because of fear and the violence in the community.

3.7.2.5.1.6 Legislation and Policy

The majority of teachers have no knowledge of the Mental Health Care Act. The few that were aware reported having attended a brief introductory workshop. They wanted follow-up sessions aimed at helping schools better understand the implications it has for them.

3.7.2.5.1.7 School Nurse

The school health team visits schools in the district as part of their annual programme or when called in by the school. They conduct basic assessment on learners referred by teachers and refer mental health cases to the appropriate channels, mainly the hospital or social services. They are also involved in providing awareness campaigns in schools. The team consists of three members, servicing approximately a hundred and ninety four schools. Given the variety of topics needing coverage and the wide area that the team has to visit, they cannot service all the schools adequately.

> *…we can't go to all the schools. For that reason we will only get to see that problem when you visit the school and by then it may be late....There is only one team, with three people, reproductive health person, the staff nurse and ASO… must be more than three teams according to school health policy.* (School Nurse)

It was reported that there are disparities with regards to resources in schools and that these influence the assistance provided to a certain school.

…we can't understand their criteria for allocating resources….. Some schools have water, electricity, telephone and they are fenced but when you get to another school, they have none of these things. And that counts because if a child needs to be cared for immediately, they can't if all these things are not there….I guess it depends on the principals. And it is also the community that the school is located in.
(School Nurse)

Substance and sexual abuse were perceived as the primary mental health concerns for learners. There is one school in the district where children with minor mental and physical handicaps are placed. Beyond that, the only support available for children is the social workers and the hospital. The leader of the school health team underwent a week long course on mental health but feels she needs a longer course, particularly on issues around sexual abuse. She has had brief training in the Mental Health Care Act.

There is one clinical psychologist employed by the Department of Education, based at the district office, who acts as a supervisor for the school health team, interacting with them telephonically. However she is too far away to provide adequate support to either the nurses or the schools. They also receive support from, and report to, the matron at the hospital. They work with SAPS and Social Welfare with whom they conduct campaigns (e.g. Child Protection week). There is a need for more support and for a social worker assigned to school health because the Social Welfare Department workers are not always available.

Summary: Government sectors – Education

- **Problems** include learning difficulties, sexual abuse, substance use, early sexual debut and pregnancy, violence, poverty, HIV/AIDS.
- **Facilities and Services** – There is 1 unregistered School for the Disabled and many other schools. No other specialized or residential facilities are available.
- **Support** – There is little support except the school nurses. There is no formally established links with service providers in the area. Can only refer to the hospital, social workers or SAPS. There are no counsellors in schools.
- **Programmes** – There has been a complete absence of school programmes in the past ten years, except for some awareness days.
- **Challenges** – Ther are no formally established referral channels. Lack of time for learners with difficulties. Teachers often feel powerless to intervene because of fear and the violence in the community. Poor parent-teacher-relationships.
- **School Nurse team** – There are 3 members, servicing approximately 194 schools and therefore not all schools are serviced adequately. There is little training in mental health.
- 1 clinical psychologist in district employed by Department of Education on a community service post (ie new person each year).

3.7.2.5.2 Police

The police would have contact with people with mental health problems if they are behaving violently or aggressively in the community, when they have committed a crime or when they need to be taken to hospital or to court.

> … a person was arrested say for like committing an offense and the person is taken the next day to court then it's realized that this person is mentally ill. It's the courts refer them to a mental institution for observation, and then we do that, transport the prisoner. (Police Management)

If someone is simply behaving aggressively, and has not committed a crime, they restrain the person and take them to hospital where they are booked in as an outpatient. They use the same guidelines as for criminal offences. There are no special handcuffs or vehicles for mentally ill people. They would rather not have to deal with them as they can be violent and break things in the cell and the van. In spite of this, they were not interested in having more appropriate facilities or equipment because they felt the department should rather equip the ambulances better:

> …I call the emergency services so that by the time that we get there, the ambulance people are there to inject the person and calm them down. My only task after that is to accompany them from point A to point B, making sure that there is safety for those around the person, should they become violent. (Respondent 2, Police Personnel)

There seems to be a lack of communication between the Department of Health and the Police. Department of Health personnel complained that the Police Department has been trained on the Mental Health Care Act but police officers are still not always willing to provide transport for people with mental health problems.

> …they are afraid of taking this person. "Don't know what will happen, I don't know where…" the SAPS are saying no we are not going there because this person has guns…. we had a workshop on this new Mental Health Care Act 17 of 2002. So SAPS were part of it. It was mentioned that seemingly they need their own training on handling of mentally ill person. (District Health Management, MHCO).

On the other hand, the Police Department's view of mental health is that it is not their concern but an issue the Department of Health must deal with.

> They are shifting the responsibility. They should be taking these people from the community….Somebody who has not really done anything criminal is not our case because for them it is all about illness. (Police Commissioner)

Department of Health that must do it but… they're more constrained than we are so we still are doing it but I think the new Act actually states that when a person is referred from the court to a mental institution we are not now liable for that transport (Police Commissioner)

The extent of police personnel's training on mental health they received in college, was that they were told to act with "caution" if they recover a person with a mental illness. The police manager thought this could be an area where they are lacking. But the personnel didn't feel they needed specific training because they treat them exactly the same as anyone else who has committed an offence. They are handcuffed, put in the van and taken to the station or the hospital,

our job is to take them in, whether they are mentally ill or not and there is no training necessary for that. We do not treat them in any special way, we handcuff them just like anyone who has done something wrong and if we have to take them to hospital, we take them there and take our handcuffs back once they have injected him. (Respondent 2, Police Personnel)

There are guidelines for how police must deal with victims of crime and witnesses in terms of their mental health needs. This means making sure they receive the necessary help such as a doctor or social worker, and treating them with sensitivity. They have trauma rooms at the stations for victims of rape and violence where they can be counselled.

stations have a list of people on standby….somebody of the community, the Department of Health, Social Welfare on standby to know that if there somebody like that you can call them for their support….So we will do then the same you know if we realize well any rate we can say if its then also a mental health person a ill person we call in the social workers. (Police Management)

They only really come into contact with children and adolescents with mental heath problems if they have been raped or taking drugs, or have committed a crime. They have no training in child and adolescent mental health. Police personnel have no training on the Mental Health Care Act and most do not see the need. There was a workshop done for police management on changes in the Act but only the legal official attended and said there were no changes.

Summary: Government sectors – Police

- **Contact with people with mental disorders** – This occurs if a person is behaving violently or aggressively, when committed a crime or need to be taken to hospital or to court.
- **Guidelines** – same as for criminal offences. There are no special handcuffs or vehicles for mentally ill people.

- Lack of communication between the Department of Health and the Police regarding transport of people with mental health problems.
- **Training** – Need training in mental health. There was a workshop done for police management on changes in the Act but only the legal official attended and said there were no changes.
- **Victims and witnesses** – Make sure they receive the necessary help such as a doctor or social worker, and treating them with sensitivity

3.7.2.5.3 Social Development

The Social Services Department works mostly with the Child Protection Unit and Childline who refer child and adolescent cases to them. Mental health problems in children are also identified and referred by teachers, clinics and school nurses. Referrals often occur through the social security section to social services when the person has come for a grant application. The role of the social worker is that of identifying, assessing and referring individuals with mental health problems. There is not a social worker dedicated to deal with mental health issues. Rather, they are assigned to specific areas and if a problem occurs in their area, they will then attend to it. They do not have referral forms but would write a report on their observations.

> *If you come to our office, we don't just refer you…we give the service whatever service we can give and after that we refer….We deal with the case first and then if we see that there is a need for the referral and then you refer. You write a report where you state the social worker interpretation, what have you done. (Resondent 1,* Social Worker)

When a person is discharged back into the community, the social worker must conduct follow-up visits to the home,

> *If the person is discharged there is a form that is filled by a social worker. That is where the social worker is required to state the condition and how you feel about the person. In fact we are required to supervise the person even if he has been discharged to the community. You supervise the person by making visits, the home visits…* Social Worker (001).

In addition, Social Development gives talks and runs awareness campaigns in the community. They are invited by schools to give awareness talks and they deal with problems referred by the school. However there is an urgent need for more social workers to provide these services adequately. Because of the lack of facilities for children, the Department of Social Development often relies on community members or places of safety outside the area and an outside NGO.

The social work degree at university covers mental health, and they have in-service training. But there is a lack of knowledge about the Mental Health Care Act and a lack of support mechanisms for mental health. There is no district management committee or intersectoral links to support the delivery of

mental health care within the district. They report on cases to which they have attended and these are reflected in the statistics that are sent to the regional Social Development office on a monthly basis.

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Summary: Government sectors – Social Development

- **Referral** - From Child Protection Unit, Childline, teachers, clinics and school nurses, social security section
- **Services -** identifying, assessing and referring individuals with mental health problems, and follow-up visits. Talks and awareness campaigns in the community and schools.
- Urgent need for more social workers
- **Support** – Lack of support
- **Training** – In degree and in-service training. But lack of knowledge about the Mental Health Care Act.

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3.7.2.5.4 Housing

According to the municipal housing manager, there is no special allocation of housing for people with mental health problems. It is simply one of a package of social problems which is considered for housing. The Housing Department is currently assessing housing needs for the district and developing a housing sector plan to allocate housing. The tendering process for the proposal for the housing plan is also underway. The only governmental housing available is the Housing backlog project, which provides two-bedroom houses. If they identify a housing need they will allocate housing.

There is no multi-sectoral forum for housing where mental health is discussed. The housing department has no links with any other mental health programmes that are currently run in the district. There is no report back except to the management of the municipality. Overall, no support mechanisms are in place currently to assist in supporting people with mental health problems except those provided by the the Department of Health, South African Police Service (SAPS) or Social Services . The Department of Housing does not have any formal documents or guidelines on mental health.

The town is the economic hub for the district and many people with mental health problems reside there, therefore there is a need for more trained staff, a mental health centre, and help with the management of people with mental health problems. Respondents stated that more awareness and education should be done with government sectors other than health, and with the community.

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Summary: Government sectors: Housing

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- No special allocation of housing for people with mental health problems
- No multi-sectoral forum for addressing housing needs of people with mental health problems
- There are no links with any programmes
- No formal documents or guidelines on mental health
- No support mechanisms for mental health except DoH, SAPS or Social Services
- The town has many people with mental health problems. There is a need for more trained staff, a mental health centre, and help with management. More awareness and education are needed.

3.7.2.6 Community Health workers

The Community Health Workers are employed by the Department of Health and managed by the hospital. For the most part, they provide services for people living with HIV/AIDS and TB. They have no training in child and adolescent, or adult mental health issues. However, they often come across people with mental health problems during home visits. If this occurs, they will attempt to educate the household about mental illness and refer to the clinic or the hospital, if necessary:

> *"I advise their families that they must love them and teach them everything. Like the one I often visit, he herds cattle but sometimes he loses some of the cows or leaves them wondering around. But I tell them not to beat him up because if they do, it confuses him even more. I tell them to speak to him politely"* Community Health Worker.

They feel there is not enough resources and support for mental health within the community. There is a need for more education and support, and particularly services that are accessible in the community:

> *"…because sometimes they say they do not have money for transport. Even their families are not able to visit them because of a shortage of money and sometimes when patients have to go see their doctors before they start on medication, they do not afford to go and can therefore not start on treatment on time"* Community Health Worker.

Summary: Government sectors – Community Health Workers

- **Services** - for people living with HIV/AIDS and TB. However, if CHWs come across people with mental health problems during home visits they will attempt to educate the household about mental illness and refer to the clinic or the hospital if necessary. There are not enough resources and support for mental health within the community.
- **Support** – None for mental health.
- **Training** – No training in mental health issues.

3.7.2.7 Community - Other

3.7.2.7.1 General Practitioners

The General Practitioners deal mostly with common problems such as depression, bereavement and anxiety. They assess and screen for mental health problems and treat minor problems, but if the person needs counselling or it is a more serious problem they will refer to a psychiatrist or the hospital:

> "When I say minor, I am talking about things like anxiety disorders…..fear and somatization, then I treat those, mild depression I treat. Sometimes they are bereaved over the loss of their loved ones and I treat them as well. But once they start having complications like psychotic features, then I send them to the hospital" General Practitioner (SSI002).

The support mechanisms that are in place are the hospital, and the psychologist. There is a major problem with a lack of human resources to refer to, especially for patients without medical aid. They cannot afford private mental health care, but there is little in the way of mental health services in the public health sector:

> "The problem is when it comes to patients that can't afford private care and I have to refer to the hospital but then it's out of my control. I don't have a psychologist that I can send to in the clinic…. " General Practitioner (SSI001).

> "…if we were to charge private rates, an hour would cost at least R400.00. But they cannot afford that. We actually charge cash pays, R120.00. They get medication in that amount. It is a bit better for medical aid patients….But cash patients really struggle…." General Practitioner (SSI002).

General practiioners' only interaction with the health care system is through referral. They never receive proper feedback from the government hospitals. Both GPs in the area have had training in psychiatry at University and one had training in the new Mental Health Care Act. They see between one and two cases of children or adolescents with mental health problems each month. The problems are mainly life event-related or depression, learning disabilities or attention deficit disorders and they are referred by the schools. If they need specialist care they are first referred to the paediatrician for possible medical conditions, and then to the psychiatrist.

Summary: Community Other – General Practitioners

- **Services -** mostly common mental health problems such as depression and anxiety. Assess and screen for mental health problems and treat minor problems.
- **Support** – provided by hospital and the psychologist but lack of human resources to refer to, especially for patients without medical aid. Only interaction with the health care system is through referral.
- **Training** – training in psychiatry at University for GPs.

3.7.2.7.2 Non-Governmental Organisations

The only mental health NGO is the Mental Health Society which is 130 km from the sub-district site and services the entire northern KwaZulu-Natal region. The organization provides services for over a thousand people per month. The resources available are eight staff members - social workers and social auxiliary workers - and two cars, to provide services to this extremely large area. They get referrals from SAPS, Department of Social Services, Department of Health and the community. They offer services such as facilitating medical care, counselling, family support services, awareness raising and education in the community, home-based care training, trauma debriefing and management. They also have some supported employment workshops, trace families of state patients due for release and do provincial and national advocacy work. They provide counselling and education in most of the schools and have programmes for children with mental disabilities. They are also very involved in providing services for mental health issues that affect women such as rape or gender violence:

> "*….that is the training that I am involved in that we offer to community members. We train victim support volunteers and then we manage the process….at the different police stations, where now we train them to the level where they know, okay somebody reports a case and then you take them to the district surgeon, and you get all the paper work sorted out. And then we render the formal counselling and the trauma work"* Non-Governmental Organisation*.

They have contact with the housing department to assist clients to get housing and they are given some priority. They also work with churches, the Department of Justice and the sexual offences program. They work very closely with the police because according to the Act:

> "*…we are not qualified enough to transport them in our vehicles and things, especially when they are violent….And the Mental Health Act does stipulate that the police do need to get involved and in terms of transporting them and all of that, we have a very good support network*" Non-Governmental Organisation.

The services they render at the study site are very limited, and typically only referrals are made. They do render some services to individual clients and attend meetings with the district health department and the hospital.

The NGO representative who was interviewed was particularly well trained in mental health as part of her social work training and a number of other private training courses including trauma and suicide prevention. She was also very up to date with and involved in the development of legislation and policies. According to her, the new Mental Health Care Act has thusfar had little impact on the lives of people with mental health problems. Most government workers, including police and nurses, are not interested in mental health and ensuring proper implementation of the Act. People working with mental health issues have been trained, but the implementation of these skills are affected by a lack of motivation and money.

Support given by the Department of Health and Department of Social Services is purely financial. The Mental Health Society is funded by the Department of Social Services, but not for running costs, so they must fundraise to make up the shortfall. If they had more resources they would provide more education for children and parents, and service provision would be more intensive and more frequent.

Summary: Community Other - NGOs

- **Services** – Only 8 staff and 2 cars providing service to over 1000 service users per month in northern KwaZulu-Natal. Provide a wide range of mental health services to people with mental health problems and their families. Also service schools and do prevention and promotion work. But only provide limited services at the district study site.
- Have links with most sectors in the district such as health, housing, social development, churches.
- **Support** – Little support from other sectors: only financial support from government.
- **Training** – Well trained in all areas of mental health and legislation.

3.7.2.7.3 Religious Leaders

Religious leaders offer their services in the form of prayer, advice and guidance to individuals and families experiencing difficulty. The church also supports families in need by providing for their basic needs, for instance food and clothing which has been collected by church members. Although this support is useful for families, it is very clearly based on a religious understanding of difficulties such as mental illness:

> *"As a pastor, I preach that people must not sit with issues that are troubling them because that causes illnesses. I tell that keeping issues inside allows the difficulty to grow and intensify such that it confuses the mind. When they start feeling burdened as a result of this, Satan strikes through the demons and that is when illness sets in. I preach*

that the moment people feel that something is troubling them, they must come to me so that I can pray with them" Religious Leader (002).

The religious leaders lack links and interaction with mental health service providers and programmes in the area, except for referral to the clinics and the hospital. There is a need for organizations in the area to assist individuals, families and those who work with them. Particularly because the churches are constrained by limited budget and this impacts negatively on the possibilities of running prevention programmes and providing food and clothing for the needy, as the churches have to do the fundraising.

Religious organizations expressed a lack of awareness of any support mechanisms with regards to child and adolescent mental health issues:

> "….*I work with the child and their parents because there are no organizations where these children and their families can go…. it is not right that children get into relationships and drink alcohol so it would help if there could be such organizations so that they can advise children against these things"* Religious Leader (002)

Problems noted among children and adolescents were mainly behavioural, where children were deemed to behave in deviant ways, for example through courting, perceived as deviating from the church's principles:

> *… we tell them all about these religiously unacceptable things in Sunday school so they will grow up aware of the wrong in smoking and drinking. But the main problem is relationships. They reach a certain stage where they start thinking that they should have a boyfriend… if they have gone off track they will succumb to the temptation……* Religious Leader (002).

Their lack of training emerged as critical, especially for women's groups as they most often engage in home visits, visiting families with a variety of difficulties, mostly tied with mental health concerns. Religious leaders do not possess any knowledge of the Mental Health Care Act.

Summary: Community Other – Religious Leaders

- **Services -** prayer, advice and guidance to individuals and families experiencing difficulty and providing for their basic needs. Women's groups visit homes.
- **Support** – lack links and interaction with mental health service providers and programmes in the area, except for referral to the clinics and the hospital
- **Programmes** – run some small annual programmes
- **Training** – Lack of training

3.7.2.7.4 Traditional Healers

3.7.2.7.4.1 Becoming/Training

According to respondents, most traditional healers seem to suffer from an illness or have a series of misfortunes which eventually lead to them realizing they must undergo traditional healer training. These illnesses cannot be cured by ordinary medicine but only when they are given amagobongo (the muti (traditional medicines or herbs) that is given to people who have the spirit of the ancestors) and answer the call of the ancestors. Some are trained by the ancestors while others are under the guidance of trainers. They learn what herbs are good for what ailment, how to make muthi and how to heal people:

> "*I got sick…from an illness that the doctors and traditional healers…could not treat...My uncle then took me to the forest and told me to take certain herbs. I then recovered. By the end of that day I was eating.....Then I started to have dreams at night when I was sleeping. The person on the dream will tell me to mix certain herbs to make certain muti. I then continued with this. I never received sangoma training (ukuthwasa), but I do help people*" Traditional Healer (FGD002).

Not all traditional healers treat people with mental health problems. A few had been trained on dealing with people with mental health problems but the majority had not had any special training:

> "*The man who trained us taught us the different ways of dealing with a mentally ill person. He showed us all the medicines that we needed to use in order to get them to calm down because you cannot work with them if they are not calm. He told us that after doing our part, we need to refer the person to the doctors*" Traditional Healer (FGD003).

Most of the participants have had additional training in a number of areas including HIV/AIDS, TB, maternal and child health and counselling. They would like training on mental health, and in particular would like to understand how Western medicine explains and deals with issues like stress:

> "*When we do counselling we hear that someone has stress. We need to know what exactly stress is ….. For me stroke is something that you step on. It's muthi. That will affect your side. In western thinking….it's caused by thinking too much and the blood rushes into the small veins in the brain and the veins end up tearing*" Traditional Healer (SSI002).

3.7.2.7.4.2 Diagnosis and Treatment

Participants spoke about different kinds of mental health problems which require different treatments. The causes of these problems were seen as biological, social or spiritual. The social causes included personal problems at home, bereavement, stress, rape, substance abuse and thinking too much. These would be dealt with mainly by talking to them (Or in Western terms,

offering counselling). If necessary, in rape cases especially, most healers will refer to the social worker, the hospital or the police.

> *"If they have been raped I sit down and talk to them about the problem so that they do not become severely damaged, especially with regards to trusting other people. We rebuild them. Coming to those who have lost loved ones, we also visit them and give them words of comfort. We try and normalise death while encouraging them to try and live their life fully without the person they have lost"* Traditional Healer, (FGD003)*.*

Spiritual causes are those of bewitchment by another person or having upset the ancestors, for example, by not performing certain family rituals. It can also be caused by the ancestors calling that person to take *amagobongo* and become a traditional healer.

> *"They called their name so that they will later come and read the paper. While they are reading the paper, the spell starts working. By the time they finish reading the paper, they have already started going crazy….Another cause of mental illness is that of people using sweets on the targeted people.….Sometimes they go and take the soil from the grave and use it to bewitch people, making them mentally ill…"* Traditional Healer (SSI002).

Treatments included *muti* (traditional medicine), snuff, candles, prayer, herbs, incense, water and making incisions with a razor. A number of them spoke about *Ishoba* which is a power from the ancestors to heal,

> *"It is very important because it is ishoba of the hyena. It works a lot. It puts a lot of things in order…The minute I place it by my nose, it tells me a lot of things…."* Traditional Healer (SSI002)*.*

3.7.2.7.4.3 Views from other Participants

All participants felt that traditional healers have role to play in the provision of mental health care, especially in terms of providing counselling and psychological support for common or minor problems. Many community members believe strongly in traditional or faith healing and this can give them and their families' strength and aid in recovery. However, none believed that traditional healers can cure serious mental health problems:

> *"…the inyangas don't look at the possible cause. And they don't even consider looking at the possible cause because they've got their own issues about how the illness came into being, how it happened"* Clinic Nurse (FGD001).

3.7.2.7.4.4 Children & Adolescents

Traditional healers treat and counsel children and adolescents with mental and behavioural problems. They seem to have a good understanding of the connection between sexual abuse and mental health problems and how it can

affect the child. They will refer to the social worker or the police if the child is the victim of abuse. There are also the same cultural beliefs around causation, for example one healer said that if a child becomes insane it is caused by a person holding a grudge against the parent or because of jealousy because the child is performing well at school. Children are given different treatments to adults and the dosage is smaller and weaker.

3.7.2.7.4.5 Interactions with Medicine

There were mixed opinions about the use of traditional medicines while already taking psychotropic medication. Some healers thought that the medicines can be used in conjunction as long as a few hours lapse between doses of each:

> *"I help them take their medication if they are living with me during treatment. I will give them the medication, wait a while and then give them my treatment…I encourage them to continue using their medication from the hospital while also taking my medication and I monitor whether these two treatments conflict…"* Traditional Healer (SSI001).

While others thought the two treatments should not be taken at the same time because of possible negative interaction. One healer suggested burning *muti* rather than giving medicine if the person is already on medication:

> *"….After they finish the pills they can then start with my treatment. But even then, they have to at least wait for two- three days before they can start with my treatment so that the pills can go through their system….by the time they start using my treatment, they have had time for their body to process and get over Western medication"* Traditional Healer (SSI002).

3.7.2.7.4.6 Interactions with the medical sector

The hospital does not prevent patients from consulting traditional healers. However, they encourage service users to continue with psychotropic medication while going to the *inyanga* because some *inyangas* tell them to stop these while using traditional medicine. There are strong links with traditional healers for HIV/AIDS and some other health programmes but not for mental health. According to respondents, these links should be improved in order to educate traditional healers about signs and symptoms so that they know what to treat and what to refer:

> *"…there's a gap in terms of liaising, there's a gap in terms of formalizing a relationship, there's a gap in terms of understanding treatment methods…"* Mental Health Practitioner (PSYC).

However, many traditional healers were angry about the way they are treated when they take patients to the hospital. They are generally treated as if they

have no skills or knowledge and there is no acknowledgement that they are providing a service:

> "*A person that has ended up in her hands, they said that, he/she must not go out and go to traditional healers. They take us as people who do not know anything about people's illnesses. …As we end up referring patients to them even if the person gets better there is no feedback that is given to us about the well-being of that person…You won't see the person again…*" Traditional Healer (FGD001).

Some thought it necessary to work together because some illnesses such as TB and HIV/AIDS need to be cured by Western medicine while others such as stroke or bewitchment can only be treated properly by traditional healers. Others felt that they cannot work in conjunction with Western medicine because:

> "*The pills they are using are from our plants already so you see if we were to give them our methods, then we will never be able to work again ….We cannot give away our secrets because they will take them and use them but they will never give us theirs*" Traditional Healer (SSI001)*.*

3.7.2.7.4.7 Support

Traditional healers stated that they need more support from the hospital to make it easier for them to treat people with mental health problems. Ideally they would like a building to work from or secure places for treatment so they can't harm themselves or others. They would like training on mental health and the use of medication. All the participants were affiliated to the Traditional Healer's Association.

Summary: Community Other – Traditional Healers

- **Becoming/Training -** Traditional healers are given *amagobongo* and answer the call of the ancestors to undergo traditional healer training. Not all traditional healers treat people with mental health problems, majority had not had any special mental health training. Most have had additional biomedical training in a number of areas including HIV/AIDS, TB, maternal and child health and counselling. They would like training in mental health.
- **Diagnosis and Treatment** - Different kinds of mental health problems which require different treatments. Treatments included *muthi*, snuff, candles, prayer, herbs, incense, water and making incisions with a razor. *Ishoba* is a power from the ancestors to heal.
- **Children and Adolescents** – treat and counsel children and adolescents with mental and behavioural problems.
- **Interactions with Medicine** – mixed opinions about the use of traditional medicines while already taking psychotropic medication.

Some thought they can be used in conjunction, others thought they should not be because of possible negative interaction

- **Interactions with Medical Sector** – strong links with HIV/AIDS and some other health programmes but not with mental health. Many angry about the way they are treated by the hospital.
- **Support** – need more support from the hospital to make it easier for them to treat people with mental health problems. All affiliated to the Traditional Healer's Association.

3.7.2.7.5 Service Users

The ages of the service users interviewed ranged from 20s to 60s and the duration of their illness from 2 years to 22 years, although most had been ill for more than 10 years.

3.7.2.7.5.1 Help seeking and symptom management/treatment

3.7.2.7.5.1.1 Knowledge of mental health problems

While all the participants knew they had been diagnosed with what they referred to as a mental illness, none knew their specific problem. Suggestions for the cause of their illness included genetic problems, rape, an accident, death of family members, and thinking too much. As has been mentioned, the belief in witchcraft and spiritual causes was widespread,

> "*In my family, we believed I was bewitched. I would see people and hear voices. I even left school at some point and went to a traditional healer for help. I used to smoke while growing up but I have quit because I was told that it might make the problem worse but it does not make sense because this thing started long before I started smoking. I have suspected people at some point, especially my neighbour because I used to hit her kids at school but I was only a child then. But I believe the illness has something to do with imimoya (forces beyond ones power)"* Service User (SSI010).

Most participants were unsure about the cause of their illness, possibly because they had been treated and their symptoms improved by biomedicine and these interventions did not provide an explanation of causality, unlike traditional medicine.

Community awareness and knowledge about their mental health problems, seemed to depend on how they had behaved in public. If no one in the community saw them behaving strangely, they often were not aware of the person's illness. However most of the participants had been aggressive or obviously disturbed in the community, and, while severely ill, quite a few had run around naked in public:

> "…*won't just be normal like everybody else, they live differently. They can walk around half naked and that show that they are losing it. Some*

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won't even take a bath. At that time they don't even know themselves, let alone try and behave in a manner that will let others see that they are normal human beings" Service User (SSI009).

"(Sister of the user)*… here are these people that have come to fetch me, can't you see them, why aren't you stopping them….he wouldn't even look us, just wanted to kill us. He would escape through the window…at night*" Service User (SSI013).

3.7.2.7.5.1.2 Help-seeking & utilisation of services

Most of the service users or their families had initially approached medical services such as a doctor or the hospital but had also visited a traditional or faith practitioner. Only 5 out of 15 service users interviewed in the district had not been to a traditional practitioner at all. A few still went to other healers but they generally preferred the services of the clinic both because it is free and because they feel it has reduced their symptoms,

"*We started with the doctor and then went to faith healers…but when I was seeing the faith healer it seemed to get worse so I stopped and continued with the doctor only, since then*" Service User (SSI008).

One person mentioned that an added incentive to make use of the clinic services is the fact that this is a requirement for accessing the disability grant,

"*It was difficult to find something to do to bring in money so I had to go to kwa(place deleted) and see the doctor. That was when I was told to start treatment. And they helped me with getting the grant*" Service User (SSI005).

Depending on the distance from their homes to the clinic, service users either walked or took a taxi. This was also dependant on whether they could afford a taxi. Many complained that it was too far to walk but the taxi fare was too expensive so they had no choice but to walk. Emergency care was available either at the 24 hour clinic or at the hospital. Some users believed they could call an ambulance if they had an emergency, but most said they have to get own transport. This can be extremely expensive because they have to hire a car. It was thought it would be helpful to have more mobile clinics. The nurses at the clinics deal with service users quickly and respectfully. Their medication is always available unless there is a major problem like flooding and they are not forced to take particular treatments. The clinics are clean and their privacy is respected. They seem to be generally happy with the amount of information they receive about their illness and treatment although their family may be less well informed. Some users also had physical complaints and they received help for these from the clinic nurse or doctor.

When asked about their opinion on specialist services vs integrated services they were divided regarding which they prefer. This is probably a reflection of the different situations at individual clinics,

"I don't see the need why they should be separated. This clinic is fine" Service User (SSI005).

"Yes…..like when we come to the clinic and when they don't understand why we don't have to wait. They call us names" Service User (SSI010).

Most of the participants did not seem to know how or be interested in putting forward a complaint or suggestion. Also, it seems likely that they were unaware of what expectations they should have of the services provided and thus did not know what is unacceptable:

"I never ask or say anything….I am just lazy and scared" Service User (SSI002).

Some had made requests to the doctor or nurse for a change of medication or for other medical problems and they were attended to without any problems:

"I have told the doctor before, that my medication made me sleep all the time and he changed it. He did listen to me" Service User (SSI011).

3.7.2.7.5.1.3 Attitudes

Generally the service users stated they have accepted that they have a mental illness, and are happy to be receiving appropriate medical treatment and access to the disability grant. They were grateful to be relatively stable:

"It used to be bad when I was going to all these places for treatment and everyone just took me as this sick person. I know that I and other sick people can live better lives but some things are difficult to achieve. Like now, I cannot just work anywhere. But at least I have a home and I get some money at the end of the month. And I am stable" Service User (SSI006).

Their experiences of community attitudes towards people with mental health problems varied. These ranged from accepting and helping them, to not taking them seriously, to verbal abuse. They would like a lot more respect and tolerance from the community:

"… even at the times when I felt I was getting better people would still think of me as crazy. Once you have been called something, you will always be that thing. Even when you are trying to do things the right way, people would still say "Oh leave it!" You have become labelled as something. It breaks the heart" Service User (SSI008).

"They never really say anything but you can see that some of them are either angry with you or are scared of you. But some are supportive. The other time a councillor from my community took me to the hospital. That was a supportive gesture because we voted for him and he is

ploughing back to the community and he really helped me…" Service User (SSI010).

3.7.2.7.5.1.4 Police or legal contact

When asked about their experiences with the police, only two of the participants reported having had any contact with the police in the past. In all of these cases the police had been helpful and friendly, and the incident had been resolved quickly,

> *"(Sister of the user)…we called and asked "is so and so there"? They said he is there and told them we have a problem regarding that person, he is on treatment from the doctor; there is nothing you can talk to that person about because he has such and such a problem. Then they said, "No we must come with his papers". We got there and gave them the papers… They then realised and said we must look after him"* Service User (SSI013).

3.7.2.7.5.1.5 Gender

With respect to gender, users did not report major differences regarding their gender and the effect of having a mental illness. Both men and women had the same concerns about getting or keeping a partner and wanting to work to support their family. One issue mentioned by two men was erection problems due to their medication injection.

> *"It has disturbed my life a lot because I would like to have a partner just like every other man but I cannot because I am sick and no one will ever take me seriously. I would also like to have children and a family of my own but I do not have anyone in my life. As a man, I know that my family was expecting that I will grow up and support them but I can't. As a child I used to dream of having a good job and a good life…"* Service User (SSI010).

> *"…I am always worried about taking care of my family. I want to live and survive, but it is not easy to cater for a big family if you are a woman and even if I could try, the illness has made it difficult"* Service User (SSI011).

3.7.2.7.5.2 Needs of users

3.7.2.7.5.2.1 Housing

As with most rural areas in South Africa, users' homes are generally made up of a number of small structures such as traditional huts made of mud and stone, or brick buildings. A few participants had electricity and most have access to a communal source of water. A number of family members, young and old, live together at one home:

"We do have water just outside home but sometimes we just turn on the tap and there is not water and that happens a lot. Like today, we do not have water…." Service User (SSI002).

"…do not have electricity and sometimes I have to go into the bush and get fire wood if we do not have candles. I sometimes have to do this as tired as I am. We also fetch water from a far away source" Service User (SSI007).

3.7.2.7.5.2.2 Employment

With regard to employment, respondents complained that there were no jobs available in the area, not only for them but for the community as a whole. Only one participant was working as a manual labourer. Several of them wanted help with obtaining work or with learning more skills in order to find work. They expressed concern about supporting and providing for their family. Other issues around employment which arose were the fact that the injection makes the men tremble so they can't do manual work, and can't always cope with the conditions in the workplace. Also, if service users are gainfully employed they are not eligible for the disability grant:

"It's the registration….It won't work if I get registered while I am getting paid" Service User (SSI014).

"I did get the job but I had to leave….On my first day, they started singing so that they could pray. When they started singing, I got disturbed again….There is no place to look around here" Service User, (SSI005).

3.7.2.7.5.2.3 Education & Skills

The majority of service user participants had very low levels of education and literacy. This ranged from one person who had never attended school to one participant who had been studying mechanical engineering, but could not finish due to mental health problems. For many there was not enough money or time for their schooling or they fell ill and couldn't finish.

"It's just that I am not educated….It's just that people from then said we must usher the cattle" Service User (SSI015).

Most were not interested in furthering their education due to their age or their mental health problems, but would like to develop their practical skills such as ploughing or sewing:

"….I don't think I could be able to study because I forget a lot, but I can try other practical things like sewing" Service User (SSI007).

3.7.2.7.5.2.4 Benefits & Money

All of the service users' households relied predominantly on grants (disability grant, old age pension, child care grant) to survive. In the worst situation, one disability grant was supporting 6 people in the household. But most households are receiving more than one grant. The disability grant is not enough to live properly, even for one person:

> "I am also not able to buy my church uniform. It costs about R1000 and I have only paid R200 so far....I still have to put a fence around our house because people just walk in our yard. I also need travelling money a lot" Service User (SSI006).

The disability grant must be renewed often; therefore service users said that they sometimes have problems with payment being stopped because they have not renewed the grant. Most households were constantly struggling and needed help with basic necessities such as food, as it runs out before the end of the month:

> "We do not have enough food. We have very little money coming in and you cannot depend on the vegetables in the garden because sometimes other people's cattle eats the crops and people steal the vegetables as well. Sometimes it is so dry, vegetables cannot grow...." Service User (SSI011).

Other participants said that mental health service users often don't have the necessary identity documents required to access grants:

> "...they don't have IDs, and they don't have someone to take them to the welfare so they end up not getting that grant." Clinic Nurse (FGD001).

One nurse claimed that in some cases, the disability grants appeared to be an incentive to use medical facilities and take psychotropic medication. Some patients only take the pills because:

> "...they know that if they don't, then their grant will be terminated. So when they don't get the money ....once they are told that their grant has been cut off, you can see they are hurt, they come sweating, you can just see their grant was cut off" Clinic Nurse (003).

3.7.2.7.5.2.5 Social Contact & Activities

All of the service user participants were able to take care of their personal care activities and some household chores. Other than this they generally had very few activities to keep them busy. Most of them had some involvement with the church – attending services, preaching in the community and other religious activities. Some spent time with friends or partners, but most only had their family and church, and a few perceived friends as being a destructive influence.

Some expressed a desire to have the opportunity to meet and talk with other people in the community with mental health problems, but others did not see the need for this:

> *"It would be nice because we can talk to other people and help each other with problems like feeling bad when people discriminate you"* Service User (SSI008).

> *" …I do because being alone all the time is burdensome. Now I keep talking to my family even when I can see that at times they get bored"* Service User (SSI010).

3.7.2.7.5.2.6 Intimate partner

Of the fifteen service users interviewed, five were married and ten were single. Those who had partners living with them received quite a lot of support from them. One partner who actually took part in the interview was especially supportive of his wife and accepting of her condition. This may be a reflection of his deeply religious views,

> *"As her husband I have accepted her condition, and I have persevered….All these things that have been said about her, God has helped me in ignoring them. I have been asked how I could possibly live with uhlanya (a mentally ill person). I ask them, what am I supposed to do now? Am I supposed to leave her just because she has run out naked?"* Service User (SSI008).

The two brothers who mentioned their erection problems due to the injection said that this problem is the reason why they don't have partners. One spoke of a hurtful incident where a woman left him because he could not perform sexually,

> *"She said what is she going to do with me because I do not give her anything….It is painful"* Service User (SSI015).

Some of them wanted assistance with meeting and keeping a partner, especially the males:

> *"Yes I would. Like how to treat her right and make sure that she is not scared of you"* Service User (SSI010).

3.7.2.7.5.2.7 Childcare

All of the service users had young children living in their household, although they were not necessarily the primary caregiver. Therefore all were involved in childcare to some degree whether financial, emotional or physical. They did not have a problem caring for them physically and emotionally but there was a great deal of financial strain because of expensive necessities such as school materials and school fees,

"I am taking care of my late nephew's son. He passed away. My sister, my nephew's mother, also passed away….I always have a problem with his school fees and the things the teachers want. But I can bathe him and iron his clothes" Service User (SSI011)

3.7.2.7.5.2.8 Harm

When asked about hurting themselves or someone else due to their illness, all of the users claimed not to have hurt themselves or others on purpose. But in some interviews where a caregiver or family member was present, it was revealed that this had in fact occurred but they did not remember the incident.

"(Mother) It has happened. Once you almost hurt your father and the other time you hit your sister. You almost injured her. You said she was, she had made your pants dirty. You were very ill then. Don't you remember?" Service User (SSI005).

There were also a few instances where users had been the victim of verbal or physical harm from those around them.

3.7.2.7.5.2.9 Respect, Treatment & Opportunities

All participants, aside from the service users, were asked whether they thought people with mental health problems are given the same respect, treatment and opportunities as other people. There were varied opinions on this with some saying that government is ensuring that they are given respect, treatment and opportunities,

"…looked after with regards to respect, getting things. They are looked out for in getting those things, like people. They are also the nation, they should be looked after. So, it does make plans to arrange for them when they are make plans, even though it is not all of them that are taking medication and getting the grant, but I think government legislation…has helped some of them." Clinic Nurse (003).

While others indicated that although the situation has improved somewhat, it was insufficient and more resources and effort were needed to ensure that the Act was implemented at community level,

"…a…move towards making sure that people with mental illness have those rights, are respected and are afforded, you know, the same opportunities. And I don't think that there's enough at the ground level you know. I don't think there is enough resources placed at the ground level …in terms of, if you are a mentally ill person and you want to resume work, …community and public knowledge is…still what it was ten years ago…" Mental Health Practitioner (PSYC).

3.7.2.7.5.2.10 User participation

In terms of advocacy, service users had little knowledge of how to put forward their opinions. There are no programmes for awareness and no opportunities for participation. A couple mentioned that discussion forums would be useful as a platform for giving ideas:

> "….So far no one has asked me this question that you have just asked me, no one is there to listen" Service User (SSI006).

There is a perception on the part of service providers and nurses that service users should participate in developing government policies, plans and actions that affect them. It was felt that certain clients are very high functioning and should be involved at all levels:

> "At SA federation it is happening. They are very, very involved. You know sadly in (bigger area) we don't have that level of high functioning clients where we can take them to these things because if I take my clients and go, they will sleep. Or they won't know what's going on…we have met a lot of them from Jo'burg and Cape Town where they are very, very involved" Non-Governmental Organisation.

All service providers felt that as long as service users are stable and capable they should be allowed and assisted to take part in planning and developing policy. This will enable them to see that they have a role to play:

> "It is important because even thinking for them is not right. We as people in the community can accept and not…put them aside because as we put them aside, they are affected….It's important that they get involved in their programs and they know them, but who is going to do that, who's going to motivate them?... If we get some information, and also get someone to help them we can say, how far did so and so go and we can take over from there. But now there is no one to help them and there is no one encouraging us" Clinic Nurse (003).

Summary: Community Other – Service Users

- **Knowledge** - Knew they had been diagnosed with a mental illness but did not know the specific diagnosis.
- **Utilisation of services** - Most had initially approached medical services such as a doctor or the hospital, but had also visited a traditional or faith practitioner. Few still went to other healers but they generally preferred the services of the clinic. Transport to clinic/hospital is a problem. Generally happy with clinic services.
- **Complaint/Suggestion** – didn't seem to know how or to be interested in putting forward a complaint or suggestion.
- **Attitudes** – Generally have accepted their condition. Community attitudes varied from acceptance to verbal abuse. Would like more respect and tolerance.

- **Police contact** - Only a couple reported any contact and the police had been helpful and the incident had been resolved quickly.
- **Basic Needs** - A few had electricity and most have access to a communal source of water. Several wanted help with obtaining work or with learning more skills. They expressed concern about supporting and providing for the family. Very low levels of education and literacy.
- **Basic Needs** - Households relied on grants to survive. A disability grant is not enough to live properly, even for one person. Most households were constantly struggling and needed help with basic necessities such as food.
- **Basic Needs** - Few activities to keep them busy. Some expressed a desire to have the opportunity to meet and talk with other people.
- **Intimate Partner** – Did provide support. Some of them wanted assistance with meeting and keeping a partner, especially the males.
- **Childcare** - Great deal of financial strain because of expensive necessities such as school materials and school fees.
- **User Participation -** No opportunities for participation in policy or service planning. Suggested that discussion forums would be useful as a platform for giving ideas.

3.8 Key issues in current mental health service provision in South Africa

The following key issues were identified by respondents during semi-structured interviews at the national and provincial level. They highlight several of the cross-cutting themes that are alluded to in the description of current service provision at provincial and district levels, above.

3.8.1 Integration of mental health with general health

Respondents expressed varying views regarding the integration of mental health into general health services. Policy makers and programme managers supported the policy in principle, but felt that human resource constraints at primary health care level impact significantly on primary health care workers' ability and willingness to treat mental health care users.

Mental health care users accustomed to the care of qualified psychiatric nurses in the "verticalised" mental health system, agreed that integration, over time, could assist with de-stigmatisation of mental disorders, but expressed dissatisfaction with their current experience of reduced level of expertise, constant change in practitioner, long waiting periods for services and for appointments for referral to more specialised care when required within the integrated service:

> *Yes, I thought about it (integration) a lot. By definition it (mental health) is a specialised field. With primary health care you would go see a specialist after complications or when it's needed, our illness, by*

*definition, is a specialised field, with psychiatrists. (*Respondent 01, mental health care user and mental health user advocate).

Readily and regularly accessible medication at different points in the system was also considered essential by several respondents:

> *The clinics and state psychiatric hospitals, the problem there is like recently, that they take medication off their hospital list, which means that you're stabilised on this medication, and now they say according to restraints they have to take this type of medication off the list. So if you've been stabilised on it, now you can't get it, you don't have money to buy it, so you relapse, so you go back to hospital.   (*Respondent 35, mental health care user and mental health user advocate).

> *Some of your rural hospitals… medication and that type of thing is not available or at a certain day there is not available. The clinic comes in there and that person is out of repeats…it's practical, logistical problems. It's not about the fact that there is no medication, it's an issue in terms of training and prioritisation of issues, and also mental health in the priority list, is actually the last. (*Respondent 04, director, mental health NGO).

Most programme managers and practitioners agreed that training alone was insufficient to reduce negative or fearful attitudes among primary health care workers and to assist them to effectively treat users. Heavy workloads and limited human resources were felt to impact on the quality of care offered within primary health care settings.

> *And in the strategic plan, it is stated there that one of the main priorities is to integrate mental health, that it should no longer be stand-alone, that it's integrated into general primary healthcare. In practice that is not really happening. I: And do you know what the constraints might be there? R: There's a couple of things. One is from the side of the generalists, the medical officers and so on, they don't want to take on that responsibility because they feel under-skilled and not confident in dealing with psychiatric disorders. So they don't want to take that on. I don't think they see it as a major priority because they're busy with chest drains and seizures and goodness knows what else so I don't think they want to deal with the psychiatric problems. That's the one , and on the other side I think there's a hesitation from those in mental health, your psychiatric nurses, for example what they say that people say is that "If we are integrated into general PHC we're gonna have to do general primary healthcare duties". (*Respondent 33, public sector psychiatrist).

> *I: But you're finding that those people and even the people who have been trained are not eager to take on the assessment of people with mental health problems? R: I don't want to be unfair to them. It's because they are also having their very large workloads to deal with in their wards because they're having their wards full of patients with*

*AIDS dementia, suicidal patients, a whole lot of other medical conditions and over and above that, they're also having to deal with your psychotic patient coming into that medical ward. (*Respondent 40, provincial programme manager for mental health).

Positive attitudes among staff were reported to enhance their willingness and ability to manage mental health problems, and such attitudes were promoted where primary health care workers had access to practitioners with specialised mental health expertise for consultation and support. Across provinces, the model for this support varied, according to resources, population, urban/rural and geographical spread of the population, but the role of the experienced community mental health nurse within the support system was seen as central to the effectiveness of the support model used. The mental health nurse served variously as direct service provider, service coordinator, service development facilitator and manager and as the professional link for other practitioners placed at district, regional or tertiary level services. The services of the mental health nurse in turn benefits when s/he is embedded in a broader support team comprised of a psychologist, occupational therapist and psychiatrist. In some instances provinces are able to resource one or two such community-based multidisciplinary teams to offer direct services while others utilised these staff on an "outreach" basis from a regional psychiatric inpatient unit or mental hospital.

*I: Right. So you've got primary health care nurses, primary health care doctors, and you've integrated mental health in there, you've got the training support in place for those categories of staff; but at the next level, the service provision at the next level – what is that that you would like to have in place? R: The designated facilities. I: Do you feel that it's sufficient to have your primary health care workers able to refer to those designated centres, or like in other provinces, do you feel that they may need specialist mental health nurses as a first port of call for support, mentoring and guidance; or is that not a necessary thing, or possible thing, in your province? R: Currently it is not possible. I'll be presenting to the DDG (Deputy Director-General) a model. They will be having teams, or we need teams at primary health care, to support, because you cannot say that we are integrated when at a certain level, the only responsibility is in terms of referral: identify and refer. That is not a service. We need to capacitate them to do certain things, and immediately refer to a specialized team that is supposed to be in the community, because when we're speaking of access, we're saying the services should come to the people – we're not saying the people should wait at the apex. I: So you'd be sending an outreach team to…on a cyclical basis, to your primary health care districts? R: Yes….on a rotational…but, we need to have people like psychiatric nurses, stationed within the community itself. (*Respondent 43, provincial programme manager for mental health).

Provincial managers also mentioned the value of having district managers with positive attitudes toward and/or expertise in the mental health field. These managers either used their own initiative to allocate budgets to mental

health health developments, or were receptive to lobbying for greater support to the development of the district mental health service.

3.8.2 District and regional hospital services

The Mental Health Care Act has introduced 72 hour assessment services to assess the need for transfer of the user for more intensive care in a mental hospital setting, and/or to provide acute inpatient mental health care within a general hospital setting.

Currently there are no guidelines in respect of the human resource and infrastructural requirements to introduce appropriate, safe, effective and sustainable mental health services within the general hospital setting, and provinces are using their discretion in the establishment of these services. Centres may have been designated for this purpose, primarily using existing staff complements, while in other provinces service development is slow, with the emphasis on lobbying for appropriate resource allocations to establish services.

> *I: And you said sometimes you are having problems with these general hospitals taking on the 72 hour function? R: Ja, shortage of staff and lack of infrastructure, both of them…There are listed facilities..so that they can do the 72 hour assessment and one of the criteria was that the hospital must have two permanent doctors…But the problem now is that some of the hospitals have got only one Doctor, we leave the hospital today having two doctors and the next day one of the doctors has gone…the doctors quit, the programmes are still going on…I: And you are saying that sometimes it's difficult to contain them there because they need a little bit of extra infrastructural support? R: Ja, sometimes it is very difficult…If each and every hospital can have at least one or two strong rooms because these patients…sometimes when they are kept there, there are no strong rooms to do seclusions and so on, and most of them they abscond from the hospitals.* (Respondent 52, provincial programme manager for mental health)

> *"People disappear" means that they go into the general hospital, the general hospital cannot help them or cope with them because they do interrupt the hospital, they do disturb the hospital's day-to-day the functioning so they get discharged…Right back to me, right back into the community and then they disappear into the community. Maybe their behaviour change a little bit if they get depressed, they get quiet, but as soon as they get manic they up in arms again…What we are currently doing is we send them to other provinces if you can, but we cannot really. We have ways which is not so legal that I won't discuss on tape.* (Respondent 24, director, provincial mental health NGO)

> *And they keep the patients for at least the two weeks, if the patient doesn't get better, then they transfer the patient to XXX…. I: And who offers the service there? R: Oh, they have psych nurses, and visiting psychologists and psychiatrists. I: And so the actual people on call*

would be psychiatric nurses with consultant support from the psychiatrist and ward rounds? R: Ja. I: And is...is that model working for you to maintain a good, efficient...? R: It...it is working, it is working very well. (Respondent 22, provincial programme manager for mental health).

R: Yes, we do have…currently, hospitals that are supposed – and I'll tell you why I say, "supposed" – to be! And that are listed now, that are supposed to be doing 72-hour assessments; some are performing, others are not performing. I: And those who are performing relative to those who are not? What do you think are the key differences between them, that would need to bring them on par? R: Attitudes. (Respondent 43, provincial programme manager for mental health).

In some instances health policy maker, programme managers and practitioners expressed satisfaction with provincial freedom to lead on the setting up of their services, but in others it was strongly requested that minimum standards for the development of these services be developed, coordinated by the National Directorate for Mental Health.

3.8.3 Deinstitutionalisation and the need for community-based mental health services

The Mental Health Care Act legislates for least restrictive care, offered as close to the user's community as possible. The Act states that where outpatient services are insufficient to address users treatment needs, institutional care should provide safe treatment and stabilisation services for as short a period as is needed to enable the user to return to community life. Inpatient mental health care should preferably be offered in a general hospital setting, with specialised hospital care available for more intensive mental health care, if required. Users who have lived in institutional care for long periods need access to rehabilitation services to prepare them for a return to community life. All users who require short or long-term support for work, to study, and to enjoy family and community life should have access to psychosocial support services. To this end, the Act provides for the development of community based services and support systems that promote users' recovery and reintegration into society.

However, several respondents stated that in practice deinstitutionalisation has often been used to motivate for the downsizing of large institutions without the corresponding development of community residential, general hospital and outpatient mental health care services.

The need for the development of a community based mental health policy and services, adequately funded service level agreements with NGOs to set up and manage these services, within an intersectoral framework of service development, was among the strongest themes which repeatedly emerged during the interviews across stakeholder groups:

> *I think NGOs have a very vital role to play in providing community care – I think if the Act says every organ of state is responsible for health services, this must determine, you know, policies and measures to promote provision of community-based care. (*Respondent 31, director, provincial mental health NGO)

> *So the vision is that most of our mental health care users should be living in communities, should be getting their services at first-line clinic level; and that, as an ideal to strive for, is fantastic. However, what has happened is that the deinstitutionalization, or the de-hospitalization, of patients, has gone very rapidly, driven by a number of factors, including finance… I think that in terms of the whole issue around the funding and provision of community-based services, that growth that had to occur there didn't occur. … for a transition period there needed to be additional funding made available to first establish the community-based service and then to downsize actually to make it a supply-and-demand thing, rather than the way it was driven.* (Respondent 27, director, mental hospital complex).

> *I think even the Programme Managers at provincial level have recognised that we should not actually reduce any further at this stage so we, you know, we're not near the national recommended norm that until we can develop community based care, you know, we run the risk that we're going to end up with a lot of disasters, people, you know, relapsing and other adverse incidents* (Respondent 33, public sector psychiatrist)*.*

Respondents were also concerned about the increased burden of care on families and the negative impact on user wellbeing which results from hastily reduced hospital services in the absence of community based treatment and support services.

> *So in a situation like that, you would think that certainly we would have built in systems to make sure that those clients or those patients who cannot be with their family at least we have within a community sector what we call hostels or shared apartments, where you group them and then they are supervised maybe by a social worker or a caregiver of some kind, even if in this instance, what I personally noted was that the caregiver, the mother now was actually crying out because she was exhausted* (Respondent 28, policy maker, Department of Health, commenting on a mother in crisis around supporting her mentally ill son).

> *So, in fact, we've lost quite a large safety net, and it's presenting in various ways; one of them being that we see some of our clients returning to us via the forensic services* (Respondent 20, provincial programme manager for mental health).

The lack of community-based mental health services also burdens provision within facility based health centres, putting additional pressure on already

stretched primary health services and hospital beds, with adverse consequences for quality care provision:

> I: *You said that sometimes the patients have to stay in the psychiatric hospital because there isn't alternative family or community care for them? R: I don't have the statistics and percentages but quite a lot of them are in psychiatric hospitals because they are homeless.* (Respondent 52, provincial programme manager for mental health)

> *You know what we find, that one of the big challenges is the very limited and short stay that they have when they are actually ill, so often people are being discharged when they still have very active symptoms of psychosis or part of their mental illness and then being discharged back into their communities and their family homes, and families not being able to cope with that.* (Respondent 16, director, provincial mental health NGO).

> I: *What's the biggest impact of not having them (residential and work support services) and how would it help to have them? R: The biggest impact is that you have a revolving door: people in and out of institutions, no support once they get out there, they can't start working again etc… the psycho-social rehabilitation part of mental healthcare, which would keep people out of hospital, keep them employed, keep them supported; it would definitely greatly reduce the demand and the pressure on institutional services and it would also be a better service for the public that they are able to remain in the community and be treated perhaps as outpatients and not… I think in terms of relapse and recovery from illness…do you know what I'm saying?....You know, I really believe in it, not just because I'm working here, you genuinely see first of all an improvement in the quality of life for people with psychiatric disorders. Suddenly, if they are provided with the necessary support they are have an opportunity to engage in life and have some meaning and some quality.* (Respondent 38, manager, NGO offering day, residential and work support services).

3.8.4 The role of the national and provincial structures for Mental Health, Department of Health

In keeping with the provisions of the White Paper on Health regarding the role of the mental health authority, as with the development of mental health policy, respondents strongly emphasised the need for the National and Provincial Departments of Health, in particular the Mental Health Directorates or Programmes, to take the lead in driving the implementation of the mental health agenda set out by mental health legislation and policy in South Africa.

With respect to implementation of policy:

> I: *So on paper and in terms of policy, mental health has been prioritized, but on the implementation side, in terms of integrating, that's not happening very well. And your one suggestion was that the*

dedicated mental health unit actually has some work on that. Am I understanding that correctly? R: Well, we have a dedicated unit. What they have to do is work more closely with other units, to ensure that conceptually, people are thinking about the impact of their various own problems on the fundamental health of people. (Respondent 25, policy maker, Department of Health)

I: What do you think are the key challenges to implementing the mental health laws and policies? R: We need to stabilise this situation within government. Units needs to be stabilised with a vision and someone basically pushing that vision on the one hand and then I think also within us, as civil society, health and welfare we just need to start refining and focussing our goals. (Respondent 04, director, mental health NGO)

Regarding implementation of legislation:

R: I think we should take the matters through the social cluster because there's a lack of collaboration from health and they approach us for the implementation of that section, and it's actually also basically their Act. So they should actually take the initiative to take keep this whole matter on the table, but they've never come back to us for instance. I: So your Department will be willing but there needs to be some initiative via them through social cluster processes. R: Ja, I don' t know because I myself have a personal commitment to this, you see, but we also have to work within priorities set by our own Department. And I think that they should actually take the lead, but I mean, I think we will be putting it on to the agenda again because it's something we are very concerned about (Respondent 02, policy maker, Department of Education, regarding the educational aspects of the implementation of provisions of the MHCA).

The following table summarises the areas of action which a range of respondents identified for the attention of national and provincial offices for mental health. Again, respondents suggestions are largely consistent with the roles and functions identified in the White Paper on Health, and serve to elaborate specific actions needed at this time within those roles and functions.

National Mental Health Programme, Department of Health	
Function	**Activity**

Policy and programme development	Driving the process of developing:
	• A National Mental Health Policy and Plan which will define the scope and breadth of programmes and services for mental health in South Africa
	• Specialised norms, standards, policies, plans and programmes and protocols within the overarching framework of the National Mental Health Policy for:
	    ○ Child and adolescent mental health
	    ○ Community based mental health, within a psychosocial rehabilitation and recovery-

	based framework of service delivery

	o Substance abuse prevention and treatment
	   o Forensic services
	   o Mental health promotion
	• Targets, Indicators and information systems for monitoring and evaluating the implementation of policies and programmes.
	• Minimum standards for the provision of inpatient mental health services at district and regional hospitals.

Lobbying for and technical input to infrastructural resource development and provision for mental health	The key focus areas here included: • Guidelines for infrastructural and human resource requirements for delivery of inpatient mental health care at district and regional hospitals in compliance with the Mental Health Care Act, and the inclusion of these developments within the hospital revitalisation programme • Community based services, including permanent and transitional residential care, day care services, income generation programmes and projects, in line with the Norms and Standards for Community Based Services for Mental Health

Lobbying for human resource development and provision for mental health	Providing evidence-based input to support the prioritisation of mental health service provision through:
	• Budgetary allocations to support the implementation of the Mental Health Care Act, no 17 of 2002
	• Posts to support the appointment of national and provincial officers with the required seniority and expertise to support the implementation of the Mental Health Care Act and policies
	• Adequate provision for mental health practitioners within the Human Resource Plan of the Department of Health
	• Informing training and support for mental health professionals and professions providing mental health-related services, through the relevant Statutory Body
	• Leading on the development of training materials
	   o For practitioners involved in the implementation of the Mental Health Care Act and mental health policies.
	   o For mental health programme managers on policy and programme development, implementation, monitoring and evaluation, and in general management, planning and financial skills.
	• Promoting inclusion of relevant mental health professionals in rural allowances to support rural

	service development
Intradepartmental policy and service development	• Informing mental health-related policy and service development within other health programmes, such as the programmes for maternal child and women's health programme, chronic care and rehabilitation, reproductive health, health promotion and others. • Working closely with the Disability Directorate within the Health department to integrate mental disability issues into the broader disability programme
Intersectoral policy and service development	Liaising with a range of other sectors to promote intersectoral collaboration for mental health (see section 3.8.5. below).
Funding for mental health	Lobbying for funding mechanisms and provisions for mental health services to support provinces to obtain allocations for implementation of mental health plans and programmes run by the department directly, with other sectors and via service level agreements with NGOs

Provincial mental health coordinators have multiple roles in translating national policies to plans and programmes, and monitoring and supporting implementation of these provisions. Among these many responsibilities, respondents emphasised the value of specific attention by provincial coordinators to the following issues in the next period.

Provincial Mental Health Programmes, Department of Health	
Function	**Activities**
Policy and programmes	• Translation of national policy into province-specific plans • Engagement with provincial experts within academic and service provision sectors, including the NGOs, to support development of best practices
Intersectoral and intrasectoral programmes	• Leading provincial coordination of inter- and intrasectoral programmes and informing national developments in this area • Working closely with district health managers to promote equitable provision of resources for services for mental health care users within the general health system at district level • Attention to setting up services to support the provision of inpatient care at regional and district hospitals, including 72 hour assessments
Funding	• Lobbying for the inclusion of funding for mental health programmes, in particular the funding of programmes offered via service level agreements with NGOs

3.8.5 Intersectoral Collaboration

Respondents also repeatedly voiced the need for the National Department of Health, Mental Health Directorate to take the lead in collaborating with a range of other sectors (listed in Table below) regarding:

- The identification of relevant mental health issues which need to be addressed in their policies and programmes
- Research to provide evidence on the nature and scope of the issues to be addressed
- Delineating departmental responsibilities for different aspects of a service to people with mental and intellectual disability
- Technical expertise to improve the inclusion of relevant mental health related issues in other sectors policies
- Support in the development of guidelines and protocols for the implementation of provisions in mental health-related legislation and policy

The Table below summarises some of the main issues which were identified by respondents for intersectoral collaboration to ensure integration of mental health care users into departmental policies across sectors.

Department	Delineation of departmental responsibilities in policy and programme development	Technical Expertise from the mental health field
South African Police Services	• Guidelines for the implementation of Section 40 of the Mental Health Care Act	• Guidelines for the management of forensic and behaviourally disturbed clients in police custody while in transit to or awaiting hospitalisation
Department of Education	• Integration of people with intellectual disability into the inclusive education system • Provision of supports to children and adolescents with mental and related learning disorders within the inclusive education system • Collaboration with the department of Health to promote ongoing and re-entry to learning following periods of illness, and to develop a joint approach to management of chidren and adolescent with	• Identification and management guidelines for educators working with children and adolescents with intellectual disability and mental and substance disorders • Development of protocols for the management of, and employee assistance programmes for educators with work-related and other mental health conditions. • Development of a district based model for the management of mental health disorders presenting in school-going children

severe mental and developmental disorders. • Collaboration with the department of Labour to coordinate basic education outcomes with skills development and vocational training opportunities and career pathing for people with mental and intellectual disability (A Life Long Learning and Earning approach)	(schools as a node of identification and intervention for mental health-related problems) • Assessment and review of the need for specialised mental health expertise within the school sector
Department	**Delineation of departmental responsibilities in policy and programme development**	**Technical expertise from the mental health field**

Department	Delineation of departmental responsibilities in policy and programme development	Technical expertise from the mental health field
Correctional Services	• Assist Correctional Services in development of their Mental Health Policy for mental health care of prisoners	• Identification and treatment guidelines for the management of prisoners with mental health conditions, substance abuse and suicidality
Department of Labour	• Clarity on the roles and responsibilities of Labour for skills development, vocational training opportunities and career re-pathing for people with mental and intellectual disability. • Inclusion of people with mental disability in monitoring employers' compliance with equity targets.	• Development of technical guidelines for the implementation of the reasonable accommodation provisions of the Employment Equity Act, with respect to people with mental disabilities
Department of Social Development	Clarity on the roles, responsibilities and service interface of Health and Social Services • For children, adolescents and adults with mental disorders and intellectual disability • In respect of access to social grants • For the treatment of co-morbid substance abuse	• Identification and management guidelines for social sector workers working with intellectual disability and mental and substance disorders in Child and Youth Care Centres • Guidelines to identify people with mental and intellectual disabilities for social grants.

	and mental disorders • In the provision of community based mental health services	• Supportive arrangements for continuation of social grant support during periods of review, and for transitional benefits during job placement programmes linked to reintegration into the workplace.
Department of Justice and Constitutional development	Supporting equality under the law for people with mental and intellectual disability, for example in the areas of: • Inclusive education • Workplace discrimination on the grounds of mental disability, and • Protection of the integrity of body and mind in the provision of mental health care services	• Developmentally appropriate court procedures for child witnesses in the management of child abuse, and custody cases • Appropriate court procedures for people with intellectual disability • Training of magistrates in the identification and management of offenders with mental health conditions
Department	**Delineation of departmental responsibilities in policy and programme development**	**Technical expertise from the mental health field**
Department of Housing	• Review of special housing needs policy to accommodate subsidisation of the housing needs of people with mental and intellectual disability, and support to their access to housing provision through the national housing programme (family and community residential care) • Agreement on the responsibilities of Housing (policies to support inclusion, municipalities (provision of transitional and permanent housing), NGOs (support programmes for residents) and Social Development (programmatic funding to NGOs)	• Eligibility and procedures to accommodate subsidisation and equitable access to housing provision (family and community residential care)

Local Government	• Clarity on the role of local government in including people with mental and intellectual disability in the provision of community and municipal services to disabled people under their jurisdiction • Noting the mental wellbeing benefits of the provison of basic services such as water, electricity and sanitation • Inclusion of programmes for the promotion of mental well being and prevention of mental illness in municipal health services • Incuding the needs of people with mental disability in Accessiblity Plans, for example transport, housing, recreational needs of people with mental disabilities.	
Department	**Delineation of departmental responsibilities in policy and programme development**	**Technical expertise from the mental health field**
Public Works	• Inclusion of the development of social cooperatives for people with mental and intellectual disability in policies and provisions • Inclusion of mental health care users in the income-generating projects of the Expanded Public Works Programme	• Support revised provisions to the development of social cooperatives for people with mental and intellectual disability
Agriculture	Provision of technical expertise, information and start up provisions to initiate and maintain agriculturally based income generation projects for people with mental and intellectual disability	
Sports and Recreation	Inclusion of children, adolescents and adults with mental health problems into sporting, leisure	

	and recreational programmes planned for the general population, and for people with disability Support to NGOs and FBOs in the development of programmes to promote social interaction and integration of people with mental and intellectual disabilities	
Transport	A safe and effective public transport system will promote mental wellbeing by increasing disabled citizens access to work, social and recreational opportunies and to public services	• The idea of a travel pass or benefit for disabled citizens was suggested to increase access to work, hospital services and social supports.
Treasury	A review of treasury regulations and provisions to eliminate financial barriers to intersectoral service provision	

Several suggestions were made to address these intersectoral issues, including
- The drafting of discussion papers to inform departmental and other partners deliberations regarding the core issues for development
- The use of available technical experts within departments, academic and research settings, and in service provision to draft discussion papers, guidelines and protocols
- More concerted use of the Social Cluster as a mechanism within the public sector to address these intersectoral issues.

With respect to oversight and monitoring of departmental elaboration of their obligations to citizens with mental disability, and to assist civil society to improve prioritisation of these issues on the public agenda, respondents referred to the following structures in parliament and the presidency:
- Lobbying for greater attention to the mental disability agenda within partiament, for example through the Portfolio Committees on Health, and on Child, Youth and Disability
- Addressing rights protection for people with mental disability through the Human Rights Commissions
- Obtaining support for policy development and implementation from the Office of the Status of Disabled People (OSDP) in the Presidency

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Summary: Key issues in mental health service provision in SA

A number of key issues were raised by respondents in the interviews,

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regarding mental health service provision in South Africa. These included:

1. Integration of mental health into general health
2. District and regional hospital services
3. Deinstitutionalisation and the development of community-based care
4. The role of the national and provincial structures for Mental Health in the Department of Health
5. Inter-sectoral collaboration

3.9 Research

Chapter 12 on Mental Health in the White Paper on Health (1997) proposes that mental health and substance abuse be considered essential national health research focus areas to inform prevention, promotion, treatment and rehabilitation. The White paper recommends the following strategies to support implementation of such research:

a. Allocation of funds for research on mental illness, substance abuse and violence, and
b. Encouragement of young researchers to pursue research on mental health, substance abuse and violence.

However, respondents felt that mental health research, as with mental health service delivery, is still not a priority research area within the public domain. This is confirmed by findings from the WHO-AIMS instrument, which indicate that 2% (78/3374) of all health publications in South Africa were on mental health during the last 5 years.

The research in the country has addressed a variety of areas, including epidemiological studies in community samples; epidemiological studies in clinical samples; non-epidemiological clinical/questionnaires assessments of mental disorders; services research; biology and genetics; policy, programmes, financing/economics; pharmacological interventions; and psychosocial interventions/psychotherapeutic interventions.

Policy makers interviewed in this study appeared to be well aware of the need for research to inform their work:

> *R: You guys should take a few District Health Plans because we've got now 52 districts – each district should have a District Health Plan that is revised annually. And you guys should look at which of the national policies for mental health filter through to the district level, in terms of the integration of mental health into primary health care. And on the psychiatric hospital side, you won't find it there because psychiatric hospitals are run from the province side. But if you want to know what's happening on the psychiatric hospital, we must look at the provincial, we call them the Annual Performance Plans of provinces. So you should look there and see if they are implementing anything around*

psychiatric hospitals and psychiatric services. Psychiatric hospitals will be in the public programme of special hospitals, or something (Respondent 25, policy maker, Department of Health)

I: So you feel there's still a need to have a comprehensive study on the prevalence of mental disorders in prisons? R: That's it. I tried it two years ago, to do my Masters but I'm so busy. I actually wanted to conduct a study on the impact of imprisonment/incarceration on mental health…something around mental health. I: And today you still feel there is a need for such a study? R: There is definitely a need…like a study which will be so comprehensive also to …Like the warders: They need training in suicide risk assessment, like very basic…we do have prisons where there are no nurses so it means in those prisons nothing is done to the offenders on admission in terms of mental and healthcare issues. So we still need those things…so if somebody can just conduct an intensive study for us. (Respondent 56, policy maker, Department of Correctional Services)

A clearly defined agenda for public health research is not yet available in South Africa. It was also felt that capacity for mental health research was insufficiently developed in the country. It was suggested that researchers are more comfortable working in more well-defined areas of research, where research methodologies are more clearly defined. Policy makers who are meant to utilise the research outputs may also have insufficient research training or mental health expertise to translate policy into practice.

I: Would you think it's a research capacity issue that people don't know how to do that kind of research or that it's an emotional, overwhelming feeling that people get when they look at the large task that they have?. R: I think it's both. I think that the research is complex. And the political ramifications to this kind of research, if you say, for example, one really wants to do something about poverty…the research agenda, in other words,… one wants to make a change, one actually wants to eliminate or eradicate poverty, then most people feel that's just pie in the sky. Therefore they back off to "let's rather do a study on say the number of tuberculosis cases that are missed in a particular health sector". Can you see what I'm getting at? (Respondent 3, research director, working for a Health Research Organisation in SA)

Talking about research discussions with a public health official responsible for research:

R : You know, we're doing a case control study and she says to me 'well why do the controls have to look like the cases, we have a rainbow nation' and I mean I just want to tear my hair out! You know, this is somebody who is claiming to be a researcher and actually who is preparing a lot of stuff which is used by government. I mean, it's bloody clueless and I mean, you know….(later)   so you get bad researchers as well who say, what I've done is completely noted by declaration, by a claim. And then you go to government and you say well, I can't do a

properly valid thing for you because it's not possible. And they'll say '
oh but this other group will do it for me'. So it's both sides.
(Respondent 11, mental health researcher and academic)

3.9.1 Areas for Action

A number of areas for action were identified by respondents in developing mental health research. These included:

- Defining a research agenda for public mental health in South Africa and lobbying for its inclusion in the Essential National Health Research Agenda, as directed by the White Paper (1997), and its prioritisation on the agenda of the Research directorate in the National Department of Health

  I: Would you say that the national research agenda is as inclusive of mental health as it should be, are we prioritised there and what? R: It has been prioritised. It took a long time, but I think as from last year, the Mental Health has been prioritised. I: Could you say a little bit more about what they have prioritised? R: The specifics, I'm not really familiar with. It's up to us mental health practitioners to go in there and not say, "Is there any priority for mental health?" You must go there and make sure. (Respondent 15, Head of Clinical Service and Department of Psychiatry in one province)

- Improving the nature and extent of collaboration between researchers and public policymakers to make sure that needed evidence is generated and then that the available research is used to inform policy development and implementation.

  I: So there's a fledgling infrastructure for making the connections, but where do you think the next steps for development are around, you know, bumping up that interface between policy and research? R: Maybe that initiative should, be pushed or driven by the national Mental Health Directorate, because you know, they are, they can, they can co-ordinate nationally and they can disseminate information nationally and maybe there needs to be stronger interaction and liaison between the national provincial programme and academic institutions (Respondent 12, former provincial programme manager for mental health).

- Utilisation of research expertise in the country to provide additional capacity for public mental health.

  R: We can tell you what the need is. We've been telling them for years. This whole thing of our over-21's, what happened years ago was that we were saying there is a need for these people to be provided for, Health said no, Social Services said no, they said: " do a research project". We did research… it was a very well documented research document. It went nowhere. Now suddenly Health has come up…now they're doing another research project. We are seven years down the

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line from there, and they say only when we've proven the need will they start doing it… Meanwhile people are dying in between and why worry? I: And what do you think is the delay? R: We don't get on and deliver, do service delivery. It doesn't take a rocket scientist to work out how to…when there's a need. (Respondent 49, programme manager for an NGO supporting people with Intellectual Disability, regarding the lack of services for profoundly intellectually disabled adults)

- Generating resources to improve research capacity for mental health research.

I: And is there money also that could come to mental health research? R: Yes, self-initiated research. For instance, Registrars who want to have some seed money to do their Theses, they can apply to the MRC. Students who want to do their PHD's, can apply to the MRC. I: Yes and is it a lack of awareness of these funding opportunities that people are not doing it? R: It's not lack of awareness, because those who want to get money, they go out there and get it and those who, maybe they might make an excuse and say, "It's lack of awareness"….I think if you want money, you'll get it. There is money in the international world. There is the National Institute of Mental Health. You see, people will complain that they don't know how to access those funds. You must go there and learn how to access the funds and go to the people who have been funded before and get the information from them. I: So you feel we need to be, we lack drive as a sector? R: We lack, we lack mentors. (Respondent 15, Head of Clinical Service and Department of Psychiatry in one province)

Summary: Mental Health Research in South Africa

- The White Paper on Health (1997) identifies mental health and substance abuse as essential national health research focus areas.
- 2% (78/3374) of all health publications in South Africa were on mental health during the last 5 years.
- Several policy makers identified research areas needed to inform their work.
- Areas for action identified in developing mental health research were:
    - Defining a research agenda for public mental health in South Africa,
    - Improving the nature and extent of collaboration between researchers and public policymakers,
    - Utilising current and developing new research expertise in the country to provide additional capacity for research in public mental health, and
    - Generating resources to improve research capacity.

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4. Discussion

4.1 Context

Respondents' views on the general context of mental health in South Africa reflect a combination of optimism in the new political dispensation, satisfaction with progress in respect of legislative and policy reform, and concern at the slow pace of wider social and economic transformation. Respondents felt that government attention should now shift to implementation of legislation and translation of policy into service development and delivery. These viewpoints were reflected in discussions of the political environment, and of priorities such as poverty, unemployment and job creation, social support, HIV/AIDS, and crime and violence. There is clear support for government focus on helping communities to move out of poverty, and an additional call for government to establish partnerships with community structures to work on development priorities identified by respondents.

Further support for this approach was given by respondents' views that social, political and economic challenges are inextricably linked with mental health. Mental ill-health was seen as being caused by poverty, through the level of stress suffered by millions living in poverty and unemployment, and the trauma associated with violent crime. Poverty was also seen as being entrenched by mental ill-health through the difficulties that people with mental health problems encounter in finding employment, and participating actively in community life. These findings are consistent with wider international research that shows poverty and mental ill-health interacting in a vicious cycle (Patel & Kleinman, 2003; Patel, 2001). People with disabilities, including those with mental disability, may struggle even more than able bodied citizens to participate in and benefit from policy directives implemented in their communities. The link between HIV/AIDS and mental ill-health was emphasised, as was the need to address the mental health consequences and causes of HIV/AIDS, a finding that has been supported elsewhere (Collins et al., 2006; Freeman, 2004).

The findings regarding the context indicate that mental health policy makers need to be aware of the contextual constraints which impact on the translation of mental health policy into practice and should be mindful to address these contraints within their strategies, if they are to address mental health effectively. These constraints include poverty, unemployment, capacity to plan and deliver services, and the challenge of establishing partnerships with local government, civil society and community resources to partner with government and implement policies at local level.

4.2 Mental health situation

Several key issues were identified by respondents in their analysis of the mental health situation in South Africa, namely:

- Lack of public awareness of mental health,
- Low priority given to mental health,
- Misperceptions and negative attitudes in public awareness of mental health,
- The role of stigma in impeding progress with mental health priorities,
- The vicious cycle of poverty and mental ill-health,
- The need to increase participation of mental health care users in policy making, and
- The need for support for families of people with mental health problems.

These findings are consistent with those from many other low and middle income countries, where mental health is often given low priority and is widely stigmatised (WHO, 2001). Negative perceptions inform not only the attitudes of the wider community but also policy makers and health workers (Thornicroft, 2006). This lack of public awareness and stigma frequently acts as a barrier to mental health policy and practice (Knapp et al., 2006).

What is striking regarding these findings is the consistency of the message that emerged from a very diverse group of stakeholders (some of whom were not directly involved in mental health work). Although there were some minor differences of opinion regarding certain issues (such as progress in the fight against stigma), most respondents were in agreement about the priority issues for mental health, and the need for national, provincial and local government to address mental health urgently as a crucial health and development issue.

Among their recommendations were:

- **Public education within a rights-based framework:** Discrimination of any nature is outlawed in terms of the human rights based South African law. Advocacy action should include a focus on raising awareness of the discriminatory nature of media outputs, and the development and distribution of guidelines for media publications on mental health issues. Targeted activities should be organized to address the stigma and discrimination exhibited by health care providers and educators.
- **Early Education:** Increasing awareness and educating individuals with accurate information about mental ill-health should begin in school settings.
- **Exposure to positive images of mental health advocates.** The development of a mental health user lobby for public participation in mental health issues, and the identification of positive and prominent user role models and well-known and influential champions for mental health.
- **Lobbying for political support for the prioritisation of mental health on the public agenda.** The importance and place of mental health within the broader disability agenda, and within other development priorities and public concerns should be better articulated.

- **Recognition of the poverty-mental health link on the policy agenda.** The mechanisms of interaction and potential strategies to address the poverty-mental health link should be brought to the attention of policy developers. This focus area should be included in policies and programmes of all sectors involved in poverty alleviation and community upliftment.
- **Income generation support for mental health care users.** As with their views of the priority strategy to address poverty in the general population, respondents felt that mental health care users should be targeted for inclusion in employment creation programmes and support should be provided to community-based income generation projects for users. For users whose participation in income generation opportunities are limited by the impact of their psychosocial difficulties, there should be access to social grants, and other state-supported poverty alleviation initiatives.
- **Effective treatments and supports to users and their families**. Service inefficiencies which result in poor access to treatment and community supports to promote wellness and sustain recovery can make it difficult for the user to resume his or her place in family, work and community activities, taxing family and community resources, reducing family and community ability and willingness to accept and support users, and maintaining discriminatory and stigmatising attitudes and behaviours toward users.
- **Evidence-based support** to politicians and departmental policy makers to identify gaps in policies which may still exclude people with mental disability as potential beneficiaries, and to suggest appropriate mechanisms for ensuring that they are able to access resources on par with other citizens.

4.3 General policy making processes

The general policy making process in South Africa reflects our current historical context and the desire by the ANC government to maximise policy reform and improve service delivery to redress the injustices of the past. What is of interest from a mental health perspective is that the official process of policy making for mental health does not differ significantly from any other aspect of health policy development in South Africa. Instead the crucial difference appears to lie with insufficient political will to develop a mental health policy.

The reasons for this have been alluded to earlier and appear to include lack of public awareness of mental health, low priority given to mental health, misperceptions and negative attitudes, and the role of stigma in impeding progress with mental health priorities.

A further reason for the lack of mental health policy development appears to lie among the mental health sector. Most stakeholder groups consulted had little understanding of or experience in using political and policy making processes to develop and implement mental health policy. Many of those within the mental health sector (which is made up of clinicians, service users,

family support groups, NGOs and academics) do not have training or experience in policy or a public health approach to mental health.

Several mechanisms were identified which can be used to promote the prioritisation of mental health on the public agenda, and to muster support for mental health-related legislative and policy development. Yet few of these opportunities have been adequately used within the mental health sector. They include:

- Public hearings of parliamentary portfolio committees
- National conferences for public participation
- Community forums for policy fine-tuning
- Commissioning research to NGOs and research institutions
- Using specialists and experts from the academic sector
- Special meetings with and briefings of private sector institutions
- Meetings with lobbyists.

4.4 Process of mental health policy and law development

The findings of this study indicate that the Department of Health has not, at all levels of delivery, formally adopted and implemented the *National health policy guidelines for improved mental health in South Africa*, following their approval by MINMEC in 1997. Indeed within the Department of Health, officials state that the MINMEC approved policy does not constitute formal mental health policy, and there is currently no official mental health policy in South Africa. As noted in the results, a new policy is currently being drafted by the national Directorate: Mental Health and Substance Abuse.

Although the 1997 policy guidelines were distributed informally to coordinators at the time, no formal process of dissemination of the guidelines was conducted by the national office, nor, due to human resource constraints within national and provincial mental health offices, was its implementation lobbied for and consistently monitored and evaluated over time.

At national level, further policy development work has been conducted to develop policies, norms and standards which address specific priorities identified in the general guidelines, such as the Child and Adolescent Mental Health Policy Guidelines, the draft Psychosocial Rehabilition Policy Guidelines, and the norms and standards for severe psychiatric conditions, for community mental health services and for child and adolescent mental health.

Extensive national energy and resources have been devoted to the development, adoption and subsequent implementation of the Mental Health Care Act (2002), with provincial structures intimately involved in this development. It appears that, in the absence of a formally accepted national mental health policy, the legislation is currently driving service reforms and development at provincial and district level. Most respondents who were familiar with the Mental Health Care Act agreed that the legislation is based on a thorough consultation process with a range of stakeholders and that as a

key instrument of community-based mental health care, the Act appears to be a highly appropriate and important milestone in the development of the mental health system in South Africa. In the light of the lack of broad policy support for mental health, the Mental Health Care Act is a major achievement for the national Mental Health Directorate and the various stakeholders involved in its development and promulgation.

In South Africa's case, it would seem that the legislation is beginning to have a more powerful impact than the policy guidelines, at least from the point of stated prioritisation, and inclusion in provincial implementation plans.

Respondents interviewed in this study suggested that this may be attributed to at least four reasons:

- from the perspective of implementation, failure to implement legislation by provincial and district services has clearer consequences than policy,
- more effort and resources have been devoted to the promulgation and implementation of the legislation than the 1997 policy guidelines,
- sufficient attention has been given to ensuring that the legislation has been prioritised on the national health agenda for the next period, necessitating provincial attention to its implementation. In contrast, political support for and development of policy proved insufficient to counter the low priority given to mental health by provincial leadership and decision-makers;
- capacity for policy development in the mental health sector has been limited in the last few years. There has been a loss of experienced policy makers and advocates within the mental health directorate, with a lengthy period of time (2004 to 2007) taken to replenish these lost skills by appointment of suitable policy makers to the vacant positions. There has also been a paucity of senior posts to attract adequate skills and to position programme managers strategically within the departmental hierarchy to allow for effective impact on policy development and implementation. Finally, there has been inadequate attention to skills development in policy making and implementation for new and existing national and provincial mental health coordinators.

In addition to the above, the lack of widespread acceptance of the 1997 policy guidelines as official policy may be due to: (a) change over in national leadership structures with new leadership being insufficiently informed of previous developments, (b) insufficient use of formal national-provincial dissemination/communication channels to promote the policy, (c) insufficient lobbying and technical support from the national office for the implementation of the policy in the provinces, and (d) insufficient development of activism within the community, and the mental health and disability movement, to lobby for implementation of the provisions of mental health policy, a problem which to some extent is still present today.

At provincial level, legislation is driving service development, but in the absence of clear national policy (and related provincial plans and budgets),

the effect on service delivery across provinces has been uneven. Already at this early stage of legislative implementation, stated prioritisation of the implementation of the legislation at national and, to some extent, at provincial level, has not being accompanied by the resources required for successful implementation.

This is illustrated in Figure 4.1: In order for the structures set out in the Mental Health Care Act to function consistently across the provinces, there is a need for provincial plans and budgets to fund these structures. In turn, provincial plans need to be aligned to a national policy that is consistent with the legislation, and based on a thorough process of consultation with a range of stakeholders across sectors. The national policy needs to be consistent with national legislation, to give a consistent message to health planners at provincial and district levels. In the absence of national policy, many provinces are using the legislation to inform their planning (as illustrated by the arrow with the dotted lines), but without sufficient directives to inform the allocation of resources for services at provincial and district level. There is therefore an urgent need to develop and adopt a national mental health policy to guide provincal and district planning, budget allocations and service development, in keeping with the Mental Health Care Act.

Figure 4.1 The need for both mental health policy and legislation
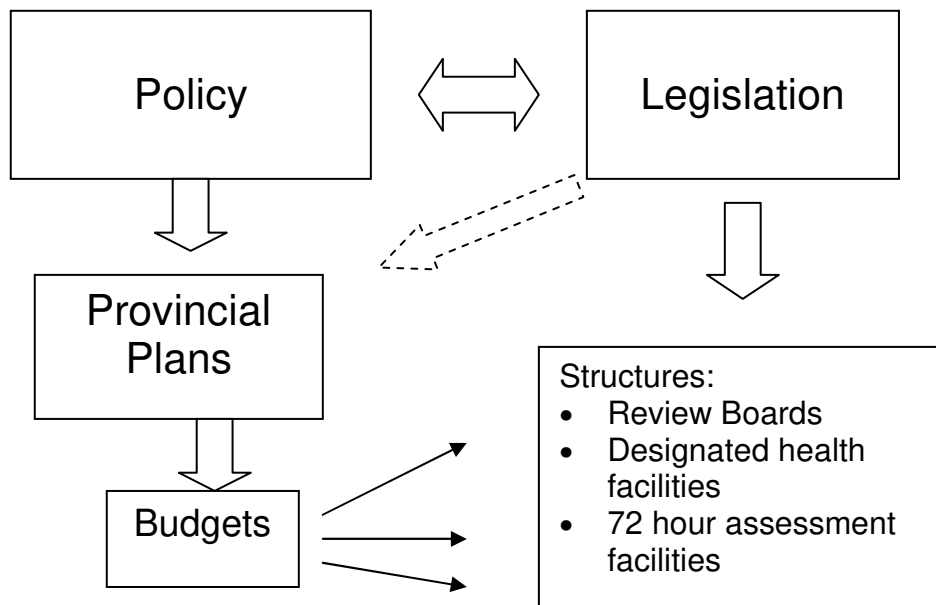
At provincial and district level, there are also varying attitudes and capacities for mental health service planning and budgeting, which exacerbate the uneven development of services at these levels. Provincial mental health coordinators frequently do not occupy senior management positions within provincial health department heirarchies. They are therefore not able to influence budgets for mental health service provision, nor does mental health enjoy "priority status" amongst the health programmes to secure sufficient

proportions of the allocated integrated budget at the district (primary health care) level to fund mental health developments in the district.

The national and provincial coordinators' roles in driving the mental health agenda go beyond the intrasectoral, health focussed role of the directorate and provincial offices, and require a wide range of skills. Other sectors who have mental health-related issues in legislation which govern their work, and in their policies, see the Department of Health as the lead department to initiate and oversee developments and discussions on these issues. Departments who have not yet articulated the mental health related aspects of their policies will also need guidance and support from the Department of Health to identify and include mental health related issues within their legislative reviews, policies and plans.

Further, within broader civil organisations and roleplayers, there are needs and expectations for:

- Support to stakeholders to engage meaningfully with the policy consultation processes,
- The policy to be based on sound evidence, and
- The policy to address a wide range of issues which require specialised legal, technical and clinical knowledge.

The National Directorate Mental Health and Substance Abuse was also called upon by respondents to:

- finalise outstanding specialized policies including the draft policies on Psychosocial Rehabilitation and the Substance Abuse, and to develop a policy on Community based mental health, and
- cost the implementation of policies and plans to promote adequate financing of the policies.

These findings indicate the need for support and capacity development for staff in the National Directorate: Mental Health and Substance Abuse, as well as Provincial Mental Health Coordinators. Skills need to be developed in:

- development of mental health policy and strategic plans,
- monitoring of policy implementation,
- interpreting research findings for policy development, and
- consultation with a range of sectors involved in mental health, such as education, social development, housing.

A range of international guidance materials have been developed by WHO, specifically for this purpose (http://www.who.int/mental_health/policy/essentialpackage1/en/index.html). The modules in this guidance package could be used for training of national and provincial mental health policy makers and planners, to address many of the issues outlined above.

4.5 Appropriateness of Mental health policy and law

In the absence of a formally recognised mental health policy a review of the 1997 mental health policy guideline was conducted using the WHO Policy Checklist (Annex 3). This review indicated that the content of the policy guidelines addresses most of the recommendations for effective policy in the Policy Checklist, and do address many of the key mental health challenges facing South Africa, as identified in the semi-structured interviews at national, provincial and district levels, and the WHO AIMS survey. These include developing community mental health services; downsizing large mental hospitals; developing a mental health component in primary health care; strengthening human resources for planning and service delivery; involvement of users and families; advocacy and promotion; human rights protection of users; equity of access to mental health services across different groups; adequate financing; quality improvement; and a monitoring system.

In addition, the WHO Policy Checklist has helped to identify key issues for attention in the development of the new mental health policy. These include:

- The mental health needs of children and adolescents,
- Gender issues,
- Intellectual disability,
- HIV/AIDS and mental health, and
- Poverty and mental health.

With respect to the content of the Mental Health Care Act (2002), a review of the Act using the WHO Legislation Checklist were also consistent with findings from the interviews: Most respondents felt that the legislation is consistent with international human rights standards. A few respondents noted that the legislation is still too focussed on mental health care for mental illness and suggested that attention is still needed for:

- the promotion of mental wellness
- the integration of a disability perspective into its provisions
- translation of human rights principles into implementation strategies,
- adequate financing of mental health, as a human rights issue
- safety and protection of users during treatment, including involuntary admissions,
- the protection of the rights of users declared incompetent and unable to consent or provide input to their treatment, and
- intersectoral links in legislative provisions.

Specific mental health issues which could more clearly be spelled out in legislation or regulations are those pertaining to the following groups:

- Children and adolescents,
- People with Intellectual Disabilities,
- People with substance use disorders, and

- Workers with mental disorders, and mental and intellectual disabilities, in particular as they relate to access to employment and income generation.

From the above, it can be seen that there is a wide range of expectations of the national and provincial Mental Heath Programmes within the Department of Health to drive legislative reform and policy development and implementation intra- and intersectorally. To meet these expectations improvement in capacity within these units will be essential to meet the demands for support in mental health policy and legislative development in the country. The WHO Mental Health Policy and Services Guidance Package would be a valuable resource for this task (http://www.who.int/mental_health/policy/essentialpackage1/en/index.html).

4.6 Mental health policy implementation at national and provincial levels

Among the most striking findings regarding policy implementation and current service provision in South Africa are the following:

1. There is wide variation between provinces in the availability of resources for mental health. This includes human resources, facilities, budgets and information on current service provision. For example:
   a. Mpumalanga spends 8% of its health budget on mental health, whereas the Northern Cape spends 1%. The proportion of the mental health budget devoted to psychiatric hospitals varies from 67% (in Gauteng) to 99% (in North West).
   b. The number of psychiatrists varies from 1 psychiatrist per 5,000,000 people (in North West) to 1 psychiatrist per 111,111 people (in the Western Cape) – a 45 fold difference. The number of psychologists varies from 1 psychologist per 1,234,567 people (in KwaZulu-Natal) to 1 psychologist per 124,843 people (in Limpopo) – a 10 fold difference.
   c. The number of beds in psychiatric inpatient units in general hospitals per 100,000 population varies from 0 in the Northern Cape and North West to 7 in Limpopo.
2. There is generally a lack of accurate routinely collected data regarding mental health service provision. For example no provinces were able to report a breakdown by gender, age or diagnosis of the mental health service users who enter any mental health facilities. This includes mental hospitals, psychiatric inpatient units in general hospitals, outpatient facilities, day treatment facilities or community residential care.
3. There is a continued dominance of psychiatric hospitals as a mode of service provision, with 23 psychiatric hospitals in the country, and 56% of beds found in psychiatric hospitals.

These findings are consistent with previous research on mental health services in South Africa (Dawes et al., 2004; Flisher et al., 1998; Lund &

Flisher, 2001; Lund & Flisher, 2002b; Lund & Flisher, 2002a; Lund et al., 2002; Lund & Flisher, 2003).

The wide variation in resources between (and within) provinces appears to be at least partially symptomatic of the lack of clear national mental health policy. Without clear imperatives from the national Department of Health, provincial Departments are free to address their own priorities, with little guidance, pressure or support to adequately prioritise mental health amongst the chosen priorities. This results in inconsistent approaches to programme development and resource allocation, inconsistent data collection and lack of standardisation of the training of primary health care staff in mental health.

As with the need to focus on implementation to address development priorities or the country as a whole, respondents felt that a national, provincial and local focus on implementation of existing legislation and policy is needed. Respondents expressed the need for technical support at national and provincial levels to assist in the translation of legislation and policy into provincial and district plans for mental health services. A major challenge for the future remains the monitoring and evaluation of provincial and district health services by the provincial and district health authorities, as well as elaboration of the the role of other sectors in implementation, such as the role of police and criminal justice system in implementing the Act.

Clearly the Mental Health Care Act has played a crucial role in beginning to address some of these difficulties. For example, the identification of certain "designated" health care facilities, and 72-hour assessment facilities in district hospitals, as well as the establishment of review boards are important developments, which could only have been brought about by a national directive with the consequences of failure to implement that are associated with legislation.

Yet this has still not sufficiently promoted the resourcing of these developments. This fact points to the limited role of legislation as a vehicle for mental health system transformation. While it can bring about changes through legislative provisions and regulations, it is not possible to legislate budgets. The Mental Health Care Act provides for "allocation within available resources," while the White Paper on Health specifies budget allocations as a provincial responsibiiltiy. The role of policy and subsequent planning in ensuring appropriate budget allocations and adequate monitoring mechanisms is therefore essential.

4.7 Mental health policy implementation at district level

4.7.1 Key Findings

With regard to serious mental disorders, the new Mental Health Care Act of 2002 appears to have facilitated the decentralization of psychopharmacological treatment of mental health care users with chronic conditions as well as procedures for emergency management of mental disorders requiring hospitalization.

At clinic level, primary health care nurses provide follow-up medication for chronic stabilized psychiatric conditions, as part of their routine service package and felt quite comfortable with this task, although the need for better referral information from the hospital was reported. There was, however, a distinct absence of any other rehabilitation programmes for these mental health care users. There were virtually no psychosocial or vocational rehabilitation programmes for the chronically mentally ill at a community level, nor was there any form of housing assistance.

With regard to emergency management of mental health care users with serious mental disorders, primary health care nurses expressed a lack of confidence, indicating that they would prefer these patients to be seen by a mental health practitioner. Stigma associated with mental illness appears to still be pervasive amongst general health care workers, stemming from a lack of understanding and fear. Further, this stigma extends to other sectors, notably the police who expressed reticence to assist in transporting psychiatric patients. Even though police in this district have specific guidelines on how to deal with psychiatric patients, fear and stigma remains pervasive. In the face of a shortage of ambulances, police transportation of psychiatric patients emerged as a major problem.

With regard to common mental health problems such as depression and anxiety, these disorders are generally not identified or treated. If they are identified, these mental health care users are treated similarly to those with more severe mental disorders requiring specialist attention. Nurses felt that they have insufficient time, training and support to deal with these problems.

There are no specialist services for child and adolescent mental health problems in the district, with children and adolescents being seen as part of the general mental health service provision. Further, children were generally only referred for externalizing disruptive problems or as a result of abuse.

With respect to mental health promotion and prevention, awareness days represent the sum total of interventions. These interventions are normally provided by the school nurses. There is a great need for evidence-based prevention and promotion programmes. School-based programmes, particularly for substance abuse as well as sexual violence were identified as a major need, as were programmes to increase parental involvement with their children.

A number of systemic issues were identified which impede the provision of a more comprehensive package of mental health services at the primary health care level.

In the first instance, given the rural nature of the site, there appears to be a general problem with recruitment and retention of professionally trained staff. This has an impact on the delivery of integrated mental health care in a number of ways:

1. While the district mental health coordinator's post was recently changed to the dedicated post of Technical Advisor for mental health, the development and co-ordination of mental health services in the district is still seriously compromised as she is required to undertake other programme coordination roles due to staff shortages resulting from unfilled posts;
2. While there has been some training of PHC nurses in mental health care and the Mental Health Care Act, the lack of a stable PHC nursing staff due to high staff turnover, required continual training of new PHC nurses which was not possible given resource constraints;
3. While there were a number of specialist psychiatric nurses, they were not utilized in specialist roles and were required to perform general nursing care as well. In addition, nurses untrained in mental health were expected to care for mental health care users; and
4. There is no psychiatrist dedicated to the district, even on a consultancy basis.

Second, while theoretically there is supposed to be a supervision and support structure in place, in practice, this does not seem to be working efficiently. In the first instance, there is a great need for a psychiatrist to be dedicated to the district, who could provide supervision with regard to psychopharmacological care in particular. Further, while the matron at the district hospital and the technical advisor for mental health are responsible for providing training, supervision and support to the PHC nurses, this did not appear to be effective given work role overload on the part of the matron and technical advisor for mental health.

Third, the budget for mental health care programmes at district level is insufficient and not clearly ring-fenced. This budget is supposed to support training of primary health care personnel in mental health care, mental health promotion and prevention programmes as well as psycho-social rehabilitation programmes. Given the extent of psycho-social problems such as substance abuse and sexual violence reported at a community level, the need for prevention and mental and behavioural health promotion programmes is thrown into sharp relief.

Fourth, there is no multi-sectoral forum for the district. A multi-sectoral forum is central to ensuring the involvement of other sectors besides health in the delivery of mental health services. This applies equally to government as well as non-government sectors. Traditional healers, for example, play a large role in the care of mental health problems at the community level in this district, with the majority of users indicating that they had used both systems of health care either simultaneously or sequentially. Collaboration around patient care and treatment between the two healing system is, however, non-existent. Schools can also play a large role in the delivery of mental health services for children and adolescents but these services are distinctly absent in the educational sector.

Fifth, there is no mental health plan for the district. A district mental health plan is essential to ensuring treatment and referral pathways, multisectoral

links, mental health programmes as well as maximum and efficient utilization of mental health resources.

4.7.2 Implications and Recommendations for district level developments

The results of the situational analysis supports the assertion made by Flisher, Lund & Muller (1998) that the focus of district mental health care in South Africa appears to be on the psychopharmacological management of chronic stabilized mental conditions as well as the emergency management of new conditions (Flisher et al., 1998). Further, this focus appears to be driven by the Mental Health Care Act, which stipulates legislative requirements with respect to measurable indicators such as availability of medicines and beds at district level. The district appears to have fared quite well in relation to meeting these legislative requirements. The number of dedicated psychiatric beds within the general district hospitals are generally reflective of the national average which is estimated by the WHO to be 3.8 per 100 000 population (WHO, 2005a). Per 100 000 population, the district as a whole has 4.4 dedicated psychiatric beds and the sub-district 3.3 dedicated psychiatric beds per 100 000.

De-institutionalization and integration of mental health into primary health care, however, goes beyond emergency management and ongoing psychopharmacological care of mental health care users It requires psychosocial rehabilitation for those with chronic conditions, access to care by service users with common mental disorders, as well as mental health promotion and prevention interventions at community level.

In the face of the large number of people requiring mental health care, and the lack of mental health specialists, especially in rural areas, as well as policy shifts towards the integration of mental health into primary health care, psychiatrists and psychologists would be more efficiently used in supervisory and consultant liaison roles to primary health care workers. The same applies to psychiatric nurses, with the situational analysis in the target district revealing a ratio of psychiatric nurses per population of 4 per 100 000 population which is lower than the national average of 7.5 per 100 000 (WHO, 2005a). These scarce mental health human resources are used mainly for the provision of general health care and could be more efficiently used in specialist training and supervisory roles to generalist health care workers at the primary health care and community levels of care.

In the context of South Africa being a medium resourced country and drawing on lessons and evidence from previous research on the integration of mental health into primary health care, we propose a framework for mental health services at district level for the South African context, using the target district as an exemplar. This framework, depicted in Figure 4.2, is similar to previous frameworks in its demands for greater equity and efficient use of existing mental health resources, but differs in that it proposes the incorporation of additional categories of lower level mental health workers.

Figure 4.2 Proposed Framework for District Mental Health Services

Role	Level of Care
Specialised treatment Acute inpatient Care Long-term inpatient care Outpatient Care Support to Regional Hospitals Alcohol & drug rehablitation Community Outreach	**Tertiary Specialist Services** Psychiatrist, Medical Officer, Psychologist, Social Worker, Psychiatric Nurse, Occupational Therapist
Short-term acute inpatient care Outpatient Care Support to district hospital Consultation liaison psychiatry Community Outreach	**Regional Hospital** Psychiatrist, Medical Officer, Psychiatric Nurses, Psychologist, Social Workers, Occupational Therapists
Assesment and Admissions 72 hr hospital admissions Outpatient Care Training, support & supervision of PHC personnel & counsellors Programme Initiation & coordination	**District Hospital** (specialist MH team) Psychiatrist (PT), Medical Officer, Psychiatric Nurses, Psychologist, Social Workers, Occupational Therapists
Identification Management of CMD & chronic conditions Referral Support & supervision to community	**Primary Health Clinics** PHC Nurse Psychological Counsellor
Psycho-social rehabilitation Psychoeducation Prevention & promotion programmes (School & community) Poverty Alleviation Programmes Identification & referral of MH probs	**Community** MH Assistants, Traditional Healers, Police, Spiritual Leaders, Social Workers, Community Health Workers, Private Practice GPs, CBOs/NGOs/DPOs, teachers

Proposed framework for district mental health services

At the district hospital level, the proposed framework is similar to previous frameworks in relation to proposed human resources as well as their functions (Mkhize et al., 2004; Petersen et al., 2000; Robertson et al., 1997). In this regard, specialist mental health resources are understood to include a consultant psychiatrist at district hospital level, notably absent in the target site

of the situational analysis. Given that the country has an estimated 0.28 psychiatrists per 100 000 population in South Africa in the public sector alone, and given that the district has over 500 000 people, efforts should at least be made to ensure the services of a consultant psychiatrist to the district. National level policies requiring psychiatrists in private practice to spend a percentage of their time consulting for government health services may assist in facilitating greater equity in access to psychiatrists.

Further, a clinical psychologist post is recommended at district level as in previous plans. Through the creation of community service posts, many districts now have access to psychological services. These posts are however, not permanent, with recently qualified clinical psychologists having to spend one year, often without supervision, in one of these posts before being able to register as a clinical psychologist with the Health Professions Council of South Africa. This lack of supervision and continuity creates a problem for the quality and delivery of ongoing sustainable mental health programmes. The need for permanent posts at district level, as has been recently accomplished in the target district, is highlighted.

Further, as with previous plans, specialist mental health practitioners including psychiatric nurses at district hospital level are understood to be most effectively used in referral, training and support roles to primary health care level. The situational analysis suggests, however, that psychiatric nurses, in particular, were not optimally utilized in these roles in this district as they are used as stop gaps for shortages in general nursing care. Efforts to ensure recruitment and retention of staff are crucial to reducing this problem. Integration of mental health into primary health care is unlikely to succeed if insufficient support is provided as was evidenced in the situational analysis, where PHC nurses complained of a lack of support for the treatment of mental health care users. Further, using psychiatric nurses in specialist mental health roles would also allow them to pay greater attention to working with other mental health practitioners such as occupational therapists and social workers to develop community based rehabilitation programmes for service users with disabling mental disorders , which are integral to de-institutionalization and recovery.

At the primary health care clinic level, the proposed plan deviates, however, from previous plans. A basic assumption underlying previous plans that have been proposed, (Mkhize et al., 2004; Petersen et al., 2000) has been that PHC nurses would be primary resources for the delivery of primary mental health care. While the situational analysis reveals that this is feasible for the delivery of psychopharmacological care for chronic mental conditions, this does not appear to be the case for emergency management of serious mental health problems, nor for the management of common mental health problems. It is suggested that the former can be addressed through improved and refresher training programmes in psychiatry for primary health care nurses. This should help to reduce stigma, as well as ensuring greater support and supervision from trained psychiatric nurses, as suggested in the proposed plan.

Effective management of common mental health problems is, however, more difficult to achieve with the existing resources. Previous research suggests that without a dramatic drop in service user numbers; a complete reorientation of nurse training, which remains largely biomedical in focus, towards holistic care; and restructuring of the entire health care system to accommodate this form of care, this notion is unlikely to become a reality (Freeman & Pillay, 1997; Petersen, 2000). These problems are not unlike those encountered in other low to middle income countries in their attempts to integrate mental health into primary health care, where primary health care workers are overburdened with multiple tasks and large service user numbers. Added to this is the common problem of insufficient training, supervision and support which together leads to either neglect or inappropriate management of mental health problems (Saraceno et al., 2007).

Further, a recent review of efficacious treatments for depression at primary health care level in low and middle income countries revealed that group therapy, anti-depressants and cognitive behavioural therapy for mild depression showed the most promise (Patel et al., 2007a). None of these interventions, all of which require specialist training, fall within the current scope of practice of primary health care nurses.

In the face of this evidence, and with a recent call for a new group of health worker to detect and deliver psychosocial interventions in low to middle income countries to be considered (Patel et al., 2007b) we would suggest that South Africa, being a middle-income country, can afford to create posts for 'psychological counsellors' at primary health care level who could provide the necessary services to fill the treatment gap for common mental disorders. The category of 'psychological counsellor' was introduced as part of the professional practice framework for Psychology in South Africa in 2001. The introduction of this category of psychological professional, also introduced in other parts of the world like Australia, was in response to the unmet need for psychological services in South Africa against a backdrop of a paucity of psychologists and the expense entailed in their training (Petersen, 2004). South African universities have been training psychological counselors, who have a 4 year Bachelors degree in South Africa for the past 6-7 years and would be equivalent to the post level of a social worker in the health system.

At the community level, the proposed plan also deviates from previous plans in that it includes the new category of mental health worker, that of 'mental health assistant' that has been proposed by the South African Health Ministry. This category of worker would have a two year diploma level training and have a similar status to other community level rehabilitation assistants such as occupational therapy assistants. The introduction of this category of worker has been criticized by the psychological profession on the grounds that it is being introduced in the absence of a clear scope of practice, clear referral pathways and absence of support and supervision structures. In this regard, evidence suggests that mental health service work undertaken by low level workers can have good outcomes, but only in the context of adequate training and close supervision and support (Swartz, 1998). As is illustrated by the situational analysis of mental health services in this one district of South

Africa, the existing mental health specialists do not have sufficient time to provide the supervision and support that is required at the primary health care level, let alone to take on this responsibility in relation to mental health workers at the community level.

Having psychological counselors at primary health care level would, however, render the introduction of this category of worker far more feasible as they would be well placed to take on this support and supervision role of mental health assistants at the community level. Further, their presence would facilitate a clear referral pathway for people identified as having common mental health problems at the community level and enable the scope of practice of 'mental health assistants' to be delimited to community level mental health activities. As indicated in the proposed plan these would include prevention, promotion and psychosocial rehabilitation as well as the identification and referral of mental health problems. Previous research suggests that low level workers can be effectively used in the implementation of such interventions (Patel et al., 2007b).

In addition to 'mental health assistants', as indicated in Figure 4.2, the community level incorporates a range of other stakeholders in mental health care as has been suggested by other district level mental health plans. Given this, a multisectoral approach to mental health service provision at the community level is imperative to facilitate coordinated care.

In relation to the functions envisaged for the community level of care, in the first instance, *identification and referral* of people with mental health problems can occur from many different sectors. Community health workers, for example, have been successfully trained to identify and refer people with mental health problems (Petersen & Pillay, 1997). Schools are important access points to mental health services for children and adolescents. While children and adolescents comprise approximately 50% of the population in South Africa, as the situational analysis showed there are no dedicated services for this population in the district. The early identification and referral of children with developmental disabilities such as intellectual disability, autism and attention deficit hyperactivity disorder by teachers could play an important role in secondary prevention of these mental disorders. Further, traditional healers play an important role in mental health care at community level, with mental health care users indicating that they used both systems of care. There is, however, no collaboration between the two systems on the care and treatment of mental health care users. The need for referral pathways to facilitate collaborative care for these users is thrown into sharp relief.

A second function of community-based mental heath services is *community-based rehabilitation* of users with disabling mental disorders. This also demands a multisectoral response, drawing on a range of services from multiple sectors, including health, social welfare and housing. While antipsychotic medication is fundamental to the treatment of schizophrenia, a review of intervention studies for the treatment of psychotic disorders in low and middle income countries suggests that psychosocial rehabilitation aimed

at improved treatment adherence, strengthening social integration and reducing stigma and discrimination is an important aspect of community-based care which has been shown to improve clinical and social outcomes for these patients (Patel et al., 2007a). A truly multisectoral approach to community-based rehabilitation is thus required which includes vocational skills development, psycho-social support and psycho-education of families and community members as well as facilitating access to employment or grants and housing.

Further, community-based rehabilitation programmes have been successfully applied using local resources. In India, a community based rehabilitation programme for people with chronic schizophrenia using the mental health care users , families and local community members trained as rehabilitation workers demonstrated improved clinical and disability outcomes for participants on the programme compared to service users receiving outpatient care alone (Chatterjee et al., 2003). Given the lack of any such programmes in the situational analysis of the target district it is imperative that such programmes be initiated at community level within districts, using local resources. The proposed category of 'mental health assistants' as well as existing community (health) workers could be trained to assist with such programmes under the supervision of mental health team including psychiatric nurses, occupational therapists and social workers based at the district hospital.

Third, mental health *promotion and prevention* are also important aspects of community mental health services at district level, and also span multiple sectors. Schools, for instance, are important points of intervention for such programmes, as are clinics. There is mounting evidence from high income countries of the effectiveness of prevention trials targeting depressive symptoms, alcohol and drug abuse, child abuse and aggressive behaviour (Patel et al., 2007a). While there is a paucity of prevention trials in low to middle income countries, there is emerging evidence that promotion and prevention programmes, when adapted for cultural contexts have universal effects (Patel et al., 2007a).

The need for prevention and promotion programmes for children in low and middle income countries is particularly great given evidence that the cognitive development of more than 200 million children under the age of 5 years living in developing countries is impaired as a result of poverty associated poor health, nutrition and inadequate care. Children coming from low socio-economic backgrounds consistently show developmental deficits in social emotional development and educational and cognitive attainment compared to children from higher socio-economic backgrounds (Grantham-McGregor et al., 2007). As these children grow up, impaired cognitive and social emotional development traps them in a negative cycle of poor educational achievement and reduced productivity and wage earning potential which is transmitted to the next generation (Grantham-McGregor et al., 2007). In the face of this evidence, there are efficacy trials which have shown that nutritional interventions to improve the diet of at-risk pregnant women, reducing iron and iodine deficiencies in infants and early stimulation programmes have long

term positive impacts on cognitive and social emotional developmental outcomes (Engle et al., 2007).

Adolescents are also a particularly vulnerable group, particularly with respect to risk for substance abuse and suicide. Suicide is reported to be a leading cause of death among young people in low and middle income countries (Prince et al., 2007). In South Africa, suicide is reported to be among the top 5 causes of death amongst youth (Schlebusch, 2005). While prevention trials for such problems are scarce in low and middle income countries, school-based programmes for substance abuse in high income countries have been found to be effective (Tobler & Stratton, 1997) as have suicide prevention programmes (Aseltine et al., 2007).

While mental and behavioural health promotion and prevention programmes would necessarily need to be initiated, coordinated and supervised by mental health specialists within the district mental health system, such as psychologists and psychological counsellors, mental health assistants and teachers would be important resources to assist in the implementation of these programmes at the community level.

4.7.3 Conclusion: district level

Driven by the Mental Health Care Act of 2002, it would appear that the focus of decentralization and integration of mental health care into primary health care in South Africa at the district level remains on the emergency management and ongoing psychopharmacological care of patients with chronic stabilized mental disorders. While this is an understandable starting point, South Africa, 13 years into its democracy, should now strive towards increasing coverage and access of mental health care to all who need it. Decentralized psychopharmacological management of people with chronic mental health problems needs to be accompanied by community-based rehabilitation programmes for de-institionalisation to be successful. Shifting the burden of psychosocial care for these mental health care users to the community without supportive programmes is irresponsible and could result in the violation of human rights.

Further, South Africa has a high number of people with common mental disorder (16.5%) (Williams et al., 2007), the majority of whom do not receive any treatment. Williams et al., (in press) found that 3 out of 4 people having a common mental disorder over the last 12 months did not receive any care for their disorder. Besides a moral obligation, the economic cost of common mental disorders such as depression to individuals in low to middle income countries (Patel et al., 2007b) needs to be considered as does the impact on the health care system and economy.

Moreover, South Africa has made virtually no investment in mental health promotion and prevention. The evidence of the effectiveness of such programmes, particularly with children and adolescents, to prevent cognitive and socio-emotional impairment as well as behavioural problems which trap them in a cycle of poverty as they enter adulthood is compelling. The role of

such programmes in achieving the millennium development goals should not be overlooked (Miranda & Patel, 2005).

The existing overstretched resources within most districts are unlikely to ever be able to accommodate the expanded focus of integrated mental health care being proposed. In order to achieve the vision of a more comprehensive approach to integrated mental health care expected of a middle income country like South Africa, existing resources need to be used more efficiently. This includes the creation of additional posts within the health care system for lower level mental health practitioners such as psychological counselors who have been trained for some years in South Africa, but for whom no posts exist within the health care system.

4.8 Research

Although there is a wide range of research into mental health in South Africa, the volume of work is small, and mental health research remains poorly prioritised and funded, with little coordination of research outputs to inform developments in the public domain, despite the identification of mental health related research as essential research by the White Paper for Health (Department of Health, 1997).

A clearly defined agenda for public mental health research is needed, to promote uptake of research and to support the generation of funds for this research in the country. Though additional development of capacity for mental health research in the country is needed, there are already opportunities to use available research expertise to improve capacity. Collaboration between researchers and public policy makers should be improved to make sure that needed evidence is generated and that the available research is used to inform policy development and implementation.

4.9 Limitations of the study

There are several limitations to the study:

1. The purposive sampling and limited time and resources meant that we were not able to interview a wider range of stakeholders. This may have limited diversity in the opinions we solicited.
2. For the WHO-AIMS, we were not able to gather data for all items, partly because these data were not routinely collected, and partly because our limited resources curtailed the extent to which we were able to visit all provinces and districts to obtain data. The quality of the data from the WHO-AIMS instrument was also limited at times, as noted in specific situations where this is relevant in the Results, Section 3.6.

5. Conclusion and Recommendations

Thirteen years after the election of the first democratic government in South Africa, steady progress has been made with regard to overall legislative and policy reform. Respondents to this study echoed a strong current theme in public discourse in South Africa today, namely the need for government to step up implementation of the legislation developed in the past decade, and to translate policy into service delivery aimed at addressing key developmental priorities such as poverty, unemployment and job creation, social supports, HIV/AIDS, and crime and violence. These social, political, economic and implementation issues are equally relevant to mental health, but there is insufficient inclusion of mental health in the national transformation agenda of the country, and inadequate inclusion of people with mental disability into strategies already underway to address these development priorities.

5.1 Strengths and Weaknesses of the Mental Health System in South Africa

There are several strengths in the South African mental health system. There has recently been a reform in the mental health legislation, with the promulgation of the Mental Health Care Act (2002), which is in keeping with international human rights standards. Many of the reforms currently being implemented in the country, such as the introduction of Mental Health Review Boards, introduction or expansion of inpatient services offered from general hospitals, and the establishment of 72 hour assessment facilities in district level general hospitals, appear to be driven by the new Mental Health Care Act. Compared to many other African countries, South Africa has relatively well resourced mental health services, including human resources, facilities and available psychotropic medications.

In spite of these strengths, there remain several weaknesses in the current system:

1. There is currently no officially endorsed mental health policy, which provides the vision and overall national leadership for developing the mental health system. The result is that many of the inequalities between provinces (some of which have their origins in apartheid divisions) are not being adequately addressed.
2. Related to this problem there is a lack of nationally agreed indicators for mental health information systems, with the result that information on current service resources (budgets, staff, facilities) and provision (admissions, outpatient visits) is extremely sparse. If data are collected they are seldom made available for planning, and if they are made available, they are seldom reported on systematically.
3. In general, mental health services continue to labour under the legacy of colonial mental health systems, with heavy reliance on mental hospitals. There are 23 mental hospitals in the country, and 56% of mental health beds are located in these facilities. This is an outdated

form of care, which is vulnerable to human rights abuses and stigmatisation of service users (Lucas & Stevenson, 2006). There is an urgent need to increase the rate and quality of inpatient mental health care being developed at regional and district general hospitals and to develop community-based mental health services (which include community-based residential care, day services and outpatient services), in keeping with international best practice.

4. There is also an urgent need for mental health training of general health staff and public sector staff in a range of other sectors (such as education, social development, criminal justice, housing and labour). Evidence from this report indicates that while some training does occur, it is frequently not monitored and evaluated, and where training of PHC staff takes place, it is not supported by ongoing supervision and the establishment of referral pathways to and from specialist mental health care. There is currently a lack of clinical protocols at PHC level and standardised mental health training for health care providers.

5. There is some evidence of the establishment of consumer and family associations, often with the support of NGOs, such as the SA Federation for Mental Health, but the role of these associations in the formulation of policy and planning of services is limited.

5.2 Recommendations to strengthen the mental health system and promote mental health in South Africa

Recommendations to strengthen the mental health system and promote mental health follow logically from the weaknesses identified above.

5.2.1 Strengthening the mental health system

In order to strengthen the mental health system, the following steps need to be taken:

1. Develop a national mental health policy, through a thorough process of consultation and consensus building with a range of stakeholders throughout the country. Guidelines for the development of such a policy are available from WHO.
2. Develop provincial strategic plans for mental health, in keeping with national policy, which outline specific strategies, targets, timelines, budgets and indicators.
3. Develop a national mental health information system, integrated with the district health management information system, based on a set of nationally agreed indicators and a minimum data set.
4. Develop guidelines for safe and effective mental health services within regional and district hospitals.
5. Build community mental health services that include three core components:
   a. Community residential care
   b. Day services
   c. Outpatient services (combining general health outpatient services in PHC and specialist mental health support)

These community mental health services need to be developed before further downscaling of mental hospitals can proceed.

6. At district level:
   a. Conduct and evaluate mental health training programmes for general health staff at PHC level.
   b. Develop specialist mental health teams to support PHC staff.
   c. Develop clinical protocols for assessment and interventions at PHC level.
   d. Strengthen the role of consumer and family associations in policy development and implementation, as well as the planning and monitoring of services.
   e. Develop mechanisms for intersectoral collaboration between a range of sectors involved in mental health.
7. Increase the capacity of local government, civil society and community resources to partner with government to shape and assist with implementation of policies at local level.
8. Develop a national mental health research agenda, based on identified priority areas.

To enable many of these recommendations, it is essential to train and build capacity for staff in the national Directorate: Mental Health and Substance Abuse, and the provincial mental health coordinators in policy development, planning, service monitoring and interpretation of research findings.

5.2.2 Promoting mental health

Four strategies are suggested:

1. Lobbying for political support for mental health on the public agenda. The importance and place of mental health within the broader disability agenda, and within other development priorities and public concerns should be better articulated. Mental health related policy makers and implementers, lobbyists and other stakeholders would benefit from skills development in mobilising political interest in mental health.
2. Public education, exposure to positive images of mental health advocates, prominent user role models and well-known and influential champions for mental health should be used to change discriminatory attitudes toward mental disability. This work should be framed within the provisions of the UN Convention of the Rights of Disabled Persons and the human rights based framework of South African law. The development and distribution of advocacy strategies and media guidelines could support this work. The WHO has produced an advocacy guideline which could inform this work.
3. The poverty-mental health link needs to be included on the policy agenda. The mechanisms of interaction and potential strategies to address the poverty-mental health link should be brought to the attention of policy developers and implementers to promote the integration of this focus area into policies and programmes of all sectors involved in poverty alleviation and community upliftment. This requires evidence-based support to promote recovery and inclusion of people with mental disability in general community life, such as access to:

- education and skills development,
- income generation opportunities for users, and reasonable accommodation provisions in the workplace,
- social insurance where income generating work is not possible for the user,
- housing support and
- transport

This work can assist politicians and departmental policy makers to identify gaps in policies which may still exclude people with mental disability as potential beneficiaries, and to suggest appropriate mechanisms for ensuring that they are able to access resources on par with other citizens.

4. The development of a mental health user lobby for public participation in mental health issues. Emphasis should be placed on ensuring representation of people with mental disability on the broader disability agenda, and developing capacity to place mental health user concerns on the political, development and public health agenda.

6. References

Abas, M. & Broadhead, J. (1997). Depression and anxiety among women in an urban setting in Zimbabwe. *Psychological Medicine, 27,* 59-71.

Ahmed, S., Chowdhury, M., & Bhuiya, A. (2001). Micro-credit and emotional well-being: Experience of poor rural women from Matlab, Bangladesh. *World Development, 29,* 1957-1966.

Araya, R., Lewis, G., Rojas, G., & Fritsch, R. (2003). Education and income: which is more important for mental health? *Journal Of Epidemiology And Community Health, 57,* 501-505.

Araya, R., Rojas, G., Fritsch, R., Acuna, J., & Lewis, G. (2001). Common mental disorders in Santiago, Chile: prevalence and socio- demographic correlates. *British Journal of Psychiatry, 178,* 228-233.

Aseltine, R. H., James, A., Schilling, E., & Glanovsky, J. (2007). Evaluating the SOS suicide prevention programme: A replication and extension. *BMC Public Health, 7,* 161.

Bhorat, H. & Kanbur, R. (2005). Poverty and Well-being in Post-Apartheid South Africa:An Overview of Data, Outcomes and Policy. 05[101]. Development Policy Research Unit. Working Papers.
Ref Type: Serial (Book,Monograph)

Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K. F., Wickramaratne, P. et al. (2003). Group Interpersonal Psychotherapy for Depression in Rural Uganda: A Randomized Controlled Trial. *JAMA: The Journal Of The American Medical Association, 289,* 3117-3124.

Booysen, S. & Erasmus, E. (2001). Public Policy- making. In A.Venter (Ed.), *Government and politics in the new South Africa* (pp. 233-275). Pretoria: Van Schaik.

Bradshaw, D., Norman, R., & Schneider, M. (2007). A clarion call for action based on refined DALY estimates for South Africa. Editorial. *South African Medical Journal, 97,* 438-440.

Case, A. (2004). Does Money Protect Health Status?Evidence from South African Pensions. In D.Wise (Ed.), *Perspectives on the Economics of Aging* (pp. 287-305). Chicago: University of Chicago Press.

Chatterjee, S., Patel, V., Chatterjee, A., & Weiss, H. (2003). Evaluation of a community based rehabilitation model for chronic schizophrenia in a rural region of India. *British Journal of Psychiatry, 182,* 57-62.

Collins, P. Y., Holman, A. R., Freeman, M., & Patel, V. (2006). What is the relevance of mental health to HIV/AIDS care and treatment programs in developing countries? A systematic review. *AIDS, 20,* 1571-1582.

Dawes, A., Lund, C., Kafaar, Z., Brandt, R., & Flisher, A. J. (2004). *Norms for South African Child and Adolescent Mental Health Services: Report for the Directorate Mental Health and Substance Abuse – National Department of Health (Tender No. DOH 48/2003-2004).* Cape Town: Human Sciences Research Council.

Department of Health (1997a). *National health policy guidelines for improved mental health in South Africa* Pretoria: Department of Health.

Department of Health (1997b). *White paper for the transformation of the health system in South Africa.* Pretoria: Government Gazette.

Engle, P. L., Black, M. M., Behrman, J. R., Cabral de Mello, M., Gertler, P. J., Kapiriri, L. et al. (2007). Strategies to avoid loss of developmental potential in more than 200 million children in the developing world. *Lancet, 369,* 229-242.

Fleitlich, B. & Goodman, R. (2001). Social factors associated with child mental health problems in Brazil: cross sectional survey. *BMJ: British Medical Journal, 323,* 599.

Flisher, A. J., Lund, C., Funk, M., Banda, M., Bhana, A., Doku, V. et al. (2007). Mental health policy development and implementation in four African countries. *Journal of Health Psychology, 12,* 505-516.

Flisher, A. J., Lund, C., Muller, L., Dartnall, E., Ensink, K., Lee, T. et al. (1998). *Norms and standards for psychiatric care in South Africa: A report submitted to the Department of Health, Republic of South Africa (Tender No. GES 105/96-97)* Cape Town: Dept of Psychiatry, University of Cape Town.

Flisher, A. J., Riccitelli, G., Jhetam, N., & Robertson, B. A. (1997). A survey of professional activities of psychiatrists in South Africa. *Psychiatric Services, 48,* 707-709.

Freeman, M. (2004). HIV/AIDS in developing countries: heading towards a mental health and consequent social disaster? *South African Journal of Psychology, 34,* 139-159.

Freeman, M. & Pillay, Y. (1997). Mental health policy - plans and funding. In D.Foster, M. Freeman, & Y. Pillay (Eds.), *Mental health policy issues for South Africa* (Cape Town: MASA.

Geller, J. L. (2000). The last half-century of psychiatric services as reflected in Psychiatric Services. *Psychiatric Services, 51,* 41-67.

Grantham-McGregor, S. M., Cheung, Y. N., Cueto, S., Glewwe, P., Richter, L., & Strupp, B. (2007). Developmental potential in the first 5 years for children in developing countries. *Lancet, 369,* 60-70.

Harpham, T., Grant, E., & Rodriguez, C. (2004). Mental health and social capital in Cali, Colombia. *Social Science & Medicine, 58,* 2267-2277.

Harpham, T., Snoxell, S., Grant, E., & Rodriguez, C. (2005). Common mental disorders in a young urban population in Colombia. *The British Journal Of Psychiatry: The Journal Of Mental Science, 187,* 161-167.

Inandi, T., Elci, O. C., Ozturk, A., Egri, M., Polat, A., & Sahin, T. K. (2002). Risk factors for depression in postnatal first year, in eastern Turkey. *International Journal Of Epidemiology, 31,* 1201-1207.

Jacob, K. S., Sharan, P., Mirza, I., Garrido-Cumbrera, M., Seedat, S., Mari, J. J. et al. (2007). Mental health systems in countries: where are we now? *The Lancet, 370,* 1061-1077.

Kaminer, D., Stein, D. J., Mbanga, I., & Zungu-Dirwayi, N. (2001). The Truth and Reconciliation Commission in South Africa: relation to psychiatric status and forgiveness among survivors of human rights abuses. *British Journal of Psychiatry, 178,* 373-377.

Kleintjes, S., Flisher, A., Fick, M., Railon, A., Lund, C., Molteno, C. et al. (2006). The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa. *South African Psychiatric Review, 9,* 157-160.

Knapp, M., Funk, M., Curran, C., Prince, M., Grigg, M., & McDaid, D. (2006). Economic barriers to better mental health practice and policy. *Health Policy Plan., 21,* 157-170.

Lopez, D. A., Mathers, D. C., Ezzati, M., Jamison, T. D., & Murray, J. L. C. (2006). *Global Burden of Disease and Risk Factors*. New York: Oxford University Press and The World Bank.

Lucas, M. & Stevenson, D. (2006). Violence and abuse in psychiatric in-patient institutions: a South African perspective. *Int J.Law Psychiatry, 29,* 195-203.

Lund, C., Breen, A., Flisher, A. J., Swartz, L., Joska, J., Corrigall, J. et al. (2007a). Mental health and poverty: a systematic review of the research in low and middle income countries. *The Journal of Mental Health Policy and Economics, 10, Supplement 1,* S26-S27.

Lund, C. & Flisher, A. J. (2001). South African mental health process indicators. *Journal of Mental Health Policy and Economics, 4,* 9-16.

Lund, C. & Flisher, A. J. (2002a). Staff/bed and staff/patient ratios in South African public sector mental health services. *South African Medical Journal, 92,* 157-161.

Lund, C. & Flisher, A. J. (2002b). Staff/population ratios in South African public sector mental health services. *South African Medical Journal, 92,* 161-164.

Lund, C. & Flisher, A. J. (2003). Community/hospital indicators in South African public sector mental health services. *The Journal of Mental Health Policy and Economics, 6,* 181-187.

Lund, C. & Flisher, A. J. (2006). Norms for mental health services in South Africa. *Social Psychiatry and Psychiatric Epidemiology, 41,* 587-594.

Lund, C., Flisher, A. J., Lee, T., & Porteus, K. A. (2002). Bed/population ratios in South African public sector mental health services. *Social Psychiatry and Psychiatric Epidemiology, 37,* 346-349.

Lund, C., Stein, D. J., Flisher, A. J., & Mehtar, S. (2007b). Challenges faced by South African health services in implementing the Mental Health Care Act. Editorial. *South African Medical Journal, 97,* 352-353.

Miranda, J. J. & Patel, V. (2005). Achieving the Millennium Development Goals: Does Mental Health Play a Role? Plos Medicine [On-line]. Available: www.plosmedicine.org

Mkhize, D., Green-Thompson, R. W., Ramdass, P., Mhlaluka, G., Dlamini, N., & Walker, J. (2004). Mental health services in KwaZulu-Natal. *South African Journal of Psychiatry, 10,* 8-13.

Patel, V. (2001). Poverty, inequality, and mental health in developing countries. In D.A.Leon & G.Walt (Eds.), *Poverty, inequality and health: An international perspective* (pp. 247-262). Oxford: Oxford University Press.

Patel, V. & Kleinman, A. (2003). Poverty and common mental disorders in developing countries. Bulletin of the World Health Organization 81, 609.
Ref Type: Generic

Patel, V., Todd, C., Winston, M., Gwanzura, F., Simunyu, E., Acuda, W. et al. (1997). Common mental disorders in primary care in Harare, Zimbabwe: associations and risk factors. *The British Journal of Psychiatry, 171,* 60-64.

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M. et al. (2007a). Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet, 370,* 991-1005.

Patel, V., Chisholm, D., Kirkwood, B. R., & Mabey, D. (2007b). Prioritising health problems in women in developing countries: comparing the financial burden of reproductive tract infections, anaemia and depressive disorders in a community survey in India. *Tropical Medicine & International Health, 12,* 130-139.

Patel, V., Chisholm, D., Rabe-Hesketh, S., Dias-Saxena, F., Andrew, G., & Mann, A. (2003). The efficacy and cost-effectiveness of a drug and psychological treatment for common mental disorders in general health care in Goa, India: a randomised controlled trial. *Lancet, 361,* 33-39.

Patel, Vikram, Araya, Ricardo, and Bolton, Paul (2004, May). Editorial: Treating depression in the developing world. *Tropical Medicine & International Health*.

Petersen, I. (2000). Comprehensive integrated primary mental health care for South Africa. Pipedream or possibility? *Soc.Sci.Med., 51,* 321-334.

Petersen, I. (2004). Addressing the need for psychological services at the primary level of care in South Africa. Can a new psychological professional fill the gap? *Health Policy And Planning, 19,* 33-40.

Petersen, I., Bhagwanjee, A., & Parekh, A. (2000). From policy to praxis. A framework for the delivery of district mental health care for KwaZulu-Natal. *South African Medical Journal, 90,* 798-804.

Petersen, I. & Pillay, Y. (1997). Facilitating community mental health care in South Africa - the role of community health workers in the referral system. *South African Medical Journal, 87,* 1621-1626.

Pickett, K. E., James, O. W., & Wilkinson, R. G. (2006). Income inequality and the prevalence of mental illness: a preliminary international analysis. *Journal Of Epidemiology And Community Health, 60,* 646-647.

Plagerson, S., De Silva, M., Harpham, T., & Patel, V. (2007). Can cash transfers and loans to the poor alleviate the global burden of common mental disorders? *Bulletin of the World Health Organisation, in press*.

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R. et al. (2007). No health without mental health - a slogan with substance. *Lancet, 370,* 859-877.

Reichenheim, M. E. & Harpham, T. (1991). Maternal mental health in a squatter settlement in Rio de Janeiro. *The British Journal Of Psychiatry: The Journal Of Mental Science, 159,* 683-690.

Ritchie, J. & Spencer, L. (1994). Qualitative data analysis for applied policy research. In Bryman & Burgess (Eds.), *Analysing qualitative data* (pp. 173-194). London: Routledge.

Robertson, B. A., Zwi, R., Ensink, K., Malcolm, C., Milligan, P., Moutinho, D. et al. (1997). Psychiatric service provision. In D.Foster, M. Freeman, & Y. Pillay (Eds.), *Mental health policy issues for South Africa* (pp. 69-93). Cape Town: Medical Association of South Africa.

Saraceno, B., Levav, I., & Kohn, R. (2005). The public mental health significance of research on socio-economic factors in schizophrenia and major depression. *World Psychiatry, 4,* 181-185.

Saraceno, B., Van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J. et al. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *The Lancet, 370,* 1164-1174.

Schlebusch, L. (2005). Risk factors in repeat non-fatal suicidal behaviour. *South African Journal of Psychiatry, 11,* 72-74.

Seedat, S., Nyamai, C., Njenga, F., Vythilingum, B., & Stein, D. (2004). Trauma exposure and post-traumatic stress symptoms in urban African schools. Survey in CapeTown and Nairobi. *British Journal of Psychiatry, 184,* 169-175.

Siskind, D., Bolton, P., & Kim, J. (2007). Country contextualization of cost-effectiveness analysis of treatments for depression in Chile and Uganda using a Markov model. *Journal of Mental Health Policy and Economics, 10,* S40-S41.

Stein, D., Seedat, S., & Emsley, R. (2002). Violence in the world and in South Africa: What is a doctor to do? *South African Medical Journal, 92,* 789-790.

Stein, D. J. (1998). Psychiatric aspects of the truth and reconciliation commission in South Africa. *British Journal of Psychiatry, 173,* 455-457.

Swartz, L. (1998). *Culture and mental health: a southern African view*. Cape Town: Oxford University Press.

Thornicroft, G. (2006). *Shunned: Discrimination against people with mental illness*. London: Oxford University Press.

Thornicroft, G. & Tansella, M. (1999). *The mental health matrix: a manual to improve services*. Cambridge: Cambridge University Press.

Tobler, N. S. & Stratton, H. H. (1997). Effectiveness of school-based drug prevention programmes: a meta-analysis of the research. *Journal of Primary Prevention, 18,* 71-128.

Truth and Reconciliation Commission (2000). *Report of the Truth and Reconciliation Commission of South Africa* London: MacMillan.

US Department of Health and Human Services (2000). *Mental health: a report of the surgeon general* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Walt, G. & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy Plan., 9,* 353-370.

Ward, C., Flisher, F., Zissis, C., Muller, ML., & Lombard, C. (2001). Exposure to violence and its relationship to psychopathology in adolescents. *Injury Prevention, 7,* 297-301.

WHO (1996). *Psychosocial rehabilitation: a consensus statement.* Geneva: WHO.

WHO (2001). *World Health Report 2001, Mental Health: new understanding, new hope* Geneva: WHO.

WHO (2004). *Prevention of mental disorders: effective interventions and policy options.* Geneva: WHO.

WHO (2005a). *Atlas: mental health resources in the world* Geneva: WHO.

WHO (2005b). *Mental health policy, plans and programmes. Mental health policy and service guidance package* Geneva: WHO.

WHO (2005c). *WHO Assessment Instrument for Mental Health Systems (AIMS) Version 2.1* Geneva: WHO.

Williams, D. R., Herman, A., Stein, D. J., Heeringa, S. G., Jackson, P. B., Moomal, H. et al. (2007). Prevalence, Service Use and Demographic Correlates of 12-Month Psychiatric Disorders in South Africa: The South African Stress and Health Study. *Psychological Medicine, doi:10.1017/S0033291707001420.*

World Bank (2007). *Development results in middle income countries: an evaluation of the World Bank's support* Washington: The World Bank.

7. Glossary: definitions

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2001).

Mental health is the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until later life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self esteem (US Department of Health and Human Services, 2000).

Mental health service definitions from WHO-AIMS:

Bed: A bed that is continuously available for use by people with mental disorders for round the clock (day and night) care.

Community-based facility: A mental health facility outside of a *mental hospital*.

Community residential facility: A non-hospital, community-based mental health facility that provides overnight residence for people with mental disorders. Usually these facilities serve *users* with relatively stable mental disorders not requiring intensive medical interventions.

 Includes: Supervised housing; un-staffed group homes; group homes with some residential or visiting staff; hostels with day staff; hostels with day and night staff; hostels and homes with 24-hour nursing staff; halfway houses; therapeutic communities. Both public and private nonprofit and for-profit facilities are included. *Community residential facilities for children and adolescents only* and *community residential facilities* for other specifics groups (e.g. elderly) are also included.

 Excludes: Facilities that treat only people with a diagnosis of alcohol and substance abuse disorder or mental retardation; residential facilities in *mental hospitals*; generic facilities that are important for people with mental disorders, but that are not planned with their specific needs in mind (e.g. nursing homes and rest homes for elderly people, institutions treating mainly neurological disorders, or physical disability problems).

Community residential facility for children and adolescents only: A facility that meets the definition for *community residential facility* and exclusively serves children or adolescents.

 Excludes: Facilities for children with social problems (e.g. orphans, children from disrupted families) but without necessarily a mental disorder.

Complementary/alternative/traditional practitioner: A practitioner who primarily practices traditional or complementary/alternative medicine rather than allopathic/modern medicine.

Forensic inpatient unit: An inpatient unit that is exclusively maintained for the evaluation or treatment of people with mental disorders who are involved with the criminal justice system. These units can be located in *mental hospitals,* general hospitals, or elsewhere.

Human rights protection of users/patients: Action related to the following issues to ensure the protection of *users*' human rights: least restrictive care,

informed consent to treatment, confidentiality, avoidance of restraint and seclusion when possible, voluntary and involuntary admission and treatment procedures, discharge procedures, complaints and appeals processes, protection from abuse by staff, and

protection of *user* property.

Medical doctor: A health professional with a degree in modern medicine who is authorized/licensed to practice medicine under the rules of the country.

Mental health day treatment facility: A facility that typically provides care for *users* during the day. The facilities are generally: (1) available to groups of *users* at the same time (rather than delivering services to individuals one at a time), (2) expect *users* to stay at the facilities beyond the periods during which they have face-to-face contact with staff (i.e. the service is not simply based on *users* coming for

appointments with staff and then leaving immediately after the appointment) and (3) involve attendances that last half or one full day.

  Includes: day centres; day care centres; sheltered workshops; club houses; drop-in centres; employment/rehabilitation workshops; social firms. Both public and private non-profit and for-profit facilities are included. *Mental health day treatment facilities for children and adolescents only* and *mental health day treatment facilities* for other specifics groups (e.g. elderly) are also included.

  Excludes: Facilities that treat only people with a diagnosis of alcohol and substance abuse disorder or mental retardation without an accompanying mental disorder diagnosis; generic facilities that are important for people with mental disorders, but that are not planned with their specific needs in mind; day treatment facilities for inpatients are excluded.

Mental health day treatment facility for children and adolescents only: A facility that meets the definition for *mental health day treatment facility* and exclusively serves children or adolescents.

Mental health legislation: Legal provisions related to mental health. These provisions typically focus on issues such as: civil and human rights protection of people with mental disorders, treatment facilities, personnel, professional training, and service structure.

Mental health outpatient facility: A facility that focuses on the management of mental disorders and the clinical and social problems related to it on an outpatient basis.

  Includes: Community mental health centres; mental health ambulatories; outpatient services for specific mental disorders or for specialized treatments; mental health outpatient departments in general hospitals; mental health policlinics; specialized NGO clinics that have mental health staff and provide mental health outpatient care (e.g. for rape survivors or homeless people). Both public and private non-profit and for-profit facilities are included. *Mental health outpatient facilities for children and adolescents only* and *mental health outpatient facilities* for other specifics groups (e.g. elderly) are also included.

  Excludes: Private practice; facilities that treat only people with alcohol and substance abuse disorder or mental retardation without an accompanying mental disorder diagnosis.

Mental health outpatient facility for children and adolescents only: A facility that meets the definition for *mental health outpatient facility* and exclusively serves children or adolescents.

Mental hospital: A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental disorders. Usually these facilities are independent and standalone, although they may have some links with the rest of the health care system. The level of specialization varies considerably: in some cases only long-stay custodial services are offered, in others specialized and short-term services are also available (rehabilitation services, specialist units for children and elderly, etc.)

  Includes: Both public and private non-profit and for-profit facilities; *mental hospitals* for children and adolescents only and *mental hospitals* for other specifics groups (e.g., elderly) are also included**.**

  Excludes: *Psychiatric inpatient units in general hospitals*; *forensic inpatient units* and forensic hospitals. Facilities that treat only people with alcohol and substance abuse disorder or mental retardation without an accompanying mental disorder diagnosis.

Non-doctor/non-nurse primary health care worker: A *primary health care clinic* staff member who provides basic health services and links with other aspects of the health care system. These staff members include medical assistants, aide-level workers, multi-purpose health workers, health assistants, community health workers, among others. The training and functions of these workers vary across countries, but are usually less than those for doctors and *nurses*. Doctors, *nurses* and other health professionals may supervise their work.

Non-physician based primary health care clinic: A *primary health care clinic* without a *primary health care doctor* as part of their regular staff.

Number of admissions: The *number of admissions* in one year is the sum of all admissions to the facility within that year. In WHO-AIMS, this number is a duplicated count. In other words, if one user is admitted twice, it is counted as two admissions.

**Number of patients treated in a *mental hospital:* (a) the *number of patients* in the *mental hospital* at the beginning of the year plus (b) the *number of admissions* during the year.

Number of *users* treated in a c*ommunity residential facility*: (a) the number of *users* in the facility at the beginning of the year plus (b) the *number of admissions* to the facility during the year.

Number of *users* treated through a *mental health day treatment facility*: The number of *users* with at least one attendance for treatment at the facility within the year.

Number of *users* treated in a *mental health outpatient facility*: The number of *users* with at least one outpatient contact with the facility. A contact refers to a mental health intervention provided by a staff member of a *mental health outpatient facility*, whether the intervention occurs within the facility or elsewhere.

Nurse: A health professional having completed a formal training in nursing at a recognized, university level school for a diploma or degree in nursing.

Occupational therapist: A health professional having completed a formal training in occupational therapy at a recognized, university-level school for a diploma or degree in occupational therapy.

Other health or mental health worker: A health or mental health worker that possesses some training in health care or mental health care but does not fit into any of the defined professional categories (e.g.

medical doctors, *nurses*, *psychologists*, *social workers*, *occupational therapists*).

  Includes: *Non-doctor/non-nurse primary care workers*, professional and paraprofessional psychosocial counsellors, special mental health educators, and auxiliary staff

  Excludes: This group does not include general staff for support services within health or mental health care settings (e.g. cooking, cleaning, security).

Other residential facility: A residential facility that houses people with mental disorders but does not meet the definition for *community residential facility* or any other mental health facility defined for this instrument (*community-based psychiatric inpatient unit, community residential facility, forensic inpatient unit, mental hospital*).

  Includes: Residential facilities specifically for people with mental retardation, for people with substance abuse problems, or for people with dementia. Included are also residential facilities that formally are not mental health facilities but where, nevertheless, the majority of the people residing in the facilities have diagnosable mental disorders.

Physician-based primary health care clinic: A *primary health care clinic* with *primary health care doctors* as part of their regular staff.

Primary health care clinic: A clinic that often offers the first point of entry into the health care system. *Primary health care clinics* usually provide the initial assessment and treatment for common health conditions and refer those requiring more specialized diagnosis and treatment to facilities with staff with a

higher level of training.

Primary health care doctor: A general practitioner, family doctor, or other non-specialized medical doctor working in a *primary health care clinic*.

Primary health care nurse: A nurse working in a *primary health care clinic*.

Psychiatric inpatient unit in general hospitals: A psychiatric unit that provides inpatient care for the management of mental disorders within a *general hospital facility*. These units are usually located within general hospitals, they provide care to *users* with acute problems, and the period of stay is usually short (weeks to months).

> **Includes:** Both public and private non-profit and for-profit facilities; *psychiatric inpatient units in general hospitals* for children and adolescents only; *psychiatric inpatient units in general hospitals* for other specific groups (e.g. elderly).
>
> **Excludes**: *Mental hospitals*; *community residential facilities*; facilities that treat only people with alcohol and substance abuse disorder or mental retardation.

Psychiatrist: A *medical doctor* who has had at least two years of post-graduate training in psychiatry at a recognized teaching institution. This period may include training in any sub-specialty of psychiatry.

Psychologist: A professional having completed a formal training in psychology at a recognized, university-level school for a diploma or degree in psychology. WHO-AIMS asks for information only on *psychologists* working in mental health care.

Psychosocial intervention: An intervention using primarily psychological or social methods for the treatment and/or rehabilitation of a mental disorder or substantial reduction of psychosocial distress.

Includes: psychotherapy; counselling; activities with families; psycho-educational treatments; the provision of social support; rehabilitation activities (e.g. leisure and socializing activities, interpersonal and social skills training, occupational activities, vocational training, sheltered employment activities).

Excludes: Do not include intake interviews; assessment; follow-up psychopharmacology appointments as psychosocial interventions.

Public education and awareness campaign: An organized, coordinated effort to educate the public and raise their awareness about issues related to mental health using a variety of tools (e.g. media, brochures, face-to-face initiatives).

Excludes: Commercial advertisements (e.g. by pharmaceutical companies); advertisements for research studies.

Refresher training in psychiatry/mental health: The provision of essential knowledge and skills in the identification, treatment, and referral of people with mental disorders. *Refresher training* occurs after university (or vocational school) degree training. Eight hours of training is equivalent to one day of training.

Includes: In-service training.

Excludes: Training exclusively in neurology.

Social worker: A professional having completed a formal training in social work at a recognized, university-level school for a diploma or degree in social work. WHO-AIMS asks for information only on *social workers* working in mental health care.

User/Consumer/Patient: A person receiving mental health care. These terms are used in different places and by different groups of practitioners and people with mental disorders, and are used synonymously in WHO-AIMS.

8. Annexures

8.1 Annex 1. Sample of SSI and FGD instruments

The instruments provided in this annexure provide an indication of the range of semi-structured interviews and focus group discussions that were used during the fieldwork. Not all instruments could be provided for reasons of limited space. The following are three instruments used at the national/provincial level and three instruments used at the district level.

TOOL 3.1: SEMI STRUCTURED INTERVIEW GUIDE FOR NATIONAL POLICY MAKERS OF OTHER GOVERNMENT SECTORS (EDUCATION, INTERIOR, PRISONS, SOCIAL WELFARE, WOMEN AFFAIRS AND OTHERS)

Background to interview

The purpose of this interview is to look for information regarding perceptions of:
- The policy context and its implications for mental health, with particular focus on the role of other sectors
- Mental health
- Key stakeholders in mental health policy and law development
- Mental health policy implementation

This interview is important to understand how **different government sectors** regard mental health. National policy makers from different sectors are key stakeholders in this study. They have the responsibility for developing policies and implementing laws and policies that could have an impact on the health status of the society. This is also true when it comes to issues related to mental health.

A secondary purpose of the interview is to check and cross-validate data gathered from other sources.

Before the meeting:
- Send the background document on research (letter and consent form) Take additional copies with you to the interview
- Go through the interview guide to make sure that you are clear as to questions and their relative importance for the particular interviewee.
  - It is important to recognise that the interview may take longer than the time available (which may be broken off short or interrupted); as such highlight before the interview the critical questions for this particular respondent
  - Include any relevant extra questions or probes based on information received to date from other informants or background documents.
  - Remember you do not need to ask all probes for all questions. Use probes to get more information where the respondent is not answering fully or freely, if the respondent doesn't appear to understand the question (they can be used as examples) and to follow up interesting points. **Use your judgement.**

Check the IC recorder and battery to make sure they are working.

Informed consent agreement: *Interviewer copy*

Good morning/afternoon. My name is _____from_____. We are conducting interviews with key people, like you, about how mental health policies are developed and implemented in _____ *(country).* The purpose of this study is to gather information that will help us to understand the factors necessary for the development and effective implementation of appropriate mental health policy. I would like your permission to talk with you today about your ideas and experiences related to mental health policies in this country.

We will use what you tell us to improve our knowledge of mental health policy development and implementation. I would like to tape record our conversation. Everything you say will be kept confidential. Your name will not be used in any reports of our research findings.

It is up to you if you wish to take part in the interview. It is up to you if you wish to answer any or all of my questions. The interview should take no longer than _____ minutes, but can be stopped by you at any point.

Do you have any questions about the purpose of the interview or how the interview will be conducted?

If you agree to participate in this interview, please sign two copies of this form – one for you to keep and one for me to take away with me as a record of your agreement to participate.

I agree to take part in this interview

I   agree / do not agree   to this interview being tape recorded
(Cross out as appropriate)

Participant's signature_____

Date _____

Interviewer's signature_____

Date _____

If you have any further queries regarding the research or issues discussed during your interview, please contact Dr_____ *(country coordinator)* at _____ *(telephone number).*

Informed consent agreement: *Participant copy*

Good morning/afternoon. My name is _____from_____.
We are conducting interviews with key people, like you, about how mental health
policies are developed and implemented in _____ *(country)*. The purpose of
this study is to gather information that will help us to understand the factors
necessary for the development and effective implementation of appropriate mental
health policy. I would like your permission to talk with you today about your ideas
and experiences related to mental health policies in this country.

We will use what you tell us to improve our knowledge of mental health policy
development and implementation. I would like to tape record our conversation.
Everything you say will be kept confidential. Your name will not be used in any
reports of our research findings.

It is up to you if you wish to take part in the interview. It is up to you if you wish to
answer any or all of my questions. The interview should take no longer than _____
minutes, but can be stopped by you at any point.

Do you have any questions about the purpose of the interview or how the interview
will be conducted?

If you agree to participate in this interview, please sign two copies of this form – one
for you to keep and one for me to take away with me as a record of your agreement
to participate.

I agree to take part in this interview

I   agree / do not agree   to this interview being tape recorded
(Cross out as appropriate)

Participant's signature_____

Date _____

Interviewer's signature_____

Date _____

If you have any further queries regarding the research or issues discussed during
your interview, please contact Dr_____ *(country coordinator)* at
_____ *(telephone number)*.

TOOL 3.1: SEMI STRUCTURED INTERVIEW GUIDE FOR NATIONAL POLICY MAKERS OF OTHER GOVERNMENT SECTORS (EDUCATION, INTERIOR, PRISONS, SOCIAL WELFARE, WOMEN AFFAIRS AND OTHERS)

	QUESTION	Notes/key points
1.	Can you briefly introduce yourself; tell me about your background and interest in mental health? (Prompt: *Note down the sector which the respondent represents, e.g. education, social services, etc)*	
	A. I would like to start with general background questions.	
2.	What are main social and development priorities in this country? (Prompt: *For example: poverty alleviation, health service coverage, universal education, etc)*	
3.	How do these development and social priorities impact on your department?	
4.	What is the focus of the work of your department? (Prompt: *For example: health, prison services, social welfare, women affairs, etc.)*	
5.	What legislation and policies of your department have an impact on health? (Prompt: *For example: policies in education, interior, prisons, social welfare, women affairs and others)*	
6.	**B. Now I would like to ask you questions about and mental health.**	
7.	How does the general public in this country view mental illness (Prompt: *Are there any differences between different groups, e.g. rural farmers vs urban workers)* • Is there a need for change with regard to public opinion about mental health? If yes, what can be done? How do you view mental illness?	
8.	What initiatives are needed to address stigma and discrimination toward people with mental health problems? (Prompt: *E.g., anti-stigma campaigns, support for user advocacy/organisation, inclusion in government activities, etc)*	
9.	How important is mental health for the government compared to other health conditions? Why is that? (Prompt: For example, HIV/AIDs, TB and malaria?	
10.	How important do you feel other sector's policies and programmes are for mental health? (*For example, education, social welfare, prisons, you and sports, women affairs, etc*)	
11.	Does the work of your department involve issues related to mental health? What is this work? (Prompt: *For example, in education whether they have any school mental health programmes, etc.)*	
12.	*(If it does involve issues related to mental health)* What particular groups or individuals does your department deal with on mental health issues? (*Prompt: specific gender, social and age groups, e.g. men, women, children, adolescents, prisoners, etc*)	
Note: For Department of Social Development request statistical information on page 6 at this point.		
13.	Are you satisfied by the services that are provided by your department in relation to mental health? Could they be improved? (Prompt: *Services could include school mental health, care of victims, the elderly and children under the care of social services, care of prisoners with mental health problems, the drug addicts, etc)*	.
	C. Now I would like to ask you about mental health laws and policies and about how they are developed in this country	
14.	Can you tell me what you know about mental health laws and policies in this country?	

	QUESTION	Notes/key points
15.	How do current mental health laws and policies relate to the work of your department? *(Does the law and policy require specific activity of your department?)*	
16.	How consistent is mental health law and policy with the policy of your department?	
17.	Do you feel the laws and policies relating to mental health are adequate? How could they be improved?	
18.	Has your department been involved in mental health policy development? What is the role of your department in the process of policy development for mental health? (Prompt: Give examples). Are you satisfied with this level of involvement? If no, how could this be improved?)	
19.	How does your department collaborate with the department of health over policies related to mental health? (Prompt: How did you get involved? Task force, working groups, consultation? Are you satisfied with this?)	
20.	Does your department have access to sufficient information and support on mental health issues to be able to integrate mental health into your own policies? (Prompt: What is needed? E.g. staff, resources)	
21.	Are there any individuals or organisations who are not involved in the development of mental health laws and/or policies, but you think should be? • Why are they not involved? • Can you suggest practical ways in which they could be better involved	
22.	*If not covered above:* Should mental health care users be consulted in the development of mental health laws and policy? If yes, Who should bring them on board? (Probe: the government, NGOs, their own organisations) In which way should they be involved?	
23.	Should support be provided to people with mental health problems to influence policies which impact on mental health? Who should provide this support? (Prompt: What is done already? What is still needed?)	
24.	How well do the mental health policies and laws address the needs of people living in poverty? How can the situation be improved?	
25.	Are there mental health policy issues affecting children and adolescents which should be included in mental health laws and policies of your department?	
26.	Are there mental health policy issues affecting boys and men, and girls and women which should be included in mental health laws and policies and the policies of your department? What are these? *Explore gender related issues)*	
27.	Are you satisfied with the way mental health policies and laws are developed? How could this be improved, for example with the new mental health policy which the National Department is in the process of drafting? (*Probe for consultation processes*)	
	D. Now I would like to ask about how mental health laws and policies are implemented	
28.	Are mental health policies and laws well implemented in the country? (Prompt: *Please give examples*)	
29.	Who are the important individuals or organisations involved in implementing mental health laws in the country? (*List individuals or organisations mentioned*	
30.	Are there any individuals or organisations who are not involved in implementing mental health laws this country, but you think should be? Who? • Why are they not involved? • Can you think of practical ways in which they could be better involved? Should users be involved? How?	

	QUESTION	Notes/key points
31.	What are the key challenges for your department in implementing existing mental health laws and policies? (Prompt: *Possible challenges could include: resource constraints, lack of capacity, inadequate trained personnel, lack of clarity of the policy, etc.)*	
32.	What are the most important reasons why mental health laws and policies are not implemented effectively within your department? What can be done to overcome these problems? (Prompt: *Only ask if implementation is not happening effectively)*	
33.	Is there an implementation agency in your department? (Prompt: *Examples are tribunals, review boards, or visiting committees which are functional)*	
34.	What tools and procedures are in place for the implementation of mental health laws in your department? (Prompt: *Written regulations, professional codes of conduct, educational materials for different stakeholders?)*	
	F. Finally I would like to ask you for some more general comments.	
35.	Are there any other comments you would like to make about the mental health and MH policies, and in particular, the role of different people and government sectors or organisations in the policy making and implementation process?	
36.	Do you have any reports or documents that we might find useful for this research, for example, any government instructions / statements, annual reports and so on? (Prompt: *Only collect if the reports are new to the project)*	.
37.	Do you know of any meetings or other events in the near future that you think would be useful for us to attend?	
38.	Can you suggest other individuals who we need to interview?	

For department of Social Development

a)	Number of people who received social welfare benefits because of disability due to mental disorder in the previous calendar year (2005)	
b)	Total number of people who received social welfare benefits because of disability in the previous calendar year (2005)	
c)	What is the monthly benefit (in Rands) given to people who qualify for a social welfare benefit because of their mental disorder?	
d)	What are the criteria that are used to decide who qualifies for a disability grant due to a mental disability? (list the criteria):	
e)	What is the review process for assessing whether someone qualifies for a disability grant because of their mental disorder? (describe this briefly):	

After the interview
- Thank the respondent for her/his time.
- Reassure the respondent that this information will be treated confidentially, and that a written report on the research will be provided once it is completed.

Semi-structured interview Administrative information

Interviewer
Respondent number
Date of interview
Sex of respondent
Country
Province/Region
District
Urban or rural district
Consent procedure completed
Start time of interview
End time of interview

Interview notes
All relevant aspects of interview completed
Number of audio files used
File identification marks
Files backed-up?
Observations: Sketch an overview of the interview:

- Will this interview contribute to the analysis? (Guide: Good rapport, open participant, rich and spontaneous responses, good follow-up possible with probes, views of participant clearly expressed and verified by interviewer) or:
- Where there any ideas which emerged from the interview which can contribute to our thinking? (Guide: new, contradictory, confirming ideas, trends). What hypotheses/trends emerged from this interview?
- Any other observations?

Continue notes overleaf or on a separate sheet of paper

TOOL 2.2: SEMI-STRUCTURED INTERVIEW GUIDE FOR PROGRAMME MANAGERS AT PROVINCIAL LEVEL

Background to interview

The purpose of this interview is to look for information regarding perceptions of:
- The health context
- Mental health
- Public perceptions of mental health and stigma
- Mental health policy development
- Key stakeholders in mental health policy and law development
- Mental health policy implementation

This interview is important to understand how **programme managers at regional level** regard mental health. Programme managers at regional level are key stakeholders. They have the responsibility to provide policy advice on mental health and oversee the implementation of mental health policies and programmes at the regional level.

A secondary purpose of the interview is to check and cross-validate data gathered from other sources.

Before the meeting:
- Send the background document on research (letter and consent form) Take additional copies with you to the interview
- Go through the interview guide to make sure that you are clear as to questions and their relative importance for the particular interviewee.
  - It is important to recognise that the interview may take longer than the time available (which may be broken off short or interrupted); as such highlight before the interview the critical questions for this particular respondent
  - Include any relevant extra questions or probes based on information received to date from other informants or background documents.
  - Remember you do not need to ask all probes for all questions. Use probes to get more information where the respondent is not answering fully or freely, if the respondent doesn't appear to understand the question (they can be used as examples) and to follow up interesting points. **Use your judgement.**

Check the IC recorder and battery to make sure they are working.

Informed consent agreement: *Interviewer copy*

Good morning/afternoon. My name is _____from_____.
We are conducting interviews with key people, like yourself, about how mental health policies are developed and implemented in _____*(country).* The purpose of this study is to gather information that will help us to understand the factors necessary for the development and effective implementation of appropriate mental health policy. I would like your permission to talk with you today about your ideas and experiences related to mental health policies in this country.

We will use what you tell us to improve our knowledge of mental health policy development and implementation. I would like to tape record our conversation. Everything you say will be kept confidential. Your name will not be used in any reports of our research findings.

It is up to you if you wish to take part in the interview. It is up to you if you wish to answer any or all of my questions. The interview should take no longer than _____ minutes, but can be stopped by you at any point.

Do you have any questions about the purpose of the interview or how the interview will be conducted?

If you agree to participate in this interview, please sign two copies of this form – one for you to keep and one for me to take away with me as a record of your agreement to participate.

I agree to take part in this interview

I   agree / do not agree   to this interview being tape recorded
(cross out as appropriate)

Participant's signature_____

Date _____

Interviewer's signature_____

Date _____

If you have any further queries regarding the research or issues discussed during your interview, please contact Dr_____ *(country coordinator)* at _____ *(telephone number).*

Informed consent agreement: *Participant copy*

Good morning/afternoon. My name is _____from_____.
We are conducting interviews with key people, like yourself, about how mental health policies are developed and implemented in _____(country). The purpose of this study is to gather information that will help us to understand the factors necessary for the development and effective implementation of appropriate mental health policy. I would like your permission to talk with you today about your ideas and experiences related to mental health policies in this country.

We will use what you tell us to improve our knowledge of mental health policy development and implementation. I would like to tape record our conversation. Everything you say will be kept confidential. Your name will not be used in any reports of our research findings.

It is up to you if you wish to take part in the interview. It is up to you if you wish to answer any or all of my questions. The interview should take no longer than _____ minutes, but can be stopped by you at any point.

Do you have any questions about the purpose of the interview or how the interview will be conducted?

If you agree to participate in this interview, please sign two copies of this form – one for you to keep and one for me to take away with me as a record of your agreement to participate.

I agree to take part in this interview

I   agree / do not agree   to this interview being tape recorded
(cross out as appropriate)

Participant's signature_____

Date _____

Interviewer's signature_____

Date _____

If you have any further queries regarding the research or issues discussed during your interview, please contact Dr_____ *(country coordinator)* at _____ *(telephone number)*.

TOOL 2.2: SEMI-STRUCTURED INTERVIEW GUIDE FOR PROGRAMME MANAGERS AT PROVINCIAL LEVEL

	QUESTION	Notes/Key words
1.	Can you briefly introduce yourself, tell me about your background and your interest in mental health?	
	A. I would like to ask you some general background questions.	
2.	What are the main social and development priorities in the province? (Prompt: *If health is not mentioned, ask what the position of health is*)	
3.	What economic, political and social factors do you think affect health care delivery in this province?	
4.	Can you explain to me how health services are organised at the provincial level? (Prompt: *If not mentioned point to the difference between health and health care system*)	
5.	What are the key challenges that face the health system in the province?	
	B. Now I would like to ask you some questions about mental health	
6.	How important is mental health in the province compared to other health conditions? Why is that? (Prompt: *For example - funding patterns; media coverage; mutual links with poverty*)	
7.	How does the general public in this country view mental illness? Is there a need for change in public opinion? How can this be achieved? (Prompt: *Are there any differences between different groups, e.g. rural farmers vs urban workers.*) • How do you view mental illness?	
8.	What key initiatives are needed to address stigma and discrimination toward people with mental health problems? (Prompt: *E.g., anti-stigma campaigns, support for user advocacy/organisation, inclusion in government activities, etc*)	
9.	How important is mental health for the government compared to other health conditions? Why is that? (Prompt: For example, HIV/AIDS, TB and malaria	
10.	How important do you feel other sector's policies and programmes are for mental health? (*For example, education, social welfare, prisons, you and sports, women affairs, etc*)	
	C. Now I would like to ask you some questions about how mental health policies in this province.	

	QUESTION	Notes/Key words
11.	Can you tell me about any policies in the province outside of health that have an influence on mental health? *For each policy mentioned:* • How does that policy affect mental health? (Probe: *For example - education, social welfare, prisons, and women affairs.) Where can these policies be obtained?*	
12.	Is there a provincial mental health policy? *If yes:* Is it different from the national mental health policy? How does it differ from/relate to the national mental health policy? (Prompt: *Where is it set out? (Which documents?) When was it developed?)Request copy of policy*	
13.	*(If there is a provincial mental health policy)* How was the policy developed? (Probe: *Stages of policy development, Participatory nature, Use of evidence)*	
14.	*(If there is a provincial mental health policy)* Who was involved in the process of developing the mental health policy? (Probe: *How are they involved?* *At what stages of policy development are they involved (policy setting, policy development, or policy implementation How could their involvement be improved? What barriers were experienced, and how were they overcome?))*	
15.	(If there is no provincial mental health policy) What have been the barriers to developing a provincial mental health policy? What are the key areas which the policy will cover? What process will be followed to develop the policy?	
16.	What sort of input, if any, does the province have in the development of national mental health policy? Have you provided input to the Mental Health Policy document drafted by the National Directorate for Mental Health? (Probe: *Forms of participation, Individuals or provincial organisations that participated, What stages of development were they involved (policy setting, policy development, or policy implementation)*	
17.	Do you feel the existing mental health policies and laws are adequate? How can they be improved? (Prompt: *Ask if there are gaps)*	
18.	How well do the mental health policies and laws address the wider needs of people living in poverty? How can the situation be improved?	
19.	Are there policy issues affecting children and adolescents which should be included in mental health laws and policies?	

	QUESTION	Notes/Key words
20.	Are there policy issues affecting boys and men, and girls and women which should be included in mental health laws and policies? What are these? *(Prompt: Explore gender related issues)*	

	QUESTION	Notes/Key words
21.	Are there any individuals or organisations who are not involved in the development of mental health laws and/or policies, but you think should be? • Why are they not involved? Can you suggest practical ways in which they could be better involved	
22.	*If not covered above:* Should mental health care users be consulted in the development of mental health laws and policy? If yes, Who should bring them on board? (Probe: the government, NGOs, their own organisations) In which way should they be involved?	
23.	Should support be provided to people with mental health problems to influence policies which impact on mental health? If yes, who should provide this support? (Probe: *What is done already? What is still needed?*)	
	D. Now I would like to ask you about how mental health policies and laws are implemented.	
24.	What process is followed to implement mental health policies in the province? Do you think it is effective?	
25.	What are the key challenges that face the provincial health department in implementing mental health policies?	
26.	Is mental health policy well implemented in the province? (*Probe for examples- which are? Which are not? Why?*)	
27.	What are the most important reasons why mental health policies are not be implemented effectively? What can we do to overcome these problems? (Prompt: *Only ask if implementation is not happening effectively*)	
28.	How are mental health policies translated into plans and budgets at the provincial level? Is this effective? (*Probe for examples*)	
29.	Who are the important organisations or individuals involved in implementing mental health policies in the province? (Prompt: *List individuals and organisations*))	
30.	Are there individuals or organisations who are not involved in the implementation of mental health laws and policies, but you think should be? ⇒ Why are they not involved? ⇒ Can you think of any practical ways in which they could be better involved? ⇒ Should users be involved? How?	

31.	E. Finally I would like to ask you for some general comments about mental health policy and law	
32.	Are there any other comments you would like to make about the mental health policies in your province, and at national level and in particular, the role of programme managers in the policy making process?	
33.	Do you have any reports or documents that we might find useful for this research, for example, any statements of policy and objectives, annual reports and so on? (Prompt: *Only collect if the reports are new to the project.*)	
34.	Do you know of any meetings or other events in the near future that you think would be useful for us to attend?	
35.	Can you suggest other individuals who we need to interview?	

After the interview
- Thank the respondent for her/his time.
- Reassure the respondent that this information will be treated confidentially, and that a written report on the research will be provided once it is completed.

-
Semi-structured interview Administrative information

Interviewer
Respondent number
Date of interview
Sex of respondent
Country
Province/Region
District
Urban or rural district
Consent procedure completed
Start time of interview
End time of interview

Interview notes
All relevant aspects of interview completed
Number of audio files used
File identification marks
Files backed-up?
Observations: Sketch an overview of the interview:
- Will this interview contribute to the analysis? (Guide: Good rapport, open participant, rich and spontaneous responses, good follow-up possible with probes, views of participant clearly expressed and verified by interviewer) or:
- Where there any ideas which emerged from the interview which can contribute to our thinking? (Guide: new, contradictory, confirming ideas, trends). What hypotheses/trends emerged from this interview?
- Any other observations?

Continue notes overleaf or on a separate sheet of paper

TOOL 8.1: SEMI STRUCTURED INTERVIEW GUIDE FOR KEY INFORMANTS IN THE MENTAL HEALTH USER MOVEMENT.

Background to interview

The purpose of this interview is to look for information regarding perceptions of:
- *The health context*
- *Mental health*
- *Public perceptions of mental health and stigma*
- *Mental health policy development*
- *User involvement in mental health policy and law development*
- *Mental health policy implementation*

This interview is important to understand how **key informants in the mental health user movement** regard issues related to health and mental health, and to what extent they are involved in the policy making process.

A secondary purpose of the interview is to check and cross-validate data gathered from other sources.

Before the meeting:
- *Send the background document on research (letter and consent form) Take additional copies with you to the interview*
- *Go through the interview guide to make sure that you are clear as to questions and their relative importance for the particular interviewee.*
  - It is important to recognise that the interview may take longer than the time available (which may be broken off short or interrupted); as such highlight before the interview the critical questions for this particular respondent
  - Include any relevant extra questions or probes based on information received to date from other informants or background documents.
  - Remember you do not need to ask all probes for all questions. Use probes to get more information where the respondent is not answering fully or freely, if the respondent doesn't appear to understand the question (they can be used as examples) and to follow up interesting points. **Use your judgement.**

Check the IC recorder and battery to make sure they are working.

Informed consent agreement: *Interviewer copy*

Good morning/afternoon. My name is _____from_____.
We are conducting interviews with key people, like you, about how mental health
policies are developed and implemented in _____ *(country)*. The purpose of
this study is to gather information that will help us to understand the factors
necessary for the development and effective implementation of appropriate mental
health policy. I would like your permission to talk with you today about your ideas
and experiences related to mental health policies in this country.

We will use what you tell us to improve our knowledge of mental health policy
development and implementation. I would like to tape record our conversation.
Everything you say will be kept confidential. Your name will not be used in any
reports of our research findings.

It is up to you if you wish to take part in the interview. It is up to you if you wish to
answer any or all of my questions. The interview should take no longer than _____
minutes, but can be stopped by you at any point.

Do you have any questions about the purpose of the interview or how the interview
will be conducted?

If you agree to participate in this interview, please sign two copies of this form – one
for you to keep and one for me to take away with me as a record of your agreement
to participate.

I agree to take part in this interview

I   agree / do not agree   to this interview being tape recorded
(Cross out as appropriate)

Participant's signature_____

Date _____

Interviewer's signature_____

Date _____

If you have any further queries regarding the research or issues discussed during
your interview, please contact Dr_____ *(country coordinator)* at
_____ *(telephone number)*.

Informed consent agreement: *Participant copy*

Good morning/afternoon. My name is _____from_____.
We are conducting interviews with key people, like you, about how mental health policies are developed and implemented in _____ *(country)*. The purpose of this study is to gather information that will help us to understand the factors necessary for the development and effective implementation of appropriate mental health policy. I would like your permission to talk with you today about your ideas and experiences related to mental health policies in this country.

We will use what you tell us to improve our knowledge of mental health policy development and implementation. I would like to tape record our conversation. Everything you say will be kept confidential. Your name will not be used in any reports of our research findings.

It is up to you if you wish to take part in the interview. It is up to you if you wish to answer any or all of my questions. The interview should take no longer than _____ minutes, but can be stopped by you at any point.

Do you have any questions about the purpose of the interview or how the interview will be conducted?

If you agree to participate in this interview, please sign two copies of this form – one for you to keep and one for me to take away with me as a record of your agreement to participate.

I agree to take part in this interview

I   agree / do not agree   to this interview being tape recorded
(Cross out as appropriate)

Participant's signature_____

Date _____

Interviewer's signature_____

Date _____

If you have any further queries regarding the research or issues discussed during your interview, please contact Dr_____ *(country coordinator)* at _____ *(telephone number)*.

TOOL 8.1: SEMI STRUCTURED INTERVIEW GUIDE FOR KEY INFORMANTS IN THE MENTAL HEALTH USER MOVEMENT.

	QUESTION	Notes/Key words
1.	Can you briefly introduce yourself, tell me about your background and your interest in mental health?	
A. I would like to start by asking you about peoples view on mental health		
2.	How does the general public view mental illness? Is there need for change in these views? What can be done? (Prompt: *include general public, family/friends, employers etc. Are there any differences between groups, e.g.rural vs. urban?*)	
3.	How do people with mental health problems view mental illness? Is there need for change in these views? What can be done?	
4.	What do you think is meant by "mental health" and "mental illness"?(*Probe for traditional beliefs, biomedical stress-related, alternative views*)	
5.	What do you think is meant by "mental disability"?	
6.	Are people with mental health problems ever treated with disrespect because of their mental health problem? *(Explore where, what happens, in which settings)*	
7.	What can be done to address stigma and discrimination toward people with mental health problems? By Whom? (Prompt: *E.g., anti-stigma campaigns, support for user advocacy and organisation, user inclusion in government activities, etc*)	
8.	How important is mental health for the government compared to other health conditions and other social and development priorities of the country?	*HIV/AIDS, TB and malaria education, housing etc*
9.	What do you think are the main areas of support which a person with mental health problems needs to promote recovery and enjoyment of full citizenship?	
B. Now I would like to turn to some questions about services for the treatment of mental health problems		
10.	Are treatment services for mental health problems satisfactory? (Services include: *home visits, clinic, hospital, accommodation, support groups, clubs, crisis care, medication, etc*) Prompt: *Are they available? Are they accessible and affordable? Are they clean and safe? Are they adequately staffed? How can this be improved?*)	
11.	Do you know of any non-medical services which are effective for the treatment of mental health problems? (prompt: *Traditional healers, complementary therapies*)	
12.	Do you know of any human rights violations occurring in mental health services? If yes, what should be done to address these violations? By whom? (Prompt: *E.g., enforced treatment, physical and emotional harm, harmful practices etc*)	
13.	*(if not mentioned above)* Are the current practices for restraint and seclusion respectful? How can this be improved?	
14.	Should users of services have opportunities to give their views and opinions about the treatment they receive? If yes, how can this be done? What barriers are there? (*Guide: Complaints procedure, user boards, mental health review boards, etc*)	

	QUESTION	Notes/Key words
C. *Interviewer says*: A person with mental health problems might have short or longer-term problems taking up their home, work, learning and social lives. In this section, I will ask for your views on how people with disabling mental health problems can be supported with such difficulties in their everyday lives.		
15.	Do people with mental disability need any help with housing? What help is needed? From whom? (Prompt: *What would be the role of Housing Department, NGO's, others?*)	
16.	Compared to others in the same community, are people with mental disabilities getting enough food for their basic needs? What would help? (Prompt: *What would be the role of agriculture NGO's, others?*)	
17.	Compared to others in the same community, are people with mental disabilities getting enough basic services, such as water, electricity and sanitation? What help is needed? From whom? (Prompt: *What would be the role of social services, local government, NGO's, others?*)	
18.	Compared to others in the same community, do people with mental disabilities have the same or more problems with rent, clothes, household supplies, and school fees? Why? What help is needed? From whom? (Prompt: *What would be the role of social services, local government, NGO's, others?*)	
19.	What state benefits are available to support people with mental health problems? Are there problems accessing state benefits? What basic benefits are needed? From whom? (Prompt: *What would be the role of Social development, NGOs, others?*)	
20.	Is there a need for help with regard to education and skills training for people with mental disability? (Prompt: *What would be the role of education, labour, NGOs, others?*)	
21.	Are there any needs with regard to occupation and employment for people with mental disability? (Prompt: *What would be the role of social development and labour, NGOs, others?*)	
22.	What reasonable accommodation is needed in the work situation for people with mental disability? (Prompt: *e.g. flexible work environment, flexible work hours, supportive employer, work place disability policy to include mental health)*	
23.	*If not covered above:* Do people with mental health problems have any difficulty finding and keeping work because of their mental health problem? What would help?	
24.	*If not covered above:* What is the impact of mental health problems on people's ability to earn a reasonable income? What would help?	
25.	*If not covered above:* Are there any problems with people getting work or a disability grant because having the one affects the other? What should be done to overcome this?	

		QUESTION	Notes/Key words
26.		What help is needed among people who need help managing their daily self-care and chores at home? (washing, cleaning, tidying, preparing meals, etc) (Prompt: *Community based services: family support, community health worker support for supplies, skills training, day care support, regular supervision etc*)	.
27.		Do people with mental health problems need support to improve their social contacts, and have access to rewarding social activities within their community? What is needed? By whom? (Prompt: *Community services: drop in centres, day centres, community centre/group social clubs, couple counseling, social skills training, dating line/clubs*)	
28.		Is there a need for support with transport? What problems are encountered? What will help?	
29.		Are there any other areas of concern with which people with mental disabilities are struggling? What needs to be done?	
		D. Now I would like to ask you about mental health law and policies and user influence on the development of these policies and laws	
30.		Can you tell me what you know about mental health laws and policies in this country? (Prompt: *Where are they set out? Which documents*)	
31.		Are people with mental health problems exposed to mental health laws and policies in South Africa? How? Is this enough? How can it be improved? (*Probe: What is available to expose users to policy and law?*)	
32.		Should people with mental health problems influence the development and implementation of laws, policies and services affecting them? If yes, how can participation be improved?	
33.		What holds people back from influencing mental health laws, policies and services? What can be done to overcome this?(Prompt: *Including issues of personal and organisational capacity, lack of recognition of users*)	
34.		Are there any mental health user organizations in South Africa? Are they involved in developing mental health laws and policies in this country? **What services should they offer?** (Prompt: *Are they user or provider led? Is their involvement appropriate and adequate?*)	
35.		Is support for the development of the mental health user movement needed? What kind of support is needed? By whom? (*e.g. government, NGOs, private sector, etc*) If already available, how can this be improved? (*Explore: policy, programme, financial, technical and moral support*)	
		Now I would like to ask you about considerations for special issues in mental health law and policies in the country	
36.		Are there policy considerations regarding children and adolescents which should be included in mental health laws and policies?	

		QUESTION	Notes/Key words
37.		Do mental health problems affect men and women the same or differently? Are there policy issues concerning boys and men, and girls and women, which should be included in mental health laws and policies? What are these? (*Explore gender related issues*)	
38.		Do mental health policies and laws address the needs of people living in poverty? How can the situation be improved?	
39.		Do mental health policies protect the rights of people with mental health problems to have the same respect, treatment and opportunities as other citizens? Prompt: *What are the main areas of concern? How can this be improved?*)	
40.		Are there any key issues you feel should be included in mental health laws and policies?	
41.		Are mental health laws and policies well implemented in your country? (Prompt: *If not, What are the most important reasons for this? What can be done to overcome these problems?*)	
		E. Finally I would like to ask you for some more general comments.	
42.		Are there any final comments you would like to make about the mental health laws and policies in South Africa, and in particular, the role of users and user organisations in the policy-making and implementation process?	
43.		Do you have any reports or documents that we might find useful for this research? (*Only collect if the reports are new to the project.*)	
44.		Can you suggest other individuals who we need to interview, if time permits?	
45.		How would you think the information being collected in these interviews can best be used to support users of mental health services?	

After the interview
- Thank the respondent for her/his time.
- Reassure the respondent that this information will be treated confidentially, and that a written report on the research will be provided once it is completed.

Semi-structured interview Administrative information

Interviewer
Respondent number
Date of interview
Sex of respondent
Country
Province/Region
District
Urban or rural district
Consent procedure completed
Start time of interview
End time of interview

Interview notes
All relevant aspects of interview completed
Number of audio files used
File identification marks
Files backed-up?
Observations: Sketch an overview of the interview:
- Will this interview contribute to the analysis? (Guide: Good rapport, open participant, rich and spontaneous responses, good follow-up possible with probes, views of participant clearly expressed and verified by interviewer) or:
- Where there any ideas which emerged from the interview which can contribute to our thinking? (Guide: new, contradictory, confirming ideas, trends). What hypotheses/trends emerged from this interview?
- Any other observations?

Continue notes overleaf or on a separate sheet of paper

The Mental Health and Poverty Project
Focus Group Guide (C1): Psychiatric Nurses working in Hospitals

Informed consent agreement

Good morning/afternoon. My name is _____ from _____.
We are conducting focus group discussions with people, like yourself about how mental health policies are developed and implemented in South Africa. The purpose of this study is to gather information that will help us to **understand the factors necessary for the development and effective implementation of appropriate mental health policy in (name of the country).** I would like your permission to talk with you today about your ideas and experiences related to mental health in this country.

We will use what you tell us to improve our knowledge of mental health policy development and implementation. I would like to tape record our conversation. Everything you say will be kept confidential. Your name will not be used in any reports of our research findings.

It is up to you if you wish to answer any or all of my questions. The discussion should take no longer than ___ minutes but can be stopped by you at any point.

Do you have any questions about the purpose of the discussion or how the discussion will be conducted?

If you agree to participate in this discussion, please sign two copies of this form – one for you to keep and one for me to take away with me as a record of your agreement to participate.

I agree to take part in this discussion

I   agree / do not agree   to be tape recorded
(cross out as appropriate)

Participant's signature_____

Date _____

Interviewer's signature_____

Date _____

If you have any further queries regarding the research or issues discussed during your discussion, please contact Dr Crick Lund (country coordinator) at 021 6850120.

Informed consent agreement: *Participant copy*

Good morning/afternoon. My name is _____ from_____. We are conducting focus group discussions with people, like yourself, about how mental health policies are developed and implemented in South Africa. The purpose of this study is to gather information that will help us to understand the factors necessary for the development and effective implementation of appropriate mental health policy. I would like your permission to talk with you today about your ideas and experiences related to mental health in this country.

We will use what you tell us to improve our knowledge of mental health policy development and implementation. I would like to tape record our conversation. Everything you say will be kept confidential. Your name will not be used in any reports of our research findings.

It is up to you if you wish to take part in the discussion. It is up to you if you wish to answer any or all of my questions. The discussion should take no longer than _____ minutes, but can be stopped by you at any point.

Do you have any questions about the purpose of the discussion or how the discussion will be conducted?

If you agree to participate in this discussion, please sign two copies of this form – one for you to keep and one for me to take away with me as a record of your agreement to participate.

I agree to take part in this discussion

I   agree / do not agree   to be tape recorded
(cross out as appropriate)

Participant's signature_____

Date _____

Interviewer's signature_____

Date _____

If you have any further queries regarding the research or issues discussed during your discussion, please contact Dr Crick Lund (country coordinator) at 021 6850120.

Before the focus group, ensure you are familiar with the interviewer notes.

Introduction

Thank you for agreeing to take part in this focus group discussion. The aim of the discussion is twofold; firstly, for us to develop an understanding of how the mental health needs of patients are met within your facility, and secondly to explore your experiences of working within the mental health care system.

	QUESTION	Notes/Key words
1.	**Background**	
36	How do you view mental illness?	
37	What role do you play in caring for people with mental health problems?	
2.	**The following questions are about what mental health services and resources are available from this facility for people with mental health problems.**	
a.	What services are available for people with mental health problems within this facility?	
b.	What human resources are available within this facility for people with mental health problems?	
c.	What other resources are available for people with mental health problems and their families in this facility? (support groups, education, community care)	
d.	If there are support groups, what are these and how are they run?	
e.	If there is vocational rehabilitation, what form does this take and how is it run?	
f.	Do you have links with any mental health programmes that are currently being run in the district?	
g.	Are you currently running any awareness, educational or training programmes within your district/community?	
3.	**The following questions are about the care, treatment and rehabilitation of adults with more common mental health problems which don't require hospitalization, such as anxiety and depressive disorders.**	
a.	Do you feel that you have sufficient training to identify, counsel and refer adults with common mental health problems? *(If yes, describe the training. If limited or none, what training do you still need?)*	
b.	What support mechanisms are in place currently to assist you in working with common adult mental health problems? *(If limited or none, what support do you need?)*	
c.	What training do you receive in dealing with mental health issues which affect women, such as rape and gender violence?	

	QUESTION	Notes/Key words
d.	Are there any specific support groups/shelters for people with common mental health problems e.g. support groups and shelters for abused women, support groups for people with substance abuse problems. *(Probe number, what they do and who runs these)*	
e.	Are there any programmes for the prevention of specific problems e.g. sexual violence, substance abuse? *(Probe for number, what they do and who runs these)*	
4.	**The following questions are about the care, treatment and rehabilitation of adults with serious mental health problems requiring hospitalization and follow-up care.**	
a.	Do you feel that you have sufficient training to identify, counsel, treat and refer adults with serious mental health problems? *(If yes, describe the training frequency and comprehensiveness. If limited or none, what training do you still need?)*	
b.	Are all the nurses working with psychiatric patients in the hospital trained as psychiatric nurses?	
c.	Are there enough nurses working with psychiatric patients?	
d.	What support mechanisms are in place currently to assist you in working with serious adult mental health problems? *(If limited or none, what support do you need?)*	
e.	Is there a system of supervision and/or ongoing support from specialist psychiatric staff to other mental health staff*? (If yes, what is the nature of this support?)*	
f.	What other support do you need?	
5.	**The following questions are about the care, treatment and rehabilitation of children and adolescents with mental and behavioural problems.**	
a.	Do you feel that you have sufficient training to identify, counsel and refer children/adolescents with mental and behavioural problems? *(If yes, describe the training. If limited or none, what training needs do you still have?)*	
b.	What support mechanisms are in place currently to assist you in working with children/adolescents with mental and behavioural problems? *(If limited or none, what support do you need?)*	
c.	Are there any special facilities in the district or region for children and adolescents to be referred to e.g. Child and Adolescent Mental Health Unit?	
d.	Are there any specific support programmes for problems commonly experienced by children e.g. for children who are sexually abused, children with learning difficulties, substance abuse problems? *(Probe number, what they do and who runs these programmes)*	

	QUESTION	Notes/Key words
e.	Are there any programmes for the prevention of specific problems for children e.g., sexual violence, substance abuse, other high risk behaviours? *(Probe for number, what they do and who runs these programmes)*	
6.	**The following questions are about socio-economic and cultural factors that play a role in mental health.**	
a.	Do you feel that the care you provide is constrained by a limited mental health budget? *(If yes, what would be some things that could be achieved with more resources?)*	
b.	Do you think that there are any links between poverty and poor mental health? *(If yes, describe these. What could be done to eradicate these?)*	
c.	Do you think that there are any links between gender and poor mental health? *(If yes, describe these. What could be done to deal with these?)*	
d.	What do you think are the main reasons people develop mental health problems? *(bio-medical, cultural beliefs, stress)*	
e.	What explanations do most users have for mental health problems? *(bio-medical, cultural beliefs)*	
f.	What do traditional healers have to offer in caring for people with mental health problems?	
g.	What is hospital policy if a patient wishes to have treatment outside of the formal health system at the same time as treatment within the health care system?	
7.	**The following questions are about your knowledge of existing Mental Health Care legislation (Policies and plans).**	
g.	What do you know about the new Mental Health Care Act, no 17 of 2002?	
h.	Have you received training in the provisions of the Act?	
i.	What impact do you feel that the Act has had on your job?	
j.	What impact do you feel that the Act has had on the lives of people with mental health problems?	
k.	Are there any changes needed to the Act?	
l.	Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people? (*Probe*)	
m.	Do you think that people with mental health problems can participate in developing government policies, plans and actions that affect their mental health? (*If yes, how? Are there limits, and why? If no, why not?*)	
n.	Do you think it is necessary for people with mental health problems to be supported so that they can influence mental health policies and plans? (*If no, why not, if yes, what are they doing already? What should still be done?*)	

	QUESTION	Notes/Key words
8.	**General**	
a.	Are there any other comments you would like to make regarding mental health in your facility?	

SSI and FGD Summary Sheet

Administrative information

Interviewer	
Participant number	
Date of interview	
Sex of respondent	
Country	
Province/Region	
District	
Urban or rural district	
Consent procedure completed?	
Start and end time of interview	

Interviewer notes

File numbers used on IC recorder:	
Voice Editor Storage	File Name: Date Loaded:
Back up Storage: Interview backed up before deleting from IC recorder?	Backup location:
Tracking sheet completed for this interview?	
Observations: *Sketch an overview of the interview:* Will this interview contribute to the analysis (*Guide: Good rapport, open participant, rich and spontaneous responses, good follow up possible with probes, views of participant clearly expressed and verified by interviewer or?*) • Were there any ideas which emerged from this interview which can contribute to our thinking? (*Guide: new, contradictory, confirming ideas, trends). What hypotheses/trends emerged from this interview?*) • Any other observations?	

The Mental Health and Poverty Project
Semi-structured Interview (G7): Users

Informed consent agreement

Good morning/afternoon. My name is _____ from _____. We are conducting interviews with people about how mental health policies are developed and implemented in South Africa. We would like to find out about your experience of mental illness, your views about mental health services and what you think should be included in a mental health policy for the country.

When we speak about mental health services, we include any person or organisation that offers care and or support to people with mental health problems. These services may be offered by community workers, community health workers and counsellors, traditional healers, psychiatrists, psychologists, social workers, occupational therapists, psychiatric nurses, primary health care doctors or nurses.

When we speak about a mental health policy, we refer to a document in which government states what it aims to achieve in the future to improve the mental health of all citizens and reduce the burden of ill-health for people living with mental health problems.

We will use what you tell us to improve our knowledge of mental health policy development and implementation. I would like to tape record our conversation. Everything you say will be kept confidential.

It is up to you if you wish to answer any or all of my questions. The interview should take no longer than ___ minutes but can be stopped by you at any point.

Do you have any questions about the purpose of the interview or how the interview will be conducted? If you have any further queries regarding the research or issues discussed during your interview, please contact Dr Crick Lund (country coordinator) at 021 685 0120.

If you agree to participate in this interview, please sign two copies of this form – one for you to keep and one for me to take away with me as a record of your agreement to participate.

I agree to take part in this interview
I   agree / do not agree   to this interview being tape recorded
(Cross out as appropriate)

Participant's signature_____   Date _____

Interviewer's signature_____   Date _____

Informed consent agreement: *Participant copy*

Good morning/afternoon. My name is _____ from _____. We are conducting interviews with people about how mental health policies are developed and implemented in South Africa. We would like to find out about your experience of mental illness, your views about mental health services and what you think should be included in a mental health policy for the country.

When we speak about mental health services, we include any person or organisation that offers care and or support to people with mental health problems. These services may be offered by community workers, community health workers and counsellors, traditional healers, psychiatrists, psychologists, social workers, occupational therapists, psychiatric nurses, primary health care doctors or nurses.

When we speak about a mental health policy, we refer to a document in which government states what it aims to achieve in the future to improve the mental health of all citizens and reduce the burden of ill-health for people living with mental health problems.

We will use what you tell us to improve our knowledge of mental health policy development and implementation. I would like to tape record our conversation. Everything you say will be kept confidential.

It is up to you if you wish to answer any or all of my questions. The interview should take no longer than ___ minutes but can be stopped by you at any point.

Do you have any questions about the purpose of the interview or how the interview will be conducted? If you have any further queries regarding the research or issues discussed during your interview, please contact Dr Crick Lund (country coordinator) at 021 685 0120.

If you agree to participate in this interview, please sign two copies of this form – one for you to keep and one for me to take away with me as a record of your agreement to participate.

I agree to take part in this interview
I   agree / do not agree   to this interview being tape recorded
(Cross out as appropriate)

Participant's signature_____   Date
_____

Interviewer's signature_____   Date
_____

Before the interview, ensure you are familiar with the interviewer notes.

Introduction

Thank you for agreeing to take part in this interview. The aim of the discussion is twofold; firstly, for us to develop an understanding of how the mental health needs of users are met within your district, and secondly to explore your experiences and needs as a person who has a mental health problem.

	QUESTION	Notes/Key words
Section 1 – Demographic Information: *In this section I will ask you about yourself and your background*		
a.	Gender *Observe and note*	
b.	Urban or rural context *Observe and note*	
c.	How old are you?	
d.	What education do you have?	
e.	Where do you live? What kind of home do you have? How many rooms do you have?	
f.	How many children and adults live with you? *Note number of adults 18 years and older, and number of children under 18.*	
g.	What income does your household have each month?	
h.	Who is the main breadwinner in your home?	
i.	What is his/her main source of income?	
j.	Does anyone receive any grants? Which ones?	
k.	*If not above breadwinner, ask*: What is your own main source of income?	
l.	Does your household receive any other help with income? Describe.	
m.	Does anyone else in your household have mental health problems?	
Section 2: Help seeking and Symptom Management/Treatment: *In the next section I will ask you about your health problems and services you have received for these problems*		
2.1 Mental and Physical Health Problems		
a.	How do people in your community know when someone has a mental health problem? *(Traditional beliefs, indigenous explanations, biomedical explanations)*	
b.	Can you describe your own mental health problem? *(Traditional beliefs, indigenous health explanations, biomedical explanations)*	
c.	Have you ever been given a name (diagnosis) for your mental health problem? *(Indigenous health vs biomedical explanations)(probe who gave this diagnosis and what they understand it to be)*	
d.	Why do you think you have this mental health problem? *(Probe for traditional beliefs, biomedical explanations, or stress-related)*	
e.	How many years have you had this mental health problem?	
f.	How old you were when your mental health problem started?	
g.	How old were you when you first asked for help?	
h.	Who did you go to first for help? *(Did they help?)*	
i.	Who else have you gone to for help since then? *(Probe for family member, traditional healer, doctor. Have they helped?)*	
j.	Have you ever been to a traditional healer for treatment? If yes, what did they do and did it help? If yes are you currently being treated by a traditional healer?	
k.	Would you like to be treated by a traditional healer while using the government health services?	

	QUESTION	Notes/Key words
l.	Has your mental health problem affected your life as a woman (*man*) in any way? (*Explore*)	
m.	What can the health services do to make it easier for you to get the help you need for your mental health problem?	
n.	Do you have any physical health problems? (*Explore: What is the problem, how long has the problem been there?*)	
o.	Have you ever had problems getting help for your physical problem because of your mental health problem? (*If yes, what helped you to overcome this?*)	

2.2. Service access and satisfaction

a.	What services have you used for your mental health problem? (*home visits, clinic, hospital, homes, support groups, trad. healer*)	
b.	Are there services which you have not been able to use for any reason? (*Probe for barriers to using service*)	

Interviewer says: "Thank you. I am now going to ask you about some of the services you have received for your mental health problem. Please tell me what you feel about each of these questions.

Access and affordability

c.	How far is your clinic from your home? Is this close enough?
d.	What are the opening hours is your clinic/ treatment centre? Is it open enough hours a week?
e.	How long do you have to wait to be seen for treatment at your clinic? Is this satisfactory?
f.	Is your medication for your mental health problem always available?
g.	Can you get emergency care when you need it?
h.	Can you get hospital care for your mental health problem in your community when you need it?
i.	Can you get counselling and support when you need it (*If yes, probe: What?*)
j.	Do you have the chance to meet with people who have similar concerns about their mental health problems? *Probe if wanted, useful/not useful and how*)
k.	Can you afford to come for treatment when you need to? (*Guide: travel costs, taking off work etc*)

Service conditions and safety

l.	Is your clinic clean and comfortable?
m.	Is the hospital service clean and comfortable?
n.	Do you feel safe from physical and emotional harm when getting treatment?
o.	Have you ever been forced to take treatment you did not want or did not understand?

Staffing

p.	Do the staff at your clinic or hospital know how to give you proper treatment and support?
q.	Do the staff speak to you in a language you can understand when you come for treatment?
r.	Do the staff treat you with respect and dignity at all times?
s.	Do the staff keep your personal and treatment information private?

Information and Psycho-education

t.	Have you been given enough information to understand your treatment and medication?
u.	Does your family have enough information about your mental health problem and treatment to help and support you?

Service level participation

v.	Do you know how to make a complaint about services if you need to? (*Explore how*)
w.	Are you comfortable to give your opinion about your treatment and services? Are they given attention?

Section 3 – Stigma and Discrimination: In the next session we will talk about the way people have treated you since you have the mental health problem.

a.	What is your view about people with mental health problems? (*Explore what has influenced their attitude?*)	
b.	What do people in your community say about people with mental health problems? (*Explore attitudes and beliefs*)	
c.	How are men and women with mental health problems treated in the community, the same or differently? (*Explore*)	

	QUESTION	Notes/Key words
d.	How do you feel about using professional mental health care? (*Explore: Attitude to seeking modern and traditional care. What has influenced their attitudes?*).	
e.	Is it better for you to come for mental health care where people come for other health care, or to attend a mental health clinic away from others? (*Explore*)	
f.	Have others ever treated you with disrespect because of your mental health problem? (*What happened, with whom, where?*)	
g.	Has anyone ever stopped you from doing things other people are allowed to do, because of your mental health problem? (*What happened, where, how did you deal with it?*)	
h.	Have you ever had any contact with the law (*police, courts*) as result of your mental health problem? Did they know you had a mental health problem? How did they treat you?	
i.	What do you think must be done so that people with mental health problems can get the same respect as other people? (*Probe for details*)	
Section 4: Advocacy and Policy level Participation: In this next section we will look at having your say about the mental health policies of your district. Remember, a mental health policy is the government's written promise about what it aims to do to improve the mental health of all citizens. (*Check understanding*)		
a.	Do you know of any activities in or close to your district to make people aware of mental health and how to cope with mental health problems? (*If yes explore what. If no, are these needed, and what?*	
b.	Do you know how to keep up to date with mental health policies which affect you? (*Explore*)	
c.	What opportunities are there for you to have your say about mental health policies? (*service evaluations, hospital boards/ committees, community/departmental meetings, support groups, lobby groups, education/information, training, funding*)	
d.	Are there any people, activities or organisations in your district to help you get your needs and ideas about services and policies heard? (*If not, are these needed? Why? If yes, who leads these? Are there people with mental health problems?*)	
e.	Are you interested in having your ideas heard when government makes mental health policies which affect you? (*Explore*)	
f.	Are there things that hold you back from having your say about mental health policies? (*Probe for effect of illness on involvement, confidence, lack of skills, stigma, lack of support*)	
g.	As a woman (*man*), are there things that hold you back from having your say about mental health policies? (*Explore*)	
h.	Is there anything that should be done so that you can have your say about mental health policies? (*Probe for details*)	
Section 5: Basic Needs of People with mental health problems: In this last section, I will ask about your experiences in your home, in the community and at work.		
5.1 Housing, Employment and Education		
a.	Where and with whom do you live? (*Own home, with relatives/ friends, government, temp. accommodation, water, electricity, homeless? Brick, iron*)	
b.	Do you need any help with housing? (*If yes, what help is needed? If managing on own, explore how*)	

	QUESTION	Notes/Key words
c.	Are you working at present? (*If not, have you ever worked?*) Could you describe what kind of work you do/did and for whom you work/ed? (*Self-employed? formal job? Informal work, sheltered employment*)	
d.	Have you ever had problems finding work because of your mental health problem? (*Probe for details*)	
e.	Have you ever had a drop in your income because of your mental health problem? (*Probe for details*)	
f.	***Only ask people who have worked***; Have you ever lost your job because of your mental health problem? (*Probe*)	
g.	Have you had any problems getting work or a disability grant because having the one affects the other*? (Probe for not working for fear of losing the grant, loss of income while crossing over from a grant to work?*)	
h.	Do you need any help with work*? (If yes, what help is needed? If managing, explore how*)	
i.	Have you had any problems with getting education because of your mental health problem? (*Explore*)	
j.	Have you had any problems with getting job skills because of your mental health problem? (*Explore*)	
k.	Are your education and/or your skills enough to get work which pays for your needs/your survival? (*Explore barriers*)	
l.	Do/did you need any help with education? (*If yes, what help is/was needed? If managing, explore how*)	
m.	Do/did you need any kind of help with skills training? (*If yes what help is needed? If managing on own, explore how*)	
5.2 Material Supports		
a.	What is your situation with food for yourself and your family, compared to others in your community? (*Explore, if problems*).	
b.	Do you need any help to get enough food? (*If yes, what help? If managing, explore how*)	
c.	Are there any government or work benefits due to you? (*Unemployment insurance, medical boarding payment, disability grant (DG), pension, care dependency grant, Child support grant, child maintenance*)	
d.	Do you receive all the benefits you should get? (*Do they know which ones are due to them and how to access them? Is anyone withholding/abusing their benefits?*)	
e.	Do you need any help with getting and keeping benefits? (*If yes, what help? If managing, explore how*)	
f.	Do you have enough money to pay for your expenses? (*water, electricity, sanitation, rent, household supplies, school fees*)	
g.	Do you need any help to be able to pay for your expenses? (*If yes, what help? If managing on own, explore how*)	
5.3 Personal and Household Routine		
a.	Do you need any help with taking care of your daily self care routine? (*If yes, what help? If managing on own, explore how*)	
b.	Do you need any help with your chores at home such as doing the washing, cleaning, tidying, and preparing meals? (*If yes, what help is needed? If managing, explore how*)	

	QUESTION	Notes/Key words
c.	Do you need any help with transport, for example to work, your clinic appointment and social events? (*If yes, what help? If managing, explore how*)	

5.4 Social Supports

	QUESTION	Notes/Key words
a.	Do you have enough contact with other people? (*Friends, day centre, community centre, lonely, isolated, no opportunities*)	
b.	Do you need any help to meet people/make friends? (*If yes, what help is needed? If managing on own, explore how*)	
c.	Do you have a partner? Is your current situation to your satisfaction or would you like it to change*? (Explore)*	
d.	Do/did you need any help to start and keep a healthy relationship? (*If yes, what help is/was needed. If managing, explore how*)	
e.	Do you take care of any children younger than 18 years? Whose children are these? *If not own children:* Why do you take care of them?	
f.	Do you need any help with your children (*If yes, what help? If managing on own, explore personal and other strengths*)	
g.	Do you have sufficient things to do or places to go during the day? At night? (*What kind of activities are you involved in, what kind of activities would you like to have available?*)	
h.	Have you ever had a problem with wanting to harm yourself? *(If yes, why does this happen? What would help avoid this?)*	
i.	Have you ever had a problem with wanting to harm others? (If yes, w*hen does this happen? What would help to avoid this?*)	
j.	Have you ever had a problem with others wanting to harm you? (If yes, w*hen does this happen? What would help to avoid this?*)	
k.	Have you had any difficulties at home, work or in relationships, because you are a woman (man) with mental health problems?	

6. General

	QUESTION	Notes/Key words
a.	What do you think are the main things government should do to help people with mental health problems?	
b.	Are there any other comments you would like to make regarding mental health in your district?	

SSI and FGD Summary Sheet

Administrative information

Interviewer	
Participant number	
Date of interview	
Sex of respondent	
Country	
Province/Region	
District	
Urban or rural district	
Consent procedure completed?	
Start and end time of interview	

Interviewer notes

File numbers used on IC recorder:	
Voice Editor Storage	File Name: Date Loaded:
Back up Storage: Interview backed up before deleting from IC recorder?	Backup location:
Tracking sheet completed for this interview?	
Observations: *Sketch an overview of the interview:* Will this interview contribute to the analysis (*Guide: Good rapport, open participant, rich and spontaneous responses, good follow up possible with probes, views of participant clearly expressed and verified by interviewer or?*) • Were there any ideas which emerged from this interview which can contribute to our thinking? (*Guide: new, contradictory, confirming ideas, trends). What hypotheses/trends emerged from this interview?*) • Any other observations?	

Informed consent agreement

Good morning/afternoon. My name is _____ from _____. We are conducting interviews with key people, like yourself about how mental health policies are developed and implemented in South Africa. The purpose of this study is to gather information that will help us to **understand the factors necessary for the development and effective implementation of appropriate mental health policy in (name of the country).** I would like your permission to talk with you today about your ideas and experiences related to mental health policies in this country.

We will use what you tell us to improve our knowledge of mental health policy development and implementation. I would like to tape record our conversation. Everything you say will be kept confidential. Your name will not be used in any reports of our research findings.

It is up to you if you wish to answer any or all of my questions. The interview should take no longer than ___ minutes but can be stopped by you at any point.

Do you have any questions about the purpose of the interview or how the interview will be conducted?

If you agree to participate in this interview, please sign two copies of this form – one for you to keep and one for me to take away with me as a record of your agreement to participate.

I agree to take part in this interview

I agree / do not agree to this interview being tape recorded
(cross out as appropriate)

Participant's signature_____

Date _____

Interviewer's signature_____

Date _____

If you have any further queries regarding the research or issues discussed during your interview, please contact Dr Crick Lund (country coordinator) at 021 685 0120.

Informed consent agreement: *Participant copy*

Good morning/afternoon. My name is _____from_____. We are conducting interviews with key people, like yourself, about how mental health

policies are developed and implemented in South Africa. The purpose of this study is to gather information that will help us to understand the factors necessary for the development and effective implementation of appropriate mental health policy. I would like your permission to talk with you today about your ideas and experiences related to mental health policies in this country.

We will use what you tell us to improve our knowledge of mental health policy development and implementation. I would like to tape record our conversation. Everything you say will be kept confidential. Your name will not be used in any reports of our research findings.

It is up to you if you wish to take part in the interview. It is up to you if you wish to answer any or all of my questions. The interview should take no longer than _____ minutes, but can be stopped by you at any point.

Do you have any questions about the purpose of the interview or how the interview will be conducted?

If you agree to participate in this interview, please sign two copies of this form – one for you to keep and one for me to take away with me as a record of your agreement to participate.

I agree to take part in this interview

I   agree / do not agree   to this interview being tape recorded
(cross out as appropriate)

Participant's signature_____

Date _____

Interviewer's signature_____

Date _____

If you have any further queries regarding the research or issues discussed during your interview, please contact Dr Crick Lund (country coordinator) at 021 685 0120.

Before the interview, ensure you are familiar with the interviewer notes.

The Mental Health and Poverty Project
Semi-structured Interview (): District Mental Health Coordinator

Introduction

Thank you for agreeing to take part in this interview. We would like to develop an understanding of how mental health care is provided within your district. In relation to a framework or system for the delivery of mental health care within your district, we would like know if you have anything that is documented such as an organogram, human resources list etc., and if so could we have a copy. In addition we would like to ask a number of questions.

	QUESTION	Notes/Key words
9. Background		
38	Can you briefly introduce yourself; tell me your background, your training and your role in mental health? (*policy development, policy implementation, ensuring service delivery*)	
39.	Where does mental health stand in relation to the many other health issues within your district? Is it a priority?	
40.	Is there a mental health plan in place at the district level? (*separate plan or integrated into the district plan?*). Probe for details. Is there a plan for hospitals and clinics?	
41.	How is mental health integrated into other programmes at the district level e.g. maternal and child health, HIV/AIDS?	
10. The following questions are about existing management frameworks and intersectoral links to support the delivery of mental health care in the district		
42.	Do you have a district management committee? *(If yes, what is the composition and what support do they provide?)*	
43.	Do you have a multisectoral forum to ensure a multidisciplinary approach to mental heath care in the district? *(If yes, how does it operate and who is represented?)*	
44.	Who do you report back to on mental health? How often does this occur and in what way? What kinds of things do you report on?	
45.	Do managers responsible for mental health care in the district have a need for additional knowledge and competencies that could be addressed through training programmes?	
46.	What kind of regional support is there for district managers managing mental health care at the district level? Could this support be improved?	
11. The following questions are about the care, treatment and rehabilitation of adults with more common mental health problems which don't require hospitalization, such as anxiety and depressive disorders.		
a.	Have primary health care nurses been trained to identify, counsel and refer such people?	
b.	If so, how many have been trained out of the total number of PHC nurses and how well do you think they have been trained?	
c.	How well is the district health system working?	
d.	What are the problems with the district health system?	

	QUESTION	Notes/Key words
e.	Where do primary health care workers e.g. PHC nurses and community health workers refer people with common mental health problems that need specialist psychological help?	
f.	Is there a referral system in place for mental health? Describe the district referral pathway. What information is included on the referral forms?	
g.	Are there any specific support groups/shelters for people with common mental health problems e.g. support groups and shelters for abused women, support groups for substance abuse problems? *(Probe number and who runs these)*	
h.	Are there any programmes for the prevention of specific problems e.g. sexual violence, substance abuse? *(Probe number, who runs these and what they do)*	
i.	Have police officers and magistrates serving your district been trained to deal with issues such as sexual violence and abuse of women? *(If so, probe what training)*	
j.	Is common mental health on the agenda or is the focus primarily on serious mental health problems?	
k.	How many of the clinics have a permanent or visiting doctor?	
l.	What psychosocial support is available for mental health service users?	
12. The following questions are about the care, treatment and rehabilitation of adults with serious mental health problems requiring hospitalization and follow-up medication.		
o.	Have primary health care nurses been trained to identify, counsel and refer such people?	
p.	If so, how many have been trained out of the total number of PHC nurses and how well do you think they have been trained?	
q.	Is there training for nurses on an ongoing basis? Who organises the training?	
r.	Where are people identified as having serious mental health problems in the district referred to? Describe the referral pathway *(district, regional or psychiatric hospital)*	
s.	Does the hospital have dedicated beds for psychiatric patients? If so, how many dedicated beds are there?	
t.	What kind of referrals are made to the psychiatric hospital (*Probe: acute, long term, other?*) How many psychiatric beds are there in the hospital? Do you have specialist units?	
u.	How long is the average wait before admission into district/regional/tertiary hospitals?	
v.	Where are patients requiring long-term hospitalization referred to? *(outpatient care only, residential facilities, long term psychiatric wards?)* How many beds are there in these facilities/wards?	
w.	Who attends to admitted psychiatric patients at district level (hospital)?	

	QUESTION	Notes/Key words
x.	Is there a back referral system in place so health care providers at district level are provided with information when discharged back into the community from regional and psychiatric hospitals or tertiary units? What information is included? How well does this system operate?	
y.	What support and supervision structures are in place for mental health staff? How could this be improved?	
z.	What psychosocial support is available for mental health service users?	
aa	Do you have treatment guidelines that are adhered to for both in-patient and out-patient care? If so what are these?	
bb	Have police officers and magistrates serving your district been trained to deal with people with serious mental health problems? *(If yes, probe what training)*	

13. The following questions are about the care, treatment and rehabilitation of children and adolescents with mental and behavioural problems.

	QUESTION	Notes/Key words
f.	Have teachers and primary health care nurses been trained to identify, counsel and refer children with mental health problems?	
g.	Where do carers such as PHC nurses and teachers refer children and adolescents who need specialist psychological help? Are there any special facilities in the district or region for them to be referred to e.g. Child and Adolescent Mental Health Unit? (Ask about school for handicapped).	
h.	Has one Child and Adolescent unit closed recently? Is this a problem?	
i.	Who generally provides care for mental health problems in children and adolescents? E.g. traditional healers, priests, psychologists in private practice or PHC, nurses, teachers, social workers? What kind of care is provided by these different carers.	
j.	Are there any specific support programmes for problems commonly experienced by children e.g. for children who are sexually abused, children with learning difficulties, substance abuse problems? *(Probe number, what they do and who runs these)*	
k.	Are there any programmes for the prevention of specific problems for children e.g., sexual violence, substance abuse, other high risk behaviours? *(Probe number, what they do and who runs these)*	
l.	Have police officers and magistrates serving your district been trained to deal with issues such as child sexual abuse and neglect? *(If yes, probe what training)*	
m.	Are there any special facilities within the criminal justice system to cater for sexually abused children e.g. private and child friendly assessment rooms?	

14. The following questions are about socio-economic and cultural factors that play a role in mental health.

	QUESTION	Notes/Key words
a.	What portion of the district health budget is dedicated to mental health? What is the money spent on? Where does the money for the infrastructure requirements come from?	
b.	How well do you manage on the current mental health budget? What would you hope to achieve if more resources were available?	
c.	Are there any vacant posts for mental health staff in this district? If yes, what are the reasons for them not being filled?	
d.	Do you think that there are any links between poverty and poor mental health? If yes, describe these. What is being done to eradicate these?	
e.	Do you think that there are any links between gender and poor mental health? If yes, describe these. What is being done to deal with these?	
f.	What do you think are the main reasons people develop mental health problems? *(bio-medical, cultural beliefs, stress)*	
g.	What explanations do most users have for mental health problems? *(bio-medical, cultural beliefs)*	
h.	What do traditional healers have to offer in caring for people with mental health problems?	
15. The following questions are about your knowledge of existing Mental Health Care legislation (Policies and plans). *This must be tailored for each country*		
a.	What do you know about the new Mental Health Care Act, no 17 of 2002?	
b.	Did you have any input into the Act? *(If yes, what input. If no, do you feel you should have been consulted?)*	
c.	Have you and other staff in your district received training in the provisions of the Act?	
d.	What impact do you feel the Act has had on the provision of mental health services at district level?	
e.	What impact do you feel that the Act has had on your job?	
f.	What impact do you feel that the Act has had on the lives of people with mental health problems?	
g.	Are there any changes needed to the Act?	
h.	How easy is it to implement the Act at district level?	
i.	Do you think government policy and action ensures that people with mental health problems enjoy the same respect, treatment and opportunities as other people? (*How are rights protected, violated? What still needs to be done?*)	
j.	Do you think that people with mental health problems can participate in developing government policies, plans and actions that affect their mental health? (*If yes, how? Are there limits, and why? If no, why not?*)	

	QUESTION	Notes/Key words
k.	Do you think it is necessary for people with mental health problems to be supported so that they can influence mental health policies and plans? (*If no, why not, if yes, what are they doing already? What should still be done?*)	

16. General

a.	Are there any other comments you would like to make regarding mental health in your district?	

SSI and FGD Summary Sheet

Administrative information

Interviewer	
Participant number	
Date of interview	
Sex of respondent	
Country	
Province/Region	
District	
Urban or rural district	
Consent procedure completed?	
Start and end time of interview	

Interviewer notes

File numbers used on IC recorder:	
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Back up Storage: Interview backed up before deleting from IC recorder?	Backup location:
Tracking sheet completed for this interview?	
Observations: *Sketch an overview of the interview:* Will this interview contribute to the analysis (*Guide: Good rapport, open participant, rich and spontaneous responses, good follow up possible with probes, views of participant clearly expressed and verified by interviewer or?*) • Were there any ideas which emerged from this interview which can contribute to our thinking? (*Guide: new, contradictory, confirming ideas, trends). What hypotheses/trends emerged from this interview?*) • Any other observations?	

8.2 Annex 2. Coding framework for qualitative data analysis

1. National/provincial level coding framework

Level 1	Level 2	Level 3	Level 4	Level 5
Context				
	Child and adolescent issues			
	Crime and Violence			
	Cultural factors			
		Language issues		
	Demographic factors			
	Development priorities			
	Economic factors			
		Equity		
			reasonable accommodation	
		Poverty		
		Unemployment		
			Employment and skills development	
				EPWP
			social grants	
	Gender issues			
	Health issues			
		Health policies		
		Health system		
		HIVAIDS		
			childheaded household	
		Population health		
		rural health		
	International factors			
	Political factors			
	Regional issues			
	Social factors			

General policy making processes				
	Areas of action (general pol process)			
	Challenges (general pol process)			
	Policy development process and stages			
		Consultation		
		Development		
		Initiation		
		Users participation in policy development		
	Policy implementation			
	Policy stakeholders			
	Use of information			
Mental health policy and law content				
	Content of other laws or policies			
		Convention on the Rights of Persons with Disablities		
		National Disablity Strategy		
	Mental health law content			
		Appropriateness of law		
			Child and adolescent issues	
			Disability	
				Intellectual disability
			Feasibility	
			Financing	
			Forensics	
			Gender issues	

			Human rights	
				Guardianship
			Integration or separation	
			Poverty	
			Prevention or promotion	
			Regulation of private sector	
			Support or rehabilitation	
			Treatment	
		Areas of action (mh law content)		
		Integration with other policies or laws		
	Mental health policy content			
		Appropriateness of policy		
			Child and adolescent issues	
			Disability	
				disability issues
				Intellectual disability
			Feasibility	
			Financing	
			Gender issues	
			Human rights	
			Poverty	
			Prevention or promotion	
			Regulation of private sector	
			Separation or integration	
			Substance abuse	
			Support or rehabilitation	
			Treatment	
		Areas of action (mh pol content)		
		Integration with other policies or laws		

Mental health policy and law development				
	Mental health law development			
		Areas of action (mh law dev)		
		Challenges (mh law dev)		
		Factors influencing		
		Process or stages		
			Consultation	
			Development	
			Initiation	
			Ratification	
		Stakeholders		
			Other stakeholders	
			Users	
		Stengths		
		Use of information		
	Mental health policy development			
		Areas of action (mh pol dev)		
		Challenges (mh pol dev)		
		Factors influencing		
		Process or stages		
			Consultation	
			Development	
			Initiation	
			Ratification	
		Stakeholders		
			Other stakeholders	
			Users	
		Strengths		
		Use of information		
	Types of policies			

		child and adolescent policy		
		Community based mental health services policy		
		mental health policy		
		PSR pollicy		
		Substance Abuse Policy		
Mental health policy or law implementation				
	Funding for mental health			
		departmental funding		
			Budgeting	
		donor funding		
		Medical insurance		
		Pharmaceutical companies		
		private funding		
	Law implementation			
		72 hour assessment		
		Areas of action (mh law implementation)		
		Challenges (mh law implementation)		
		Designated facilities		
		Effectiveness of implementation		
		Monitoring and evaluation		
		Resources		
		Review Boards		
		Stakeholders		
			Other stakeholders	
			Users	
	Mental health providers			

		Employee Unions		
		Role of civil society		
		Role of community workers		
		Role of corporate sector		
		Role of FBOs		
		Role of NGOs		
			BasicNeeds	
			DPSA	
			Office of the African Decade	
			SA Federal Council on Disabllity	
			SABDA	
			SADAG	
			SAFMH	
				CMH
			SASOP	
			WCFID	
			WFMH	
		Role of other sectors		
		Role of private for profit health sector		
		Role of public health system		
			Training of mental health workers	
		role of the community		
		Role of traditional healers		
		Role of users		
	mental health related policy makers and managers			
			National mental health office	
			other health programmess	
			other sector programmes	

			Agriculture	
			Correctional services	
			Education	
			Housing	
			Justice	
				Courts
				Family Advocate
			Labour	
				Employment and skills development
			Local Government	
			Municipal services	
			National treasury	
			Parliamentary organs	
				Gender Commission
				Human Rights Commission
				OSDP
				Portfolio Committee of Children Youth and Disabilities
			SAPS	
			Social Services	
			Sport and Recreation	
			Trade and Industry	
			Transport	
		provincial mental health office		
	Mental health services and programmes			
		Health sector mental health services		
			clinic services	
			community based services	

			district and regional hospital services	
			mental hospital services	
				deinstitutionalisation
			other health programmes	
		Integration with general health		
		Integration with other sectors		
		municipal health servicse		
		Novel programmes and projects		
		Organisation of mental health system		
			provincial mental health office	
		Other sector mental health services and programmes		
		Treatment programmes		
	Policy implementation			
		Areas of action (mh pol implementation)		
			Advocacy	
		Challenges (mh pol implementation)		
		Effectiveness of implementation		
		Monitoring and evaluation		
		Resources		
			human resources	
				Human Resource Plan
			Infrastrucuture	

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		Stakeholders		
			Other stakeholders	
			Users	
	Policy or law translation into plans			
Mental health situation				
	apartheid policy and practices			
		Racial issues		
	Areas of action (mh situation)			
	Challenges (mh situation)			
	Families			
	Media and mental health			
	Mental health users			
		advocacy groups		
		barriers to user participation		
		children and adolescents		
		current status of user participation		
			ENUSP	
			Other International	
			PANUSP	
				MHU
				MHZ
			South Africa	
				CAM
				CCAB
				GCAB
				Other Bodies
			WNUSP	
		Funding for organisation		

		mental health user organisation		
		Model		274
			Ideology	
		Needs of user organisation		
		stakeholder support for user involvement		
		strategies for improving mhcu participation		
			groups	
			Self-Help	
			support groups	
	Perception of mental health			
		Areas of action (perception)		
		Causes of mental illness		
		Challenges (perception)		
		Definition of mental health or illness		
			Non-professionals' views of mental illness	
			Professional views of mental illness	
		Health seeking behaviour		
		Management or treatment of mental illness		
		Public awareness		
	Poverty and mental health			
		Areas of action (poverty and mh)		
		Relationship between poverty and mental illness		
	Priorities within mental health			

	Respondent's interest in mental health			
				275
		Suggested documents		
	Significance of mental health			
		Burden of mental illness		
		Prioritisation of mental health		
			Political will	
	Statutory councils			
		Medical and Dental Council		
		Nursing council		
		OTs		
		psychologists		
		SA Social Services Association		
	Stigma			
		Consequences of stigma		
		Impact on policy development		
		Impact on policy implemenation		
		Source of stigma		
		Strategies to address stigma		
Research				
	Areas of action (research)			
	Challenges (research)			
	Dissemination of findings			
		MHaPP dissemination strategy		
	Funding for research			
	Research agenda			

	Translation to policy			

2. District level coding framework

Parent Node Child Node   Grand-Child Node

1) Background

    a) Personal Background   Reasons Interest
                                            Perception MH
                                            Experiences MH
                                            Qualifications

    b) History Services
    c) Priority of MH
    d) Mental Health Plan
    e) Facility Type & Services available
    f) Role Played
    g) Resources   Human Resources
                                            Other Resources

    h) Programmes Mental
    i) View Mental

2) Management Frameworks & Intersectoral links

    a) District Management Committee
    b) Dedicated Person MH
    c) Multisectoral Forum
    d) Report Back MH
    e) Training Needs Managers
    f) Regional Support
    g) Links Service Providers
    h) Links Programme

3) Mental Health Problems

    a) Cases Mental monthly
    b) Training MH
    c) Referral MH
    d) Support Mechanisms MH
    e) Guidelines MH
    f) General MH
    g) Facilities MH
    h) Programmes MH

4) Serious Mental Health Problems

    a) Staff   Additional Staff Needed
                                              Staff Full-time
                                            Staff Supervision
                                            Staff trained – Serious

    b) Training Adult Serious
    c) Support Mechanisms Adult Serious
    d) Services Provided
    e) Admission & Assessment   Cases Serious monthly
                                            Average wait
                                          Distance Travelled

<div align="right">
Beds Available
Other Bed Options
Procedure for assessment
Referral for Specialised Care
</div>

f) Involuntary Admission and Treatment

g) Seclusion & Restraint

h) Follow-up Care

<div align="right">
Back Referral System
Medication & Treatment
Groups & Shelters Serious
</div>

i) Referral System

<div align="right">
District Referral System
Referral Forms
Referral Sources
</div>

j) District System operation

<div align="right">
District Needs & Problems
System Operation
</div>

k) Disability Grant

l) Programmes Adult Serious

m) Facilities Adult Serious

5) Common Mental Health Problems

a) Cases Adult Common monthly

b) General Adult Common

c) Training Adult Common

d) Support Adult Common

e) Facilities Adult Common

f) MH Issues Women

g) Support Groups & Shelters-Common

h) Programmes Adult Common

6) Children & Adolescents

a) Cases Children monthly

b) General Children

c) Staff training Children

d) Support Children

e) Problems Children

f) Treatment & Interventions Children

g) Facilities Children

h) Referral Children

i) Programmes Children

7) Traditional Healers Additional Items

a) Become Healer

b) Training Healer

c) Diagnose Problem

d) Diagnosis Mental

e) Treatment Mental

f) Hard times

g) Organisation Member

h) Interact Medical

i) Interact Medicine

j) Work together

k) Other training

8) Police Additional Items
   a) Educational Activities
   b) Members of the public with   Contact Public
       MH problems   Identify and deal
                                          Training public
       Support Mechanisms Public
       Guidelines Public
       Public Setting
       Procedure Escort

   c) Offenders with MH problems Contact Offenders
       Training Offenders
       Support Offenders
       Guidelines Offenders
   d) MH needs of victims &   Guidelines Victim/Witness
       witnesses   Training Victim/Witness
       Support Victim/Witness
       Procedure Victim/Witness
   e) Children & Adolescents   Guidelines Children &
       Adolescents
       Training Child offenders
       Training Child victim & witness

9) Social Work Additional Items
   a) Coping Workload
   b) Shortage SW Services
   c) Available help
   d) Integration

9) Housing Additional Items
   a) Adults MH
   b) Children MH
   c) RDP Housing
   d) Guidelines Mental
   e) Problems Housing Provision

10) Education Additional Items
   a) School MH Professional
   b) Teaching Experience
   c) Learner MH experience
   d) Learner MH Challenges
   e) Learner MH Support

11) Magistrate Additional Items
   a) Contact MH
   b) Training Victim/Witness

12) User Additional Items
   a) Help seeking and Symptom Knowledge Community
       management/treatment   Own Knowledge & Understanding
       Help-seeking
       Policy – Service Accessibility
       Utilisation of services
       Complaints & Opinions
       Gender

	b) Stigma and Discrimination	Attitude own Attitude others Attitude gender Help-seeking Respect & dignity Exclusion Police or Legal contact Protection from Discrimination
	c) Advocacy and Policy level Participation	Awareness Participation
	d) Basic Needs of people with mental health problems	Housing Employment Education & Skills Food Benefits Money Self-care & Household Chores Transport Social contact & activities Intimate Partner Childcare Impact MH problem Harm Gender relationships
	e) General	Comments Results & Readings

13) Socio-economic & Cultural

- a) Budget Mental
- b) Department Needs
- c) Vacant Posts
- d) Medication & Tests
- e) Poverty   Poverty
                          Poverty Reduction
- f) Gender
- g) Explanations   Explanation – Participant
                            Explanation - Users
- h) Traditional Medicine
- i) Language Issues
- j) Stigma
- k) Health Seeking Behaviour
- l) Social Factors

14) Legislation, Policy & User Rights

	a) Legislation/Policy	Legislation & Policy Knowledge Legislation & Policy Input Legislation & Policy Training Legislation & Policy Impact Legislation & Policy Need for change Legislation & Policy Implementation Other Legislation Norms and Standards

	b) User Rights	Respect, treatment & opportunities
		User participation
		User influence
		Human Rights

15) General Comments
  a) General Comments
  b) Burden of MH
  c) Integration of MH
  d) Challenges
  e) Suggestions
  f) Future Expectations

8.3 Annex 3. WHO Mental Health Policy and Legislation Checklists

8.3.1 WHO Checklist for evaluating a Mental Health Policy.

Introduction

Once a policy/draft policy has been drawn up in a country, it is important to conduct an assessment of whether certain processes have been followed that are likely to lead to the success of the policy; and whether various content issues have been addressed and appropriate actions included in the policy. This checklist is intended to assist with this evaluation.

While the checklist is limited in that it does not enable assessment of the *quality* of the processes or contents of the policy, evaluators are encouraged, when completing the checklist, to consider the *adequacy* of both the process and content. Particularly where a response is "no" or "to some extent", it is suggested that they provide either an action plan to remedy the situation or a comment.. (In some instances the comment may, for example, merely be that a particular action is covered in a different policy, or that it is not possible to implement given the current resources available). The different modules in the WHO *Mental Health Policy and Service Guidance Package* can be consulted for more guidance on how to address relevant sections and for a better understanding of the policy issues mentioned in the checklist.

This checklist may usefully be completed by those who drafted the policy and/or by employees in the government itself. However, it is also important to have *independent reviewers.* Those involved in drawing up the policy may have personal or political interests or may be "too close" to the policy to see anomalies or provide critical input. Ideally, therefore, an independent multidisciplinary team should be convened to conduct an evaluation. A team is also advantageous as no single person is likely to have all the relevant information required, and debate is crucial for arriving at an optimal policy. for the country. Furthermore, when relevant interest groups have been involved in the process of the development of the policy and/or in their evaluation, which leads to changes being made to the policy, it is likely that they will be more effectively implemented. It would be useful to include consumer organizations, family organizations, service providers, professional organizations and NGOs, as well as representatives of other government departments affected by the policy.

Finally, although the checklist should be "scored" in terms of the mental health policy document, it is important to have, or be familiar with, other relevant and related documentation. Often items are not covered in the mental health policy because they are comprehensively covered elsewhere. For example, policies on health information systems or human resources may include mental health and are therefore deliberately not repeated in the mental health policy. This explanation should then be noted in the relevant section.

CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY

Please use the following rating scale to rate each item: 1 = yes/ to great degree 3 = no/not at all 2 = to some extent 4 = unknown	Rating	If "yes" or "to some extent". please state how. If not, please state reason(s).	Action required (if any)
PROCESS ISSUES			
1a. Was there a high-level mandate to develop the policy (e.g. from the Minister of Health)?	1	**1997 Guidelines**: The Minister of Health herself was very keen to have new mental health policy and encouraged its development by the National Directorate for Mental Health and Substance Abuse. This development therefore enjoyed official sanction. The guideline is attached as Appendix 3. **Draft 2006 MH Policy**: The implementation of the Mental Health Care Act no 17 of 2002, promulgated in 2004, has been placed on the official list of Health Department priorities for the period 2005-2009.The department has therefore mandated the development of a national mental health policy to support the implementation of the new mental health legislation.	
1b..At what level has the policy been officially approved and adopted? (e.g., the department of mental health, Ministry of Health, Cabinet, Minister of Health).	2	Meeting of Minister of Health and Members of Executive Council (MINMEC), 1997 Document was approved at national level, but no formal process for dissemination to implementers at provincial level was put in place Nor was national monitoring process put in place	A formal dissemination process, support to provinces regarding implementation plans and a and national monitoring process will be needed one the new Mental Health Policy is finalised for implementation.
2. Is the policy based on relevant data:	2	Policy indicates some literature review but does not indicate where information	Formal analysis of the mental health policy environment is needed with the

			came from.	next policy draft currently underway
-- From a situation assessment?	2			
-- From a needs assessment?	2			
3. Have policies relating to mental health that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where relevant?	1		Director visited Chile, Cuba and Zimbabwe to review the mental health policies there, and wrote papers on this on his return. Extensive use was also made of WHO recommendations published in a number of documents at the time. The Free State Province had to some extent already moved to decentralised mental health. A report commissioned by the DOH to evaluate the system in the FSP was used in developing the policy	Successful policies developed in middle and low income developing countries should be reviewed to inform the current policy draft. Current provincial policies and plans should be taken into account to ensure that the new South African policy guidelines (draft, 2006) are sensitive to developments at provincial, regional and local levels of the services
Please use the following rating scale to rate each item: 1 = yes/ to great degree ; 2 = to some extent; 3 = no/not at all ; 4 = unknown	**Rating**		**If "yes" or "to some extent". please state how. If not, state reason(s).**	**Action required (if any)**
4. Has a thorough consultation process taken place with the following groups:				
-- Representatives from the Health Sector, including planning, pharmaceutical , human resource development, child health, HIV/AIDs, epidemiology and surveillance, epidemic and disaster preparedness divisions.	2		Draft document was circulated to relevant directorates within the DOH (including most of these mentioned) for their inputs and feedback before going to MINMEC.	
-- Representatives from the Finance Ministry?	1		At a national level the Minister doubled the budget on the mental health directorate after consultation with the Department of Finance. However mostly it was felt that if provinces spent their existing mental health budgets differently, much could be achieved.	
-- Representatives from Social Welfare and Housing Ministries?	2		A meeting was held with social development but not housing. The meeting mostly revolved around social grants and the potential role of social welfare in deinstitutionalisation	Discussion required with department of Housing regarding the accommodation of persons with mental disability in their Special Housing Policy. See also comments regarding housing in Legislation Checklist

	Rating		Action required (if any)
-- Representatives from the criminal justice system?	3		
-- Consumers, or representatives of consumer groups?	2	The SA Federation for Mental Health includes the co-ordination of various consumer support groups, and some consumer advocacy work as a focus area in their work. Detailed discussions were held with them.	Work is needed regarding the development of a consumer lobby in South Africa. The new mental health policy should more clearly define the need for this development. Direct input from consumers (not only via provider representatives) should obtained. SAFMH- affiated as well as other smaller independent support groups and advocacy groups should be consulted countrywide.
-- Family members or their representatives?	2	A few family associations existed and these were consulted	Family lobby remains small, but there are groups in different provinces which should be consulted as part of the drafting o the new policy
-- Other NGOs?	1	Discussions were held with professional organisations such as Society for Psychiatrists in South Africa, (SPSA) and Psychological Association of South Africa (PSYSSA)	
-- Private sector?	1	Extensive discussions held with Life Care, service providers for long term residential care for people with chronic mental health disorders	
Please use the following rating scale to rate each item: 1 = yes/ to great degree ; 2 = to some extent; 3 = no/not at all ; 4 = unknown	Rating	If "yes" or "to some extent". please state how. If not, state reason(s).	**Action required (if any)**
-- Any other key stakeholder groups? If so, please list them			
5. Has an exchange taken place with other countries concerning their mental health policies and experiences?	1	Chile, Cuba, Zimbabwe	
6. Has relevant research been undertaken to inform policy development, (e.g. pilot studies)?	1	While not all directly done on commission from the DOH, Professor Freeman spent 8 years at the Centre for health Policy doing research to inform policy for SA. Results of the research were periodically	These and other relevant research should be used to inform the new policy.

		presented to various stakeholder groups regarding the implications of these findings for policy. Some pilot studies were also put in place after the policy was passed with a view to changing/revising aspects if results showed changes were necessary. Norms and standards, and other policies have also been developed since the approval of this policy guideline. There has also been a review of mental health services research conducted by Rita Thom, HST 2001.	
CONTENT ISSUES			
1. Is there a realistic vision statement?	**3**		New policy to define
2. Are values and associated principles, which inform the policy included?	**1**		
3) Do these values and associated principles emphasize and/or promote:			For continuity, the new policy should take these principles into account as still relevant to mental health policy reform
-- Human rights?	**1**		
-- Social inclusion?	**1**	Broader issues currently addressed in the social cluster, for eg., are noted in section h).	
Please use the following rating scale to rate each item: 1 = yes/ to great degree ; 2 = to some extent; 3 = no/not at all ; 4 = unknown	**Rating**	**If "yes" or "to some extent". please state how. If not, state reason(s).**	**Action required (if any)**
-- Community care?	**1**		
-- Integration?	**1**		
-- Evidence-based practice?	**3**	Pilot studies were conducted after the policy was approved, but the policy was not reviewed after 1997.	Must be included in the drafting of new policy as there is ample research available, and a Africa wide study underway which includes SA (MHaPP)
-- Intersectoral collaboration?	**2**	There is a reference to INTRA sectoral collaboration (partnerships with private mental health professionals and traditional healers) in the key policy principles and a short statement on	Collaboration with social welfare, housing, justice, education and all other relevant sectors will have to be considered for next draft policy.

		cooperation with other government departments in the key priority areas (Special programmes,I.h., and life skills education in Schools, IV.b.).	
-- Equity with physical health care?	2	Not directly but indirectly through many principles	
4. Have clear objectives been defined?	3	The document identifies key priority areas, but these are not objectives but rather areas for action	Although not specifically framed as objectives, the priority areas are for the most part still relevant. For continuity, the new policy should take these into account
5. Are objectives consistent:	N/A		For attention in the new national mental health policy and plan
-- With the vision?	N/A	No vision	
-- With the values and principles?	N/A	There are some areas under the principles which are not elaborated under the key priority areas (see point 6 below)	
Please use the following rating scale to rate each item: 1 = yes/ to great degree ; 2 = to some extent; 3 = no/not at all ; 4 = unknown	**Rating**	**If "yes" or "to some extent". please state how. If not, state reason(s).**	**Action required (if any)**
6. Are the areas for action clearly described to indicate the main policy directions and what will be achieved?	2	Areas for action = key priority areas in the SA policy guidelines The following should be expanded: -balance in allocation of human and financial resources -promotion of mental health and prevention of mental illness, in the latter instance in particular regarding the promotion of recovery and prevention of disability -Special programmes -role and involvement of community structures The following was not clearly described: -partnership with private/traditional	For attention in the new national mental health policy and plan

		practitioners	
		-capacity development (training, supervision etc)	
		-dedicated service providers	
		-incorporation of training institutions as partners	
		-role and involvement of consumers and their support network in policy development and service evaluation,	
7. Are the areas for action written in a way that commits the governments (e.g. do they state "will" instead of "should")?	3	The document currently is written more as an advocacy document ("should") than a government policy document (will)	For attention in the new national mental health policy and plan
8. To what extent do the areas for action comprehensively address **coordination & management?**	1	In the white paper for the Transformation of the Health System in South Africa, Department of Health, April 1997 (the White Paper) adequately addresses coordination and management in chapter 12 on Mental Health	
Please use the following rating scale to rate each item: 1 = yes/ to great degree ; 2 = to some extent; 3 = no/not at all ; 4 = unknown	**Rating**	**If "yes" or "to some extent". please state how. If not, state reason(s).**	**Action required (if any)**
(a) Does the policy specify a dedicated mental health position/post within the Ministry of Health to coordinate mental health functions and services?	1	This is specified in the White paper on Health (1997) but not in policy guidelines.	
(b) Does the policy establish or refer to a multisectoral coordinating body to oversee major decisions in mental health?	3	Advisory committees were set up in some provinces in the 1990s, as recommended by the national office at the time, but this has fallen away in most provinces and could be a useful monitoring, oversight and consultation tool for national and provincial offices.	For attention in the new national mental health policy and plan
9) To what extent do the areas for action comprehensively address **financing?**	2	Generally notes the need to re redirect budget allocations and budget for new programmes.	For attention in the new national mental health policy and plan- the policy directives on financing should be informed by the current financing policy framework and mechanisms of the department – additional expertise from the finance section should be secured to assist the directorate with this aspect of the policy

	Rating	If "yes" or "to some extent". please state how. If not, state reason(s).	Action required (if any)
(a) Does the policy indicate how funding will be utilized to promote equitable mental health services?	3		
(b) Does the policy state that equitable funding between mental health and physical health will be provided?	3		
(c) If health insurance is utilized in the country, does the policy indicate whether/how mental health would be part of it?	3		For attention in the new national mental health policy. and plan, which should explicitly state how mental health should be financed, partially tax, partially private health insurance funds and with a view to minimizing out of pocket payments. Mental health should be financed consistently with other health priorities, for example included in a national social insurance scheme if developed
Please use the following rating scale to rate each item: 1 = yes/ to great degree ; 2 = to some extent; 3 = no/not at all ; 4 = unknown	**Rating**	**If "yes" or "to some extent". please state how. If not, state reason(s).**	**Action required (if any)**
10. To what degree do the areas for action comprehensively address **legislation and/or human rights?**	3	Legislation and human rights in relation to mental health are not addressed in the policy but In the Mental Health Care Act , no 17 of 2002	New Mental Health Care Act extensively addresses human rights , and should be referred to and flow into the form and content of the new policy
(a) Does the policy promote human rights?	2	Not explicitly stated, but the focus of the priority areas supports the human rights of mental health care users and their families, their inclusion in the social fabric of society and its opportunities. However issues related to their own participation and self determination is not well articulated in the policy	
(b) Does the policy promote the development and implementation of human-rights-oriented legislation?	1	In the White Paper but not in policy guidelines document Chapter 12 on mental health in the White paper provides for the review of " legislation relating to mental health and substance abuse to safeguard the human rights of all service users"	

	Rating	If "yes" or "to some extent". please state how.	Action required (if any)
(c) Is the setting up of a review body envisaged to monitor different aspects of human rights?	2	In Mental Health Care Act, no 17 of 2002 provides for setting up review boards to monitor human rights for mental health care users utilising mental health services	
11. To what extent do the areas for action comprehensively address **organization of services?**	1		
(a) Does the policy promote the integration of mental health services into general health services?	1		
Please use the following rating scale to rate each item: 1 = yes/ to great degree 3 = no/not at all; 2 = to some extent 4 = unknown	Rating	If "yes" or "to some extent". please state how.	Action required (if any)
(b) Does the policy promote a community-oriented mental health approach?	1	Needs to be more clearly spelt out in detail as was done for 11(a), as it does not sufficiently specify form and scope of these services., nor does it sufficiently spell out the conditions under which continued institutional care (e.g. 1e on care of chronic patients in specialised psychiatric hospitals and private contracted hospitals) will be necessary rather than community based services, leaving the door open or continued use of institutional care for users with chronic conditions. In the Policy guidelines, these programmes are listed as "special programmes" as they do not form part of general health care and will need a different budget. That is, left to be budgeted for within the general district health service budget, these services may not happen at all. The WHO AIMS data show that some provinces have mechanisms for transfer payments to NGOs for the development of these services. Semi-structured interviews with NGOs reveal a struggle to obtain comprehensive and adequate funding, even where transfer payments do exist. These services should be seen as core, funded options for comprehensive care	The new national mental health policy and plan should clearly state the focus of community services, and use the Mental Health Care Act, 2002 and draft Psychosocial Rehabilitation (PSR) policy guidelines, 2004, to inform this approach. The PSR Guideline should be finalised. The WHO Policy Package should be consulted to inform this work (http://www.who.int/mental_health/policy/en/

		and recovery (The service delivery platform for these services are clearly outlined in the Mental Health Care Act and in Draft 4 of the Psychosocial Rehabilitation Policy Guidelines)	
(c) Does the policy promote deinstitutionalization?	2	The policy promotes accessible care closest to home, integration into community life, and rehabilitative care as opposed to custodial care in institutions, but does not specifically mention the need for deinstitutionalisation. Departmental operational plans at national and provincial levels did however include targets and indicators for deinstitutionalisation.	For attention in the new national mental health policy and plan: The new policy should specifically outline what this means, that it is not a cost saving de-hospitalisation process as it is currently used, but requires resource allocation and development of community based services to support the process
12. To what extent do the areas for action comprehensively address **promotion, prevention and rehabilitation?** Does the policy make provision for:			Two WHO documents exist which could be used to support the development of this area.
(a) The prevention of mental disorders?	1	The White paper integrates prevention into all health programmes, and designates the Mental Health and Substance Abuse Directorate as responsible for developing national policies and norms for the prevention and control of mental illness and substance abuse. Three specific focus areas for intervention are highlighted in the i policy, namely prevention of delays in emotional and intellectual development through interventions with mothers, life skills education in schools and prevention of Foetal Alcohol Syndrome.:	The areas could be expanded in the new policy
(b) Interventions that promote mental health?	1	The white paper has a strong focus on health promotion and adopts the 5 principles of health promotion of the Ottowa Charter: development of public policies and legislation, community action, skills development,	The areas could be expanded in the new policy

		promoting healthy physical and social environments, empowerment of communities and individuals to promote their own health and a focused reorientation of the health services and service delivery. In the policy itself "Promotion of mental health and the prevention of mental illness"is emphasized	
(c) Interventions for the rehabilitation of people with mental disorders?	**1**	This is broadly discussed in the policy, more clearly outlined in the legislation and the 4th draft of the PSR Policy guideline	Core area for attention in the new policy
13. To what extent do the areas for action comprehensively address **advocacy?**	**2**		See WHO Advocacy Module for key areas of attention, including the mobilization and involvement of mental heath care users and there support networks For attention in the new national mental health policy and plan
(a) Is the policy supportive of consumers and family organizations?	**2**	Under principles but not key priority areas	For attention in the new national mental health policy and plan
(b) Is there emphasis on raising awareness of mental disorders and their effective treatment?	**2**	Public awareness campaigns and other health education initiatives is mentioned under the section on Fetal Alcohol Syndrome, but is not elaborated as a general focus area in the policy	For attention in the new national mental health policy and plan
(c) Does the policy promote advocacy on behalf of people with mental disorders?	**3**		For attention in the new national mental health policy and plan

Please use the following rating scale to rate each item: 1 = yes/ to great degree ; 2 = to some extent; 3 = no/not at all ; 4 = unknown	Rating	If "yes" or "to some extent". please state how. If not, state reason(s).	Action required (if any)
14. To what extent do the areas for action comprehensively address **quality improvement?** Does the policy	3		For attention in the new national mental health policy and plan
(a) Make a commitment to providing high quality, evidence- based interventions?	2	Notes the need for research on quality improvement, and effectiveness of interventions, but needs extensive elaboration in term of quality improvement mechanisms such as standards for care, service monitoring systems, accreditation mechanisms and	For attention in the new national mental health policy and plan
(b) Include a process to measure and improve the quality of services?	3		
15. To what extent do the areas for action comprehensively address **information systems?**	3		For attention in the new national mental health policy and plan
(a) Will mental health information systems be set up to guide decision-making for future policy, planning and service development?	3		For attention in the new national mental health policy and plan
16. To what extent do the areas for action comprehensively address **human resources and training?**	2	Principles mention partnerships with training institutions. In the White Paper	For attention in the new national mental health policy and plan. The current difficulties in recruitment, retention and skills development of mental health practitioners is a difficulty faced in human resources for health in general in South Africa, and is a specific focus of the National HR Policy for Health. It is therefore crucial that the national mental health directorate interface with and inform the National HR Policy/Plan, and the relevant Health Professions Councils which oversee the scope of practice and training of mental health practitioners. Posts need to be created for new classes of mental health service providers, e.g. the Registered counsellors and newly envisaged mental health assistants. The new policy should highlight HR as a priority

			area and outline the key areas which will need attention
(a) Does the policy commit to putting in place suitable working conditions for mental health providers?	3	The Department of Health is currently developing a comprehensive Human Resource (HR) Policy for the department. The National Directorate for Mental Health is providing mental health specific HR input to this more general process.	
(b) Have appropriate management strategies been discussed to improve recruitment and retention of mental health providers?	3	HR Policy of Health department – mental health providing input to this more general process	
Please use the following rating scale to rate each item: 1 = yes/ to great degree ; 2 = to some extent; 3 = no/not at all ; 4 = unknown	Rating	If "yes" or "to some extent". please state how. If not, state reason(s).	Action required (if any)
(c) Are training in core competencies and skills seen as central to human resources development?	2	Need for collaboration with training institutions are mentioned, and is briefly noted in the elaboration of the phc service platform, but not addressed as a key priority area in a way that will inform further policy development and provincial planning. Also mentioned in the White Paper, but not sufficiently detailed	HR Policy of Health department – mental health providing input to this more general process The new policy should specify in more detail the role of and actions required of the mental health directorate and provinces in " developing norms and standards for the education and training of mental health human resources" and interfacing with the relevant health professions councils on the scope of practice and provision of training of (mental) health practitioners.
17. To what extent do the areas for action comprehensively address **research and evaluation?**	2	Too broad and does not address evaluation	The new policy should commit to informing, and supporting a national mental health research agenda, and the development of monitoring and evaluation mechanisms for policy implementation
(a) Does the policy emphasize the need for research and evaluation of services and of the policy and strategic plan?	2	Evaluation of services and programmes mentioned, but not of	

		the policy and strategic plan	
18. To what extent do the areas for action comprehensively address intrasectoral collaboration within the health sector? Does the policy (a) emphasise collaboration with planning, pharmaceutical, human resource development, child health, HIV/AIDs, epidemiology and surveillance, epidemic and disaster preparedness divisions within the health sector (b) Contain clear statements of what role each department will play in each area for action?	**3** **3**	The need for collaboration (partnerships) with private sector and traditional healers is emphasized in the key principles but there are no clear statements on the role of each department.	The new policy should include intrasectoral collaboration as a crucial focus area to achieve integration of mental health into general health care. Key areas to ensure coordination of inter-programme development should be identified. Technical support to other health policy and programmes developers should be provided to assist them to define their role in and to integrate mental health into their existing programmes.
Please use the following rating scale to rate each item: 1 = yes/ to great degree ; 2 = to some extent; 3 = no/not at all ; 4 = unknown	**Rating**	If "yes" or "to some extent". please state how. If not, state reason(s).	Action required (if any)
19. To what extent do the areas for action comprehensively address **intersectoral collaboration?** Does the policy			
(a) Emphasize collaboration with all other relevant government departments?	**2**	Some are mentioned under outline of intervention priority areas, but in an updated policy other relevant sectors within the social cluster should be included.	For attention in new policy document
(b) Emphasize collaboration with all relevant NGOs, including consumer and family groups?	**2/3**	Only mentioned under principles	
(c) Contain clear statements of what role each sector will play in each area for action?	**2**	Examples are given, but roles not clearly specified	
20. Have all of the following groups been considered:			
-- People with severe mental disorders?	**1**		
-- Children and adolescents?	**1**		
-- Older persons?	**3**		The new draft policy at this early stage states that access to services should be based on need and specifies that there shall be no "discrimination regarding age, race or gender" Whether the mental health needs of the

	Rating	If "yes" or "to some extent". please state how. If not, state reason(s).	Action required (if any)
	1		elderly will a focus of the policy will depend on stakeholder input to the new draft policy. This was not specifically identified as a focus by reviewers for this exercise. The department of Social Development is the lead partner on the implementation of already exiting Older Persons Act, no 13 of 2006 which includes ref to mental wellbeing of older persons
-- People with intellectual disability?	1		
-- People with substance dependence?	1		
-- People with common mental disorders?	1		
-- People affected by trauma?	1		
21. Given the available resources, has a "reasonable balance" been achieved between the above groups?	1		
Please use the following rating scale to rate each item: 1 = yes/ to great degree ; 2 = to some extent; 3 = no/not at all ; 4 = unknown	**Rating**	If "yes" or "to some extent". please state how. If not, state reason(s).	Action required (if any)
22. To what degree have the key mental health policy issues been integrated with/or are consistent with the country's		Evaluating it in terms of current laws and policies, the document, passed in 1997, which predates many of the listed laws and policies below, was a progressive departure from the existing laws and policies, and is in line with current laws and polices, ten years later	
-- mental health law?	1	Policy informed the development of mental health law, which as indicated above, expanded on some of the issues which were not well articulated in this policy document.	
-- general health law?	1	In line with the white paper and other legislation developed after its adoption,	

--patients rights charter?	2	Mentioned in principles but not specified under key priority areas	South Africa has a separate Patient's Rights Charter which was launched in September 1999. The charter states that everyone has the right to a healthy and safe environment that will ensure their physical and mental health or well-being, should be included in decisions about their health, notes access rights to health care, also for the special needs of disabled persons, Confidentiality, informed consent, the right to refuse treatment and complain about services, as well as the right to continuity of care is covered.
--disability law?	1	Consistent with although not specifically elaborated, especially in the area of the role of community based supports in the prevention and reduction of disability as a result of mental disorders.	The South African Constitution specifically mentions disabled persons as a priority group for attention within public sector work (each department is required to have a disability plan which is monitored by the Office of Disabled persons in the Presidency). South Africa is also a signatory to the new Convention of the Rights of Disabled Persons, which, along with the constitution, should be referenced as a source document in the new policy. The provisions (articles) of the Convention should inform the key aspects addressed in the new policy as well.
-- health policy?	1		
-- social welfare policy?	3	Interface with social development policy is not mentioned, but while it is suggested the Department of Social development has a role in community based services, and in services for children and adolescents (along with the Department of education), this role is not sufficiently defined. .	For attention in new draft policy. The legislation review team also recommended that the national department needs to schedule discussions with other departments, including Social Development, and this would be useful for comprehensive policy development as well. With regard to Social development, it was suggested that the scope and nature of their service provision for persons with mental and intellectual disability, and

	Rating	If "yes" or "to some extent". please state how. If not, state reason(s).	Action required (if any)
			persons with substance abuse related problems in particular needs clearer delineation
Please use the following rating scale to rate each item: 1 = yes/ to great degree ; 2 = to some extent; 3 = no/not at all ; 4 = unknown	**Rating**	If "yes" or "to some extent". please state how. If not, state reason(s).	Action required (if any)
-- poverty reduction policy?	**2**	Economic functioning is indicated in the heading of one priority intervention, but the issue is not elaborated in the content of that section or elsewhere While not described in further details, the link between mental health and 'national social and economic development' is emphasized in the introduction of the SA policy guidelines	New policy needs to note the context of poverty, the impact of income equality and social and economic inequality in SA, how these conditions exacerbate mental health problems and in turn how mental health problems can lead to or perpetuate poverty. The policy should include a more development focus and should identify and suggest strategies to interface with existing poverty alleviation strategies adopted by government.
-- development policy?	**3**	The policy guidelines do not have a specific development focus, and this could be brought out in the new policy, in the light of emerging evidence regarding the importance of mental health for wider development policy: Examples include mental health related development considerations with respect to urban regeneration and rural development, access to basic amenities and housing, social supports, social assistance, inclusion in job creation and skills development opportunities, and the inclusion of mental health on the broader disability agenda.	For attention in new policy document

Taking into account the financial and human resources available in the country, please comment on the general feasibility for implementation of the policy.

Would require major restructuring of available mental health resources, including upscaling and redirecting allocation of staff, reconfiguring mental health care infrastructure to include development at general hospitals, and increasing resources to NFO-run community based mental health services. SA is still a long way from effecting these 10 years after the adoption of this policy. The promulgation of the new Mental Health Care Act which draws on this policy, has given impetus to developments in mental health in the last 2 years in some provinces, however there is still a need to mobilise political will and promote the prioritisation of mental health within government and other relevant sectors. The latter should be a priority intervention at national and provincial levels to support required

CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN.

There is no national mental health plan. Therefore this section of the checklist was not completed. See text for details.

World Health Organization

WHO Checklist on Mental Health Legislation

Introduction and how to use this checklist

This checklist is a companion to the *WHO Resource Book on Mental Health, Human Rights and Legislation*. Its objectives are to: a) assist countries in reviewing the comprehensiveness and adequacy of existing mental health legislation; and b) help them in the process of drafting new law. This checklist can help countries assess whether key components are included in legislation, and ensure that the broad recommendations contained in the Resource Book are carefully examined and considered.

A committee to work through the checklist is recommended. While an individual in, for example, the ministry of health, may be able to complete the checklist, this has certain limitations. First, no single person is likely to have all the relevant information that a well-selected team would have. Secondly, different individuals or representatives of different groups are likely to have differing views on various issues. An evaluation committee that allows critical debate and the development of a for consensus are invaluable. Although countries should decide for themselves on the composition of the committee, it is advisable to include a legal practitioner familiar with the various national laws, the governmental mental health focal point, representatives of service user and family groups, and representatives of mental health professionals, NGOs and different government departments. It is recommended that the process be led and mediated by an independent human rights and/or legal expert.

This checklist should generally *not be utilized without thoroughly studying the Resource Book itself*. A number of important items included in the checklist are explained in the Resource Book, and the rationale and different options for legislation are discussed. The Resource Book emphasizes that countries should make their own decisions about various alternatives and ways of drafting legislation as well as about a number of content issues. The format of this checklist allows for such flexibility, and aims to encourage internal debate; it thus permits countries to make decisions based on their own unique situations.

The checklist covers issues from a broad perspective, and many of the provisions will need to be fleshed out or elaborated upon with respect to details and country specifications. Moreover, not all provisions will be equally relevant to all countries due to different social, economic, cultural and political factors. For example, not all countries will choose to have community treatment orders; not all countries have provision for "non-protesting patients"; and in most countries, sterilization of people with mental disorders will not be relevant. However, while each country in its evaluative process may determine that a particular provision is not relevant, this determination should be made part of the checklist exercise. All provisions in the checklist should be considered and discussed carefully before it is decided that one (or more) of the provisions is not relevant to a country's particular context.

The Resource Book points out that countries may have laws that affect mental health in a single statute or in numerous different statutory laws relating to areas such as general health, employment, housing, discrimination and criminal justice. Moreover, some countries utilize regulations, orders and other mechanisms to complement a statutory act. It is therefore essential, when conducting this audit, to collect and collate all legal provisions pertaining to mental health, and to make decisions based on comprehensive information.

The Resource Book makes it clear that drawing up or changing mental health legislation is a "process". Establishing what needs to be included in the legislation is an important element of that process, and this checklist can be a useful aid to achieving this goal. Nonetheless, the

objective of drafting a law that can be implemented in a country must never be separated from the "content", and must always be a central consideration.

WHO Checklist on Mental Health Legislation

For each component included in the checklist, three questions need to be addressed: a) Has the issue been adequately covered in the legislation? b) Has it been covered, but not fully and comprehensively? c) Has it not been covered at all? If the response is either (b) or (c), the committee conducting the assessment must decide on the feasibility and local relevance of including the issue, leading to the drafting of locally appropriate legislation.

This checklist does not cover each and every issue that could or should be included in legislation. This does not mean that other items are unimportant and that countries should not pursue them; however, for the sake of simplicity and ease of use, the scope of this checklist has been limited.

Legislative issue	Extent to which covered in legislation
	
	a) Adequately covered
	b) Covered to some extent
	c) Not covered at all
		If (b), explain:
		• Why it is not adequately covered
		• What is missing or problematic about the existing provision
		
		If (c), explain why it is not covered in current legislation
		(Additional information may be added to new pages if required)
			If (b) or (c), explain how/whether it is to be included in new legislation
			(Additional information may be added to new pages if required)
			
			Note: All comments are consensus views unless stated as "Individual comment"

A. Preamble and objectives
 	
1) Does the legislation have a preamble which emphasizes:
    a) the human rights of people with mental disorders?
 	
    b) the importance of
	a) x
	b)
	c)
	
	a) x		

accessible mental health services for all?	b) c)		
2) Does the legislation specify that the purpose and objectives to be achieved include: a) non-discrimination against people with mental disorders?	**a) x** b) c)	*2a Mentions unfair discrimination; that a person with mental disorders and disabilities may at times require protection* 2b) The preamble recognizes that persons and property of a person with mental disorder should be protected, but also states the rights of others to be protected from persons with mental disorders.	Note: SA has equity legislation and affirmative action policies in place which permits discrimination for the purposes of post apartheid redress, in particular targeting the upliftment of black, female and disabled persons .
b) promotion and protection of the rights of people with mental disorders?	**a) x** b) c)		
c) improved access to mental health services?	**a) x** b) c)	*Talks of integrated mental health care services and "in the best interest of the user"*	
d) a community-based approach?	**a x** b) c)		

B. Definitions		1) * A fluid definition of "**mental illness**" is defined as this is the focus of the law. The other terms are not defined.	1)There was some difficulty finding **suitable definitions** to use for the Act. Definitions of the other terms should be included in a revision when done. A definition of mental disability is required
1) Is there a clear definition of mental disorder/mental illness/mental disability/mental incapacity?	**a)** *b)x* *c)*		
		Intellectual disability (ID)is also defined, but only for profound and severe ID as Health at this point offers services for persons with this degree of ID, even without a concurrent mental illness. The Act does not adequately focuses special circumstances required for treatment and care of people with ID. The issue of legal capacity with regard to people with ID also needs specific attention, although not necessarily under the MHCA. *Personality disorders and Substance Abuse disorders are not included.	*There have been some comments that **ID** should be defined covering all functional categories (moderate and mild) and leaving this out can unintentionally imply that persons with moderate and mild ID are excluded from the provisions of the Act, rather than that they are included as will all other citizens, if they have a mental illness. The above ID exclusions arose due to lack of agreement between Social Development, Education and Health around responsibilities for children and adults with ID. It was agreed that health should cover people with severe and profound ID
		*The Substance Dependency Act, 2002 provides for treatment for SA, and is overseen by the Department of Social Development. Even though **Substance use disorders** are recognised as disorders which might require mental health care (DSM1V-R list diagnostic categories for SA), substance abusers with dual diagnosis may receive inadequate treatment as they may find themselves receiving care either by Social Services or Health, rather than the necessary dual care.	***Substance use disorders** should be defined in the Act, and mental health care provisions should be clearly outlined for this

			group of users in the regulations. If there is dual diagnosis they should be treated under this Act
2) Is it evident from the legislation why the particular term (above) has been chosen?	**a)** *b)x* c)	The definition does not indicate why "mental illness" is used; it does not make a distinction between persons (for instance) with substance use disorders, personality disorders, or all persons with intellectual disability. All of these persons have different needs (for instance, with respect to informed consent) and yet are covered under the blanket term "mental illness".	Note : One respondents noted that mental illness is defined as this is a prominent focus area in the Mental Health Care Act. 2 other respondents felt that mental disability and a commitment to recovery should be more clearly spelt out in the Act, and that there is too much of an emphasis on illness, mental health promotion should be better emphasised.
3) Is the legislation clear on whether or not mental retardation/intellectual disability, personality disorders and substance abuse are being covered in the legislation?	**a)** *b) x* c)	As noted above, there is a definition for "severe or profound intellectual disability". The other issues are not specifically defined	Should be defined
4) Are all key terms in the legislation clearly defined?	**a)** *b)x* c)	The legislation is, on the whole, extremely thorough in ensuring that all key terms are defined. A few exceptions exist, as noted above and below.	Address as suggested above and below
5) Are all the key terms used consistently throughout the legislation (i.e. not interchanged with other terms with similar meanings)?	**a)x** *b)* c)	There are certain terms whose meaning are obvious to those who are more aware of South African political designations such as "Executive Council" (s. 18(1)), "head of the national department" (s. 5(1)), "provincial department" (s. 5(1)), etc.	

| 6) Are all "interpretable" terms (i.e. terms that may have several possible interpretations or meanings or may be ambiguous in terms of their meaning) in the legislation defined? | a)

b) x

c) | "**Unfair discrimination**" (s. 10) is not defined. In order to properly distinguish it from "fair discrimination", it would be best to define it.

There is no definition of "**spouse**" (s. 27). This may be problematic in the case of legally married versus traditionally married versus "common law" spouses. It is also not clear how divorced or separated spouses might be treated as opposed to new partners (for instance, if a long-time estranged spouse objected to the decision of an unmarried but long-time partner). Similarly, "**associate**" and "**partner**" are not defined. Does this include business associates or business partners? What about neighbours or close friends? What about bosses or co-workers? Finally, there is no hierarchy of decision-makers. This may be problematic. If several relatives and friends disagree on what to do, whose opinion will the law uphold? Language such as that found in section 60(2)(a) might be considered as a possible solution for clarifying ambiguities.

No definition of "**child**", "**adolescent**", or "**geriatric**" (elderly person?) are given even though there is mention of such persons at section 66(1)(h).

It would be useful to define "**informed consent**" (or "**consent**") in the Act. "Consent" and "informed consent" are fluid terms, and a | These and any other similarly ambiguous terms should be defined |

		clear definition of what constitutes consent can help to ensure that the rights of voluntary patients are properly protected	
C. Access to mental health care 1) Does the legislation make provision for the financing of mental health services?	**a x** *b)* *c)*	Yes. The legislation states that mental health care is to be regulated to make the best possible care available to the population "within the limits of the available resources" (s. 3(1)(i)). No health law in South Africa mentions how it will be financed as cannot legislate this unless assured can implement. Law says "within available resources" with the idea that improvements in this areas would be addressed as part of process and that issue is for progressive realisation within available means. Legislative provision in place, provinces to take the lead to implement in budget allocations	Respondents felt that the current provisions of the MHCA are sufficient.
2) Does the legislation state that mental health services should be provided on an equal basis with physical health care?	**a) x** *b)* *c)*	Section 10 (2) states that every mental health care user must receive care treatment and rehabilitation services according to standards equivalent to those applicable to any other health care user.	Respondents felt that the current provisions of the MHCA are sufficient.
3) Does the legislation ensure allocation of resources to underserved populations and specify that these services should be culturally appropriate?	**a)** *b)* c)x	Law mentions that services should be developed equitably, but does not specify allocation of resources to underserved populations (the majority in the SA context). Cultural appropriateness is not mentioned	Respondents felt that the current provisions of the MHCA are sufficient.
4) Does the legislation promote mental health within primary health care?	**a) x** *b)* c)	Yes (s. 4(a)).	

5) Does the legislation promote access to psychotropic drugs?	a) b) c) x	Not directly. This law says "best possible mental health care" and this must include access to psychotropic drugs as spelt out in primary health care policy and standards. The MHCA itself does not make clear that access to drugs will be promoted, or that persons in remote areas or poor people will be able to receive the medication that they need.	Respondents felt that the current provisions of the MHCA are sufficient.
6) Does the legislation promote a psychosocial, rehabilitative approach?	a) x b) c)	Section 8(2) states that every user must be provided with rehabilitation services that improve the user's capacity "to develop to full potential", Section 5(3) of the regulations provide for "psychosocial rehabilitation programmes or other services" to support recovery to optimal functioning	
7) Does the legislation promote access to health insurance in the private and public health sector for people with mental disorders?	a) b) c)x	There is no mention of insurance.	
8) Does the legislation promote community care and deinstitutionalization?	a)x b) c)	Yes , see 4(b)).	
D. Rights of users of mental health services 1) Does the legislation include the rights to respect, dignity and to be treated in a humane way?	*a) x* *b)* c)	Yes (s. 8(1).	

2) Is the right to patients' confidentiality regarding information about themselves, their illness and treatment included? a) Are there sanctions and penalties for people who contravene patients' confidentiality? b) Does the legislation lay down exceptional circumstances when confidentiality may be legally breached? c) Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to release information?	*a) x* *b)* c) *a)* *b)* c) x *a) x* *b)* c) *a)* *b)x* c)	2) Yes (see s. 13). a) Limits on disclosing confidential information is upheld by the Act ch 3, 13(1)and will be investigated via complaints procedures as per review board, but there are no sanctions specified in the MHCA. Provisions for access/refusal of access to personal records are covered in the Promotion of Access to Information Act of 2000 b) Yes, section 13(2). c) Yes, judicial review is not mentioned, but appeals are permitted via the regular appeals process before the Review Board (s. 19(1)(a)), a decision of the head of a health establishment may be appealed. Under section 13(2) a head of a health establishment is one of the persons who can release information without consent. The others are the head of the national and provincial departments, although it is not stated in section 19 that their decisions can be appealed	Respondents felt that the current provisions of the MHCA are sufficient, as covered in other legislation. No changes to the MHCA recommended by respondents
3) Does the legislation provide patients free and full access to information about themselves (including access to their clinical records)? a) Are circumstances in which such access can be	*a)* *b)* c)x	3) Not specified in the MHCA, but covered in the Access to Information Act and the Health Act 2003 a) Section 13(1) and (2) of the Act	3)Respondents felt that the current provisions of the MHCA are sufficient, as covered in other legislation

denied outlined? b) Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to withhold information?	*a)x* *b)* *c)* *a)x* *b)* *c)*	This is covered in the Access to Information Act and the general provisions under the mental health review board powers and functions Section 19	b) Respondents felt that the current provisions of the MHCA are sufficient, as covered in other legislation
4) Does the law specify the right to be protected from cruel, inhuman and degrading treatment?	*a) x* *b)* *c)*	4) See section 11 on exploitation and abuse	
5) Does the legislation set out the minimal conditions to be maintained in mental health facilities for a safe, therapeutic and hygienic environment?	*a)* *b)x* c)	The Act does not set out minimal conditions. The law provides that the minister may publish regulations on standards, but no timeframes have been set for completion of this important work. (s. 66(1)(b)). The permissive language means that there is a risk of <u>no regulations</u> being made, and thus no minimum conditions being set.	**Individual comment**: Designation of health establishments as psychiatric hospitals: In practice, this "designation" is being applied to large stand-alone hospitals as well as designated psychiatric units in district and regional level general hospitals, in the latter case, irrespective of infrastructure and staffing capabilities. Definitions (and regulations on infrastructural and staffing standards) are required in particular, for psychiatric inpatient unit in a general

			hospital (district or regional level)- address in regulations Note: One of the reviewers is currently developing a guideline of options for monitoring and ensuring that these standards are met and a tool (questionnaire) to assess whether countries are adequately implementing such a provision. should be independent of government quality assurance mechanisms and licencing inspectorates, and should have powers to ensure that their recommendations are implemented within specific timeframes. An inspectorate for this purpose should be accommodated within provisions in provincial ordinance for licencing of facilities)
6) Does the law insist on the privacy of people with mental disorders? a) Is the law clear on minimal levels of privacy to be respected?	*a) x* b) c) *a)* b) c) x	6) Section . 8(1)). b) a)No minimum levels are set.	Current provisions sufficient in the MHCA . Well covered by confidentiality provisions.
7) Does the legislation outlaw forced or inadequately remunerated labour within mental health institutions?	*a)* b)x	Section 11(1)(b) eschews forced labour, but inadequately remunerated labour is not mentioned.	

	c)	.	
8) Does the law make provision for:		**Educational activities**: Regulations provide that the Dept of Education should establish and implement programmes for learners for adults entitled to basic education programmes. Educational training is provided only for those persons "admitted" to health establishments. This may result in no educational facilities for outpatients or in-community patients.	
• educational activities,	*a)* *b) x* c)		Vocational training**: The regulations should specify that vocational rehabilitation and skills development should be provided by the Dept of Labour. There is a need for Education and Labour to discuss the a seamless platform for skills development for children and adults with mental disability.**
• vocational training,	*a)* *b)x* c)	**Vocational training**: Reg 5(3) revised Feb 2005 provides for vocational rehab programmes , which would assist the recovery of the person to optimal functioning.	
• leisure and recreational activities, and	*a)* *b)* c) x	**Leisure and recreational activities** not mentioned in the Act	Leisure and recreational activities **– most psychosocial programmes include such activities, and it certainly needs to be included in the MHCA for attention Dept of Sports and Recreation**
• religious or cultural needs of people with mental disorders?	*a)* *b)* c) x	**Religious or cultural needs** are not mentioned in the Act, but a constitutional right.	**Religious or cultural needs**: No changes recommended by respondents
9) Are the health authorities compelled by the law to inform patients of their rights?	*a) x* *b)* c)	Section 17.	
10) Does legislation ensure that users of mental health services are involved in mental health policy,	*a)* *b)*	The invaluable "inside information" obtained form current or former mental health care users can increase the usefulness and effectiveness of	Respondents felt this should not be legislated

legislation development and service planning?	c) x	services policies and law. However, respondents felt this was not something that needs to be legislated Is included as a principle in the 1997 National policy guideline, and can be included in new policy.	10) NGOs/user groups to address the issue of representation , as it's difficult to know who to engage with as this picture changes over time.
E. Rights of families or other carers 1) Does the law entitle families or other primary carers to information about the person with a mental disorder (unless the patient refuses the divulging of such information)?	*a)* *b)* *c) x*	1) Rights of family members to information about a person with mental disorder not explicitly mentioned in the law.	The Act does not sufficiently address the role and supports due (rights and obligations) to the family, an issue which should be addressed particularly with current shift to care in the community. There is not sufficient understanding of how this may be effected, and a review of the literature may be needed in this respect. May consider for inclusion with a next legislative review, but would need more information on is best kind of provision in this respect.
2) Are family members or other primary carers encouraged to become involved in the formulation and implementation of the patient's individualized treatment plan?	*a)* *b)* *c) x*	No. Depends on many factors: Families may not wish to be involved. In the case of C& A, and persons with Intellectual Disability families should be consulted. Provisions which allow family involvement would need to guard against potential abuse of the patient's rights as the patient and family may differ regarding what they would want.	Needs review
3) Do families or other primary carers have the right to appeal involuntary admission and treatment decisions?	*a) x* *b)* *c)*	Yes, Section 35.	

4) Do families or other primary carers have the right to apply for the discharge of mentally ill offenders?	a) b) x c)	While this right is not explicit, presumably it could be effected under s. 35 (right of families/caregivers to appeal involuntary admissions and treatment). However, it should be noted that s. 35 provides that families have the right to appeal within 30 days of the admission of the head of the facility. There does not seem to be a general and continuous right to apply for discharge.	
5) Does legislation ensure that family members or other carers are involved in the development of mental health policy, legislation and service planning?	a) b) c) x	No, family members can bring invaluable insight to these processes, particularly with respect to policies and service development for outpatient care, community care facilities, psychosocial rehabilitation programmes and appropriate educational and vocational training. However, as with users, not an issue which reviewers felt requires legislation, rather an issue for inclusion in policy and for organisation and advocacy by the sector.	Again, respondents felt this should not be legislated. Difficult to bring them on board due to lack of expertise, limited amounts of groups to consult, etc. Must differentiate between families (who may not be involved) and carers (who are involved)
F. Competence, capacity and guardianship 1) Does legislation make provision for the management of the affairs of people with mental disorders if they are unable to do so?	a) b) x c)	The MHCA Sections 59-65 allows for the appointment of an administrator. The powers of the administrator cover property matters only. but not other general affairs	Guardianship provisions which address the needs of people with mental health conditions should be integrated into a more comprehensive guardianship Act (There is separate draft guardianship legislation at this point. The new draft decision-making law makes provision for three levels of guardianship (persisting power of attorney, mentor and curator). This new

				draft legislation makes provision for appeal against curatorship<mark>)</mark> The development of the above should review the provision of the new convention on the rights of people with disability and make law consistent with this.
2) Does the law define "competence" and "capacity"?	*a)* *b)* c) x		No. Not included in MHCA, and this is consistent with acts in other countries who have separate legislation regulating competence and capacity. SA has draft legislation on Decision-making capacity in Adults	Respondents felt that the current provisions of the MHCA are sufficient, as covered in other legislation
3) Does the law lay down a procedure and criteria for determining a person's incapacity/incompetence with respect to issues such as treatment decisions, selection of a substitute decision-maker, making financial decisions?	*a)* *b)* c)x		No. The Master (a judicial authority) may appoint an administrator after reviewing documents and (if appropriate) order an investigation Only states that a clinical assessment must be done.. There are no criteria set for how an investigator or Master will determine whether a person is incapable or incompetent.	Could be included in regulations
4) Are procedures laid down for appeals against decisions of incapacity/ incompetence, and for periodic reviews of decisions?	*a) x* *b)* c)		Yes (s. 60(10)). It should be noted that unless the person with mental illness has professional representation it may be difficult or impossible for him or her to meet the 30-day appeal deadline. Furthermore, without a clear definition of incapacity or incompetence, it would be difficult for a person to appeal such a finding.	No changes recommended by respondents
5) Does the law lay down procedures for the appointment, duration, duties and responsibilities of a guardian to	*a)* b)x		The law provides for the appointment of an administrator <u>of property</u>, but of no other kind of administrator. The duration of the	It would be useful to elaborate to include relevant issues beyond property issues in the MHCA

act on behalf of a patient?	c)	administrator's term is not reviewed at any point, but can be termination upon application by interested parties (s. 64). The duties and responsibilities of the administrator are stated in s. 63(3-4). These do not, however, include the statement that an administrator must at all times act in the best interests of the person concerned. While procedural protections are in place, a clear statement of the best interests of the mentally ill person emphasizes the protective role of administrator. Furthermore, and most importantly, the Act does not state that administrative duties end immediately and automatically upon a person being discharged or otherwise found competent to manage their own property.	itself as there are issues which can have huge implications with regard to mental health care users' wellbeing and protection. Need also to differentiate between capacity (a legal issue) and incompetence (a clinical issue)
6) Does the law determine a process for establishing in which areas a guardian may take decisions on behalf of a patient?	*a)* b)x c)	An administrator may only be appointed with respect to property.	As noted above under 5)
7) Does the law make provision for a systematic review of the need for a guardian?	*a)* b) c) x	There is no systematic review of a patient's capacity or competence in the Act.	See comments under F1 above
8) Does the law make provision for a patient to appeal against the appointment of a guardian?	*a) x* b) c)	Yes (s. 60(10)).	Clinical guidelines and training for the expanded group of mental health care practitioners is needed to implement this . A gap analysis of practitioner skills will be needed to inform development of the guidelines, and training.

G. Voluntary admission and treatment		Not explicitly stated but implicit in the provisions of section 4c-rights and interests of MHCU to be promoted, section 7(2) best interests of MHCU to be upheld and section 8(3) care must be proportionate to mental health status and intrude only as little as possible to give effect to appropriate care.	
1) Does the law promote voluntary admission and treatment as a preferred alternative to involuntary admission and treatment?	*a)* *b)x* *c)*		
2) Does the law state that all voluntary patients can only be treated after obtaining informed consent?	*a) x* *b)* *c)*	Section 9(1) states that services provided must be done only if "the user has consented..".	
3) Does the law state that people admitted as voluntary mental health users should be cared for in a way that is equitable with patients with physical health problems?	*a) x* *b)* *c)*	Section 10(2) services…equivalent to those applicable to any other health care user.	
4) Does the law state that voluntary admission and treatment also implies the right to voluntary discharge/refusal of treatment?	*a)* *b)* *c)x*	The law does not explicitly state that voluntary patients have the right to be discharge or refuse treatment.	Legislation can ensure that voluntary patients maintain their rights to refuse treatment; in the case of voluntary patients whose conditions worsen, legislation can provide that upon application by a family member or treating physician a voluntary patient may become an involuntary patient with the same protections as all other involuntary patients. Otherwise, voluntary patients may risk losing their rights upon admission or commencement of treatment.

5) Does the law state that voluntary patients should be informed at the time of admission that they may only be denied the right to leave if they meet the conditions for involuntary care?	*a)* *b)* *c) x*		There should be some provision to give voluntary patients timely notice if there is clinical evidence that they are beginning to show deterioration in their condition which might require involuntary care. Such information should not be withheld by the clinical team. Could be included in the regulations.
H. Non-protesting patients 1) Does the law make provision for patients who are incapable of making informed decisions about admission or treatment, but who do not refuse admission or treatment?	*a) x* *b)* *c)*	Such persons are called "assisted health care users"	
2) Are the conditions under which a non-protesting patient may be admitted and treated specified?	*a) x* *b)* *c)*	Yes, see section 26 and following	**Individual comment**: The provision that an applicant for assisted care must have their application signed under oath is cumbersome and unnecessary.
3) Does the law state that if users admitted or treated under this provision object to their admission or treatment they must be discharged or treatment stopped unless the criteria for involuntary admission are met?	*a) x* *b)* *c)*	Yes (see s.31).	
I. Involuntary admission (when separate from treatment) and		a) Law states there must be evidence of mental	*Individual comment:* One respondent noted that it would be

involuntary treatment (where admission and treatment are combined) 1) Does the law state that involuntary admission may only be allowed if: a) there is evidence of mental disorder of specified severity? and; b) there is serious likelihood of harm to self or others and/or substantial likelihood of serious deterioration in the patient's condition if treatment is not given? and; c) admission is for a therapeutic purpose?	*a)* b)x c) *a)* b) x c) *a)x* b) c)	disorder, which would be a clinical decision. "Severity" is a clinical assessment. The act also covers the likely impact of mental disorder on (1)likelihood to harm self or other or (2) to harm to financial status or reputation, as a measure of severity. 1b) Section 32(b)(i) states that a person must be likely to inflict serious harm to him/herself or others. There is no mention of deterioration of the person's condition. Section 32(ii) includes financial or reputational harm as grounds for involuntary care if mentally ill Yes, It must be determined that the person has a mental illness (32b) which requires care treatment and rehabilitation services, in this instance, given involuntarily as the user is not able to give informed consent for the treatment. Care and treatment cannot be provided solely to (1) protect the user or others from harm, or (2) to protect the financial interests of the user, as mental health care practitioner assessments must also show clinical evidence of a mental illness contributing to (1) and (2) before admission will be granted for mental health care.	preferable to align the criteria for involuntary admission closer to those recommended by the WHO. The issue of "reputation" may be too weak. It would be better to come into line with international criteria. . *Individual comment:* The provision that an applicant for involuntary care must have their application signed under oath is cumbersome and unnecessary.
2) Does the law state that two accredited mental health care practitioners must certify that the criteria for involuntary admission	*a) x* b) c)	Yes (s. 33(4)). The definition of "mental health care practitioner" and the other definitions of "psychiatrist", "social worker", etc. Clearly state that persons must be accredited or registered.	

have been met?			
3) Does the law insist on accreditation of a facility before it can admit involuntary patients?	**a)x** b) c)	Yes, Section 6(5) provides for involuntary admissions to facilities designation as psychiatric hospitals under section 5(1)	
4) Is the principle of the least restrictive environment applied to involuntary admissions?	**a) x** b) c)	Section 8(3) would seem to cover this aspect of mental health care.	
5) Does the law make provision for an independent authority (e.g. review body or tribunal) to authorize all involuntary admissions?	**a) x** b) c)	Yes. See Chapter IV on the "Mental Health Review Boards". Section 19(d) deals specifically with involuntary inpatient care.	
6) Are speedy time frames laid down within which the independent authority must make a decision?	**a)** b)x c)	Timeframes are set, but not in line with international standards for "speedy". A patient may be held for observation for 72 hours (section 34). If the head of the health establishment afterwards decides that the patient must be involuntarily admitted, documents must be sent to the Review Board within seven days (s. 34(3)(c)(i)). The Review Board then has 30 days upon receiving the documents to make a decision (s. 34(7)). If the Review Board decides that involuntary admissions are warranted, the request is forwarded to the High Court (s. 36), who has 30 days to issue a decision. This means that a patient can potentially be held for a period of 70 days before hearing back – an unacceptable period of time, by international standards.	**Most respondents:** These timeframes could be reviewed once implementation of the new legislation has been underway for a sufficient time**.** **Individual comment:** The time-frame for the Review Board to make decisions on involuntary and assisted users is too long. The Head of a Health Establishment (HHE) is given 7 days to send their decision and then the Review Board is given another 30 days. This may open users to abuse of rights. Though it would I know it would be

		Although not ideal, shorter periods were not set as it was felt that shorter timeframes would not be implementable within current resources constraints in the country, hence the current timeframes. . In addition, neither sections 19 or 34 seems to say that the Review Board has the power to immediately discharge an involuntary or assisted patient on the basis of finding no reason to keep them in a health institution. Section 36explicitly states that the High Court, upon review of a request to allow involuntary admission, may order a discharge.	difficult to implement, it would be more suitable to shorten this process to 14 days in total.
7) Does the law insist that patients, families and legal representatives be informed of the reasons for admission and of their rights of appeal?	*a)* *b)x* *c)*	Section 17 implies that patients must be informed of their appeal rights. There is no mention of the rights of family members, caregivers, or legal representatives.	
8) Does the law provide for a right to appeal an involuntary admission?	*a) x* *b)* *c)*	Yes (see section 35).	
9) Does the law include a provision for time-bound periodic reviews of involuntary (and long-term "voluntary") admission by an independent authority?	*a)* *b) x* *c)*	The law provides for periodic review of involuntary admissions, six months after the commencement of care and every 12 months afterwards (s. 37). There is no periodic review of long-term voluntary patients.	
10) Does the law specify that patients must be discharged from involuntary admission as soon as	*a) x* *b)*	Yes (see s. 38).	

they no longer fulfil the criteria for involuntary admission?	c)		
J. INVOLUNTARY TREATMENT (WHEN SEPARATE FROM INVOLUNTARY ADMISSION) 1) Does the law set out the criteria that must be met for involuntary treatment, including: • Patient suffers from a mental disorder?	*a)* b) c)	SA does not have separate provision for involuntary treatment and admission	
• Patient lacks the capacity to make informed treatment decisions?	*a)* b) c)		
• Treatment is necessary to bring about an improvement in the patient's condition, and/or restore the capacity to make treatment decisions, and/or prevent serious deterioration, and/or prevent injury or harm to self or others?	*a)* b) c)		
2) Does the law ensure that a treatment plan is proposed by an accredited practitioner with expertise and knowledge to provide the treatment?	*a)* b) c)		

3) Does the law make provision for a second practitioner to agree on the treatment plan?	*a)* *b)* *c)*		
4) Has an independent body been set up to authorize involuntary treatment?	*a)* *b)x* *c)*	The Review Boards (section IV) automatically reviews and authorize (or not) involuntary admissions, and reviews, via periodic reports, treatment received by involuntary care users, on a 6 monthly, then annual basis, Where a person becomes an involuntary outpatient, the head of the health establishment providing treatment need only discharge the user subject to the conditions of the treatment, and inform the Review Board in writing (s. 34(3)(b)(ii)). Although not specified, section 37 covers all involuntary care users: treatment of involuntary outpatients and involuntary inpatients are subject to appeals or periodic reviews.	
5) Does the law ensure that treatment is for a limited time period only?	*a)* *b)* *c)*		
6) Does the law provide for a right to appeal involuntary treatment?	*a)* *b)* *c)*		
7) Are there speedy, time-bound, periodic reviews of involuntary treatment in the legislation?	*a)* *b)* *c)*		

K. Proxy consent for treatment 1) Does the law provide for a person to consent to treatment on a patient's behalf if that patient has been found incapable of consenting?	*a)* *b)* *c)x*	There are no provisions regarding proxy consent for treatment.	An area which could be addressed in a next revision of the legislation
2) Is the patient given the right to appeal a treatment decision to which a proxy consent has been given?	*a)* *b)* *c)x*		**As above**
3) Does the law provide for use of "advance directives" and, if so, is the term clearly defined?	*a)* *b)* *c)x*		**As above**
L. Involuntary treatment in community settings 1) Does the law provide for involuntary treatment in the community as a "less restrictive" alternative to an inpatient mental health facility?	*a) x* *b)* *c)*	The definition of "health establishment" includes community health and rehabilitation centres (s. 1). In addition, the Act promotes the provision of community-based care, treatment and rehabilitation services (s. 4(b)). Finally, the Act states that care, treatment and rehabilitation must intrude as little as possible (s. 8(3)).	
2) Are all the criteria and safeguards required for involuntary inpatient treatment also included for involuntary community-based treatment?	*a) x* *b)* *c)*		
M. Emergency situations 1) Are the criteria for emergency admission/treatment limited to situations where there is a high	*a)* *b) x* *c)*	s. 9(1)(c)) An additional criteria is set in 9(1)(c)(iii) states that where delay may result in serious damage to or loss of property, a person may be involuntarily admitted. .	Note reviewers comment in I(1) .

probability of immediate and imminent danger or harm to self and/or others?			
2) Is there a clear procedure in the law for admission and treatment in emergency situations?	a) x b) c)	Section 9 (1). Care, treatment and rehab services may not be provided for longer than 24 hours, unless further applications are made for voluntary, assisted and involuntary care as set out in chapter 5	
3) Does the law allow any qualified and accredited medical or mental health practitioner to admit and treat emergency cases?	a) x b) c)	Says a health care provider (defined as person providing health care services)	
4) Does the law specify a time limit for emergency admission (usually no longer than 72 hours)?	a) x b) c)	S. 9(1) provides that a person cannot be held for more than 24 hours without being admitted in terms of ch 5.	
5) Does the law specify the need to initiate procedures for involuntary admission and treatment, if needed, as soon as possible after the emergency situation has ended?	a) x b) c)	Yes, under Section 9(2), if needed, application must be made in terms of chapter 5, for involuntary or other admission procedures, such as voluntary or assisted care.	
6) Are treatments such as ECT, psychosurgery and sterilization, as well as participation in clinical or experimental trials outlawed for people held as emergency cases?	a) b) c) x	(6) These treatments are not outlawed as shown to have clinical efficacy for certain conditions. Stringent criteria for use in place. ECT and psychosurgery are dealt with in MHCA regulations, sterilisation in the Sterilisation Act and participation in trials in the Health Care Act. Exclusion of their use with emergency cases is not specifically addressed.	Respondents felt that the current provisions of the MHCA are sufficient, and sufficiently covered in other legislation where relevant
7) Do patients, family members and personal representatives have the right to appeal against emergency	a) b)	No. In practice, there would not be time to do this.	Respondents felt that the current provisions of the MHCA are sufficient.

admission/treatment?	c) x		
N. Determinations of mental disorder 1) Does the legislation: a) Define the level of skills required to determine mental disorder? b) Specify the categories of professionals who may assess a person to determine the existence of a mental disorder?	*a)* *b)* *c) x* a) x b) c)	a) The legislation does not define the level of skills required to determine mental disorder b) It defines the categories of health professionals to be included in the term "mental health practitioners": these are psychiatrist, psychologist, nurse, medical practitioner, occupational therapist, social worker.	The original drafts of the regulations were more specific and the current specifications should be reviewed now that the regulated provisions are being implemented in the health system
2) Is the accreditation of practitioners codified in law and does this ensure that accreditation is operated by an independent body?	*a) x* *b)* c)	The mental health care regulations briefly describe the specific qualifications and experience required by all of these, except the medical practitioner and psychiatrist The accreditation of practitioners is codified in other legislation.. Basic qualifications are set by the relevant Professional Regulatory Body which acts independently. These are the Health Professions Council of South Africa (HPCSA), Nursing Council of SA, Council of Social Services.	
O. Special treatments 1) Does the law prohibit sterilization as a treatment for mental disorder?	*a)* *b)* c)x	**There is no mention of sterilization in the MHCA.** This is covered in the Sterilization Act which does meet the conditions of 1) and a)	Respondents felt that the current provisions of the MHCA are sufficient, as covered in other legislation

a) Does the law specify that the mere fact of having a mental disorder should not be a reason for sterilization or abortion without informed consent?	*a)* *b)* *c)x*		
2) Does the law require informed consent for major medical and surgical procedures on persons with a mental disorder?	*a)x* *b)* *c)*	Chapter 5 (37) of the regulations set out the need for consent to treatment and operations for illnesses other than mental illness	
a) Does the law allow medical and surgical procedures without informed consent, if waiting for informed consent would put the patient's life at risk?	*a) x* *b)* **c)**	Ch 5(37 permits such surgery without informed consent if certain categories of person e.g. curator, spouse, next of kin, sibling, etc) gives consent, or in their absence, the head of a health establishment is satisfied that the most appropriate intervention is to be performed.	
b) In cases where inability to consent is likely to be long term, does the law allow authorization for medical and surgical procedures from an independent review body or by proxy consent of a guardian?	*a)* *b)x* **c)**	There is no mention of proxy consent or authorization for medical procedures via the Review Board in cases here inability to consent is likely to be long-term. However, provisions under chapter 5 (37) can be used in these circumstances.	Respondents felt that the current provisions of the MHCA are sufficient.
3) Are psychosurgery and other irreversible treatments outlawed on involuntary patients?	*a)x* *b)* *c)*	Psychosurgery is specified in chapter 5 (34.1) of the regulations, but "other irreversible treatments" are not mentioned..	
a) Is there an independent body that makes sure there is indeed informed consent for psychosurgery or other irreversible treatments on involuntary	*a)* *b)*	There is no mention of the confirmation of informed consent by an independent body.	More specific mention of role of Review Board could be included in section 34 of the regulations

patients?	c)x		
4) Does the law specify the need for informed consent when using ECT?	a)x b) c)	Section 35(3) of the regulations .	
5) Does the law prohibit the use of unmodified ECT?	a) x b) c)	Section 35(1) of the regulations	
6) Does the law prohibit the use of an ECT in minors?	a) b) c) x	There is no mention of minors.	Respondents felt that this is an area requiring clinical decisions, based on clinical review, and need not be legislated
P. Seclusion and restraint 1) Does the law state that seclusion and restraint should only be utilized in exceptional cases to prevent immediate or imminent harm to self or others?	a) x b) c)	Chapter 5 section 38(1) of the regulations	
2) Does the law state that seclusion and restraint should never be used as a means of punishment or for the convenience of staff?	a) b)x c)	Punishment mentioned, but not convenience to others	
3) Does the law specify a restricted maximum time period for which seclusion and restraints can be used?	a)x b) c)		
4) Does the law ensure that one period of seclusion and restraint is	a)	A register must be kept and sent to the Review board quarterly, however, does not specify that	Respondents felt this needs revision as not adequate Could

not followed immediately by another?	b) c)x	one period should not immediately follow another, rather states that restraint should be for "as short a period as necessary" with observation at 30 min intervals. No time specified for seclusion, but observations at 30 min intervals.	be modified in terms of (new) WHO guidelines
5) Does the law encourage the development of appropriate structural and human resource requirements that minimize the need to use seclusion and restraints in mental health facilities?	*a)* b) c)x		Needs revision as not adequate
6) Does the law lay down adequate procedures for the use of seclusion and restraints, including: • who should authorize it, • that the facility should be accredited, • that the reasons and duration of each incident be recorded in a database and made available to a review board, and • that family members/carers and personal representatives be immediately informed when the patient is subject to seclusion and/or restraint?	*a)* b)x c)	Meets most, but not all criteria: -Who should authorise -Database to review board states reason and duration - designated public health establishment	It may not be feasible to inform families immediately, but provision should be included that they are informed as soon as possible**.**
Q. Clinical and experimental research 1) Does the law state that informed	*a)* b) c)x	There is no mention of research in the Act. The Health Act, sections 11 and 71 makes provision or informed consent for experimental or research purposes but both acts do not	Respondents felt that the current provisions of the MHCA are sufficient, as covered in other legislation

consent must be obtained for participation in clinical or experimental research from both voluntary and involuntary patients who have the ability to consent?		specifically mention consent from mental health care users	
2) Where a person is unable to give informed consent (and where a decision has been made that research can be conducted): a) Does the law ensure that proxy consent is obtained from either the legally appointed guardian or family member, or from an independent authority constituted for this purpose?	*a)* *b)* c)x	Covered in the Health Act	Respondents felt that the current provisions of the MHCA are sufficient, as covered in other legislation
b) Does the law state that the research cannot be conducted if the same research could be conducted on people capable of consenting, and that the research is necessary to promote the health of the individual and that of the population represented?	*a)* *b)* c)x	Specific reference made to this in the Health Act Section 71, in respect of minors, but, not the MHCA	Respondents felt that the current provisions of the MHCA are sufficient, as covered in other legislation
R. Oversight and review mechanisms 1) Does the law set up a judicial or	*a) x* *b)* c)	Yes, the law sets up a Review Board to make preliminary decisions respecting involuntary admissions. In addition, the High Court reviews all involuntary admissions.	**Individual comment:** Sending decisions on involuntary users to a judge may not add significantly to the process, while placing an

quasi-judicial body to review processes related to involuntary admission or treatment and other restrictions of rights?			additional burden on the process and in some ways undermining the authority of the Review Boards. In terms of the common law, appeals sent to and turned down by the Review Board can be appealed through normal court processes, so access to a higher authority is available if necessary. Also any decision to turn down an appeal goes to the Judge, and this latter provision can be retained to allow the judge to still address the most contentious cases.
A) DOES THE ABOVE BODY:			
(i) Assess each involuntary admission/ treatment?	*a) x* *b)* *c)*		
(ii) Entertain appeals against involuntary admission and/or involuntary treatment?	*a) x* *b)* *c)*		
(iii) Review the cases of patients admitted on an involuntary basis (and long-term voluntary patients)?	*a)* *b) x* *c)*	The Board reviews involuntary patient admissions, six months after admission and yearly afterwards. IT does not review long-term voluntary patient treatment or admissions.	
(iv) Regularly monitor patients receiving treatment against their will?	*a) x* *b)* *c)*	Yes (see above).	

(v) Authorize or prohibit intrusive and irreversible treatments (such as psychosurgery and electroconvulsive therapy)?	a) b) c)x	Review board does not authorise or prohibit (this is done on clinical basis) but does review registers kept on such procedures (set out in the regulations chapter 5)	.
b) Does the composition of this body include an experienced legal practitioner and an experienced health care practitioner, and a "wise person" reflecting the "community" perspective?	a) x b) c)	Section 20(2) of the Act states that the members of the Board must include a mental health care practitioner, a jurist (magistrate, attorney, or advocate), and a member of the community concerned. The law does not state that the above-mentioned persons must be "experienced" or "wise".	**Individual comment**: With regard to the composition of the Board, the fact that people get sick, take leave etc was not considered. If all three groups (legal, mental health, community member) need to be there to make a decision, and they should be, this can create problems. It may be useful to add a 'reserve" list of people who can be called on to sit on the board from time to time. (In the regulations).
c) Does the law allow for appeal of this body's decisions to a higher court?	a) x b) c)	Yes. Review Board decisions are subject to judicial review by the High Court.	
2) Does the law set up a regulatory and oversight body to protect the rights of people with mental disorders within and outside mental health facilities?	a) b)x c)	The Review Board has been set up to protect the rights of people with mental disorders. However, the powers and functions of the Review Board are restricted to decisions affecting specific patients within various mental health treatment facilities, and does not include mental health care users outside of mental health facilities. It's powers and functions (s. 19) do not currently include the power to protect the	The capacity of these review boards to conduct their current functions needs to be monitored and evaluated with the implementation of the new legislation, before any amendments to their functions can reasonably be considered.

		rights of persons with mental disorders in a more general way.	
a) Does the above body: (i) Conduct regular inspections of mental health facilities?	*a)* *b)* *c) x*	This is done by Hospital Boards in terms of the Mental Health Act of 1973 (section not repealed) and Health Act (2003).	**Individual comment:** The issue of "inspectorates' to protect rights is jumbled with the Hospital Boards from the previous Act which still not having been dissolved, and hospital boards being set up in terms of the Health Act (national and provincial) and then the Review Boards themselves. The potential for duplication by the various boards must be addressed
(ii) Provide guidance on minimizing intrusive treatments?	*a)* *b)* *c)x*	May be provided by the review board, but not specifically mentioned	
(iii) Maintain statistics on, for example, the use of intrusive and irreversible treatments, seclusion and restraints?	*a) x* *b)* *c)*	Yes, based on registers sent to Review Board	
(iv) Maintain registers of accredited facilities and professionals?	*a)* *b)* *c) x*	MHCA stipulates designation of public mental health facilities by the National or provincial departments of Health (section 5-6) and the regulations specifies the licencing of private (section 47) and community (section 48) facilities by the health department. Professionals are registered with the	

		appropriate regulatory councils	
(v) Report and make recommendations directly to the appropriate government minister?	a) b)x c)	Not explicitly stated, but the Act makes provision for the Review board to determine its own procedures for conducting business (section 24.1) and for the Minister to draft regulations containing guidelines for powers and functions, and for the reporting obligations of the review boards (section 66p)	In practice, the Review Boards are still newly set up (the Act was promulgated in December 2004 and the first RB set up in April 2005) or being set up in provinces, and most are still in the process of finalising their procedures. Reporting is done annually to the provincial MEC for Health. Regulations have not yet been drafted to formalise section 66p
(vi) Publish findings on a regular basis?	a) b) c)x		See above
b) Does the composition of the body include professionals (in mental health, legal, social work), representatives of users of mental health facilities, members representing families of people with mental disorders, advocates and lay persons?	a) b)x c)	The composition of the Board includes professionals in mental health (mental health practitioners) a legal persona and a lay representative) but does not specify a representatives of users of mental health facilities, members representing families of people with mental disorders, although the community representative might also be a user or family member.	Requirements could be spelt out more clearly for some members of the board 2b Competencies should be more clearly spelt out, for example users selected to serve on the Board should a) have necessary competencies to participate. Relief arrangements should be spelt out to cover illness and absence from duty with due reason. Respondents felt that

				issues such as these could be covered by the administrative arrangements (section 24.1) drafted by the MHRB and does not need to be specified in the legislation or regulations. .
	c) Is this body's authority clearly stated in the legislation?	*a)x* *b)* *c)*	Section 19 and the minister can make further regulations in this respect (section 66p**)**	
3) a) Does the legislation outline procedures for submissions, investigations and resolutions of complaints?		*a)* *b) x* *c)*	There is no specific mention of complaints investigation or resolution. Complaints procedures are important in any institution, to ensure that patients' basic rights and needs are being respected and met. S. 19(1)(a) gives the Review Board the power to consider appeals against decisions of the head of a health establishment. It could be implied that this includes any decision made by the head (and not just a decisions respecting care, treatment or rehabilitation).	
	b) Does the law stipulate: • the time period from the occurrence of the incident within which the complaint should be made?	*a)* *b)* *c) x*	No. There is no explicit complaints procedure.	
	• a maximum time period within which the complaint should be responded to, by whom and how?	*a)* *b)* *c) x*	No. There is no explicit complaints procedure.	

• the right of patients to choose and appoint a personal representative and/or legal counsel to represent them in any appeals or complaints procedures?	*a)* *b) x* *c)*	Complaints: There is no explicit complaints procedure. Appeals: Section 15 states that a mental health car user is entitled to representation when submitting an application or appeal. Review of the Act indicates that such applications or appeals would be in the context of involuntary admissions or treatment. There is no mention of complaints or other kinds of applications or appeals	**Individual comment:** Clarity is needed on who must be present at an appeal process and who can make representation during an appeal process.
• the right of patients to an interpreter during the proceedings, if necessary?	*a)* *b)* *c) x*		This should be addressed in the regulations
• The right of patients and their counsel to access copies of their medical records and any other relevant reports and documents during the complaints or appeals procedures?	*a)* *b) x* *c)*	Section 13(3) states only that a mental health care provider may temporarily <u>deny</u> access to information in certain cases. Patients are entitled to access to medical records under the Access to Information Act	
• the right of patients and their counsel to attend and participate in complaints and appeals procedures?	*a)* *b)x* *c)*	Implied by section 15(1)	
S. Police responsibilities 1) Does the law place restrictions on the activities of the police to ensure that persons with mental disorders are protected against unlawful arrest	*a)* *b) x* *c)*	Guidelines for intervention by police to direct a person with a mental disorder to appropriate health care services are set in Section 40 , but does not cover unlawful arrest and detention.	Review of effectiveness needed with implementation. **:** An evaluation of the degree to which these guidelines are sufficient to protect users from unlawful arrest, detention would be

			needed
and detention, and are directed towards the appropriate health care services?			
2) Does the legislation allow family members, carers or health professionals to obtain police assistance in situations where a patient is highly aggressive or is showing out-of-control behaviour?	*a) x* b) c)	Section 40 (1) states a mental health care practitioner can alert police, or police through personal observation of mental disturbance (possibly brought to their attention by family, carers community) can apprehend a person and bring them to an appropriate health facility.	
3) Does the law allow for persons arrested for criminal acts, and in police custody, to be promptly assessed for mental disorder if there is suspicion of mental disorder?	*a)* b) c) x	Not in the MHCA. The Criminal Procedures Act (Act 51 of 1977) does provide for assessment of arrested persons, but through the courts, there is no special, prompt procedure.	
4) Does the law make provision for the police to assist in taking a person to a mental health facility who has been involuntarily admitted to the facility?	*a) x* b) c)	Yes. Section 33(9) provides that the head of health establishment :cause the user to be admitted for involuntary care, and section 40(4) gives the head of a health establishment the right to request police assistance in transferring the user "in the prescribed manner".	
5) Does the legislation make provision for the police to find an involuntarily committed person who has absconded and return him/her to the mental health facility?	*a) x* b) c)	Yes (s. 40(4).	
T. Mentally ill offenders 1) Does the legislation allow for diverting an alleged offender with a mental disorder to the mental health system in lieu of prosecuting him/her, taking into account the	*a) x* b) c)	Chapter vii of the MHCA outlines assessment procedures, transfer procedures and health establishments within which a person accused and in the process of being prosecuted for a criminal offence has been diverted for mental health care following a period of observation Section 79(2) of the Criminal Procedure Act of 1977 provides for referral of a defendant for a 30-day psychiatric observation	

gravity of the offence, the person's psychiatric history, mental health state at the time of the offence, the likelihood of detriment to the person's health and the community's interest in prosecution?		at a state psychiatric hospital. The primary enquiry is directed at establishing the presence of mental illness or mental disability. Section 77 requires that the defendant be tested for fitness to stand trial' (competence), and section 78 directs that the assessment consider whether the mental illness or disability interferes with the defendant's appreciation of wrongfulness, or his ability to act in accordance with such an appreciation Section 79(2) defines psychiatric observations which determine whether pathological incapacity due to mental illness or defect operates. If a defendant is not competent to stand trial and /or lacks criminal responsibility the charges are withdrawn and he is referred to a state psychiatric hospital for indefinite hospitalization under the Mental Health Care Act (whereupon he becomes known as a 'state patient'). A state patient is defined as such under the Criminal Procedures Act (as defined in the MHCA- see definitions)	
2) Does the law make adequate provision for people who are not fit to stand trial to be assessed, and for charges to be dropped or stayed while they undergo treatment?	*a) x* *b)* *c)*	**See above**	
a) Are people undergoing such treatment given the same rights in the law as other involuntarily admitted persons, including the right to judicial review by an independent body?	*a)* *b)x* *c)*	Equivalent conditions are in place: State patients are reviewed 6 monthly, are eligible for leave of absence, and application can be made to a judge in chambers for unconditional or conditional discharge, as befits the patients assessed mental health status.	
3) Does the law allow for people who are found by the courts to be "not	*a) x*	Yes, state patient provisions in chapter VI	

responsible due to mental disability" to be treated in a mental health facility and to be discharged once their mental disorder sufficiently improves?	b) c)		
4) Does the law allow, at the sentencing stage, for persons with mental disorders to be given probation or hospital orders, rather than being sentenced to prison?	*a)* *b)* *c) x*	No probation provisions, only state patient provisions, and those for mentally ill prisoners This revision would require a fundamental change from our current law and would need to go to the law commission and involve the Dept of Justice and Constitutional Development, amongst others.	This could be provided for in the Criminal Procedures Act.
5) Does the law allow for the transfer of a convicted prisoner to a mental health facility if he/she becomes mentally ill while serving a sentence?	*a) x* *b)* *c)*	Chapter VII of the MHCA outlines assessment procedures, transfer procedures and health establishments within which mentally ill prisoners may receive mental health care. A mentally ill prisoner is defined as such under the Correctional Services Act (as defined in the MHCA- see definitions) A mentally ill prisoner will already have been convicted and be serving a sentence when a mental disorder is suspected/detected.	
a) Does the law prohibit keeping a prisoner in the mental health facility for longer than the sentence, unless involuntary admission procedures are followed?	*a) x* *b)* *c)*	Yes (see. s. 58).	
6) Does the legislation provide for secure mental health facilities for mentally ill offenders?	*a) x* *b)*	The MHCA (sections 41 and 49) provides for designation of facilities suitable for the care, treatment and rehabilitation of observation cases	

	c)	(accused suspected of mental disorder sent for mental health assessment as per section 79 of the Criminal Procedures Act) or state patients (accused not found fit to stand trial by virtue of mental disorder). Regulations (section 40-43) provide for secure mental health facilities for observation cases and other mental health care users requiring secure care. Mentally ill offenders who do not require secure care, can receive treatment in the prison (s. 51).	
U. Discrimination 1) Does the law include provisions aimed at stopping discrimination against people with mental disorders?	*a) x* *b)* *c)*	Yes (s. 10).	
V. Housing 1) Does the law ensure non-discrimination of people with mental disorders in the allocation of housing?	*a)* *b)* *c)x*	Section 10(1) prohibits unfair discrimination in terms of mental health status, but does not specifically mention non-discrimination in respect of housing allocations	It was recommended by respondents that the regulations should specify that the Dept of Housing should support access to the provision of housing for people with mental disability. Programmes within certain categories of supported housing might also need the support of the Department of Social Development. Discussions to secure the necessary support for these amendments to the regulations should be commenced as soon as possible.

2) Does the law make provision for housing of people with mental disorders in state housing schemes or through subsidized housing?	*a)* b) c)x		Housing legislation has special housing provision for persons with disability, currently in development, but access by persons with mental disability is not specifically addressed.
3) Does the legislation make provision for housing in halfway homes and long-stay, supported homes for people with mental disorders?	*a) x* b) c)	Regulation 5(3) provides for community care to include residential community accommodation and day care centres, or other services which would assist recovery to optimal functioning.	Respondents felt that policy can support legislation: For example, the draft Psychosocial Rehabilitation draft policy specifies housing options to be developed. Housing policy should also specify the inclusion of persons with mental disability in its scope of those in need of housing support. However, at later stage should these policies and regulatory changes not secure the necessary focus on issues related to broader recovery, may need to consider including more stringent provisions in a revision of the law (ten years time)
W. Employment 1) Does the law make provision for the protection of persons with mental disorders from discrimination and exploitation in the work place?	*a)* b) c) x	There is no specific mention of employment protection in the MHCA. This is covered in Employment Equity Act	

2) Does the law provide for "reasonable accommodation" for employees with mental disorders, for example by providing for a degree of flexibility in working hours to enable those employees to seek mental health treatment?	a) b) c) x	This is covered in Employment Equity Act, but specifics of accommodation requirements are not specified.	Recommended that the scope and range of activities for implementation in respect of persons with mental disability still needs to be spelt out in Technical Guidelines
3) Does the law provide for equal employment opportunities for people with mental disorders?	a) b) c)x	This is covered in Employment Equity Act	
4) Does the law make provision for the establishment of vocational rehabilitation programmes and other programmes that provide jobs and employment in the community for people with mental disorders?	a) b)x c)	The MHCA regs (correction Feb 2005) provides for the establishment of vocational rehabilitation programmes The scope and range of these programmes are not specified.	It was suggested that clarity regarding the provision of this service this be addressed by Health with the Departments of Labour and Social Development. Strong support for the department of Labour to take the lead in this provision, and incorporate this into their policies
X. Social security 1) Does legislation provide for disability grants and pensions for people with mental disabilities?	a) b) c) x	Not in the MHCA, but under legislation in the Social Development sector (Social Assistance Act)	
2) Does the law provide for disability grants and pensions for people with mental disorders at similar rates as those for people with physical disabilities?	a) x b) c)	Legislation on Social Assistance provides for a care dependency grant, a disability grant and old age pension paid at one rate.	
Y. Civil issues	a) x	The MHCA specifies that the rights and duties set out in chapter 111 are "in addition to any	

1) Does the law uphold the rights of people with mental disorders to the full range of civil, political, economic, social and cultural rights to which all people are entitled?	*b)* *c)*	rights and duties (users) have in terms of any other law" and with regard to "the best interests" of users. The rights of South African citizens, including persons with mental disability, are specified in the Bill of Rights in the SA Constitution.	
Z. Protection of vulnerable groups *Protection of minors* 1) Does the law limit the involuntary placement of minors in mental health facilities to instances where all feasible community alternatives have been tried?	*a)* *b)* *c)x*		Consensus was not entirely reached on the issue of provision for minors. One perspective held that the rights section of the Act covers all citizens, including vulnerable groups, and that it would be too lengthy. unnecessary to specify every group.. Another perspective recommended that the change need not be in the Act itself, but that issues related to facilities, services and procedures for minors (children and adolescents) should be specifically addressed in the regulations
2) If minors are placed in mental health facilities, does the legislation stipulate that	*a)* *b)*	Agreed that this should be put in place	See above comment

a) they should have a separate living area from adults?	c) x		
b) that the environment is age-appropriate and takes into consideration the developmental needs of minors?	a) b) c) x		See above comment
3) Does the law ensure that all minors have an adult to represent them in all matters affecting them, including consenting to treatment?	a) x b) c)	While the law does not define what a "minor" is, in some cases persons under the age of 18 are represented by parents or guardians (ex. sections 27(1)(a)(i) and 33(1)(a)(i)).	
4) Does the law stipulate the need to take into consideration the opinions of minors on all issues affecting them (including consent to treatment), depending on their age and maturity?	a) b) c) x		See above comment
5) Does legislation ban all irreversible treatments for children?	a) b) c) x		See above comment

Protection of women 1) Does legislation allow women with mental disorders equal rights with men in all matters relating to civil, political, economic, social and cultural rights?	*a)* *b)x* *c)*	There is no specific mention of women's rights. However, The MHCA specifies that the rights and duties set out in chapter 111 are "in addition to any rights and duties (users) have in terms of any other law" and with regard to "the best interests" of users. (Section 7) The rights of South African citizens, including equal rights for women, are specified in the Bill of Rights in the SA Constitution.	
2) Does the law ensure that women in mental health facilities : a) have adequate privacy?	*a)* *b)* *c)x*		
b) are provided with separate sleeping facilities from men?	*a)* *b)* *c)x*		
3) Does legislation state that women with mental disorders should receive equal mental health treatment and care as men, including access to mental health services and care in the community, and in relation to voluntary and involuntary admission and treatment?	*a)* *b)* *c) x*	Not in the MHCA, but equality is a constitutional right	

Protection of minorities 1) Does legislation specifically state that persons with mental disorders should not be discriminated against on the grounds of race, colour, language, religion, political or other opinions, national, ethnic or social origin, legal or social status?	*a)* *b)* *c)x*	There is no mention of minority rights**.** In the South African context, respondents felt that this is appropriate: the emphasis in this period is on the marginalised majority. Minority issues may come up for attention in the future if evidence becomes available that there is a need to attend to this. The Bill of Rights in the SA Constitution provides for 1), which the MHCA endorses in section 7. .	
2) Does the legislation provide for a review body to monitor involuntary admission and treatment of minorities and ensure non-discrimination on all matters?	*a)* **b)** **c)x**	**See above comment**	
3) Does the law stipulate that refugees and asylum seekers are entitled to the same mental health treatment as other citizens of the host country?	*a)* *b)* *c)x*	Not specifically mentioned, but would be covered under section 10 on unfair discrimination	
AZ. Offences and penalties 1) Does the law have a section dealing with offences and appropriate penalties?	*a) x* *b)* *c)*	Yes. Penalties are dealt with in section 70 of the Act.	
2) Does the law provide appropriate sanctions against individuals who violate any of the rights of patients as established in the law?	*a) x* *b)* *c)*	Yes, see s. 70(1)(c).	

8.4 Annex 4. Ethical clearance

8.4.1 Letter of support: Minister of Health, South Africa

Private Bag X399
Pretoria, 0001
Tel: +27 12 328 4773/4
Fax: +27 12 325 5526

MINISTRY OF HEALTH
Republic of South Africa

Private Bag X9070
Cape Town, 8000
Tel: +27 21 465 7407/8
Fax: +27 21 465 1575

Dr Alan Flisher
Director: Research Program Consortium
Groote Schuur Hospital
OBSERVATORY
7925

Dear Dr Flisher

**DFID RESEARCH PROGRAMME CONSORTIUM: PROPOSAL ON MENTAL
HEALTH POLICY DEVELOPMENT AND IMPLEMENTATION IN AFRICAN
COUNTRIES**

Your request for a letter of support for the above-mentioned initiative refers.

Evidence from the World Health Organization indicates that mental health disorders
significantly contribute to the global burden of disease. Mental disorders account for
four of the ten leading causes of health disability. The situation in developing
countries may be worse considering factors such as poverty, poor access to
appropriate health services etc.

Most developing countries have no policies in place to address mental health issues.
Many factors impede such development and effective implementation. These vary
from region to region and between countries. Your proposal to investigate and
determine what these factors are is an important contribution to all affected countries.
It would inform us on the contextual factors that are essential for developing mental
health care policy as well as on the essential factors for its implementation.

0800 0123 22

The Department of Health fully supports this initiative as it promises to provide us with a better understanding of the work that lies before us both in the continent and in our country.

Kind regards,

DR M TSHABALALA-MSIMSANG
MINISTER OF HEALTH
DATE: 20. 2. 2005

8.4.2 Research ethics approval: University of Cape Town

UNIVERSITY OF CAPE TOWN

Research Ethics Committee
E52 Room 24, Old Main Building Groote
Schuur Hospital, Observatory, 7925
Queries : Lamees Emjedi
Tel : (021) 406-6338 Fax: 406-6411
E-mail : lemjedi@curie.uct.ac.za

22 August 2005

REC REF: 314/2005

Prof A Flisher
Psychiatry & Mental Health

Dear Prof Flisher

MENTAL HEALTH POLICY DEVELOPMENT AND IMPLEMENTATION IN FOUR AFRICAN COUNTRIES: BREAKING THE CYCLE OF MENTAL ILL-HEALTH AND POVERTY

Thank you for submitting you study to the Research Ethics Committee for review.

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

Please quote the REC. REF in all your correspondence.

Yours sincerely

PROF T. ZABOW
CHAIRPERSON

8.5 Annex 5. Key resources for policy makers

- o Mental health and poverty project:
  http://workhorse.pry.uct.ac.za:8080/MHAPP

- o WHO Mental health policy and service guidance package:
  http://www.who.int/mental_health/policy/essentialpackage1/en/index.html

- o WHO Mental health and development website:
  www.who.int/mental_health/policy/development/index.html

- o WHO AIMS:
  http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

- o DFID Research for development portal: www.research4development.info