THE LIFE ESIDIMENI CRISIS: WHY A NEOLIBERAL AGENDA LEAVES NO ROOM FOR THE MENTALLY ILL

Abigail Ornellas & Lambert K Engelbrecht

The Life Esidimeni crisis in South Africa is a shocking tragedy in which an estimated 141 mental health patients died after being transferred to some unlicensed non-government organisations (NGOs), as a result of the termination of a government-subsidised contract. The subsequent public arbitration hearings cast blame upon certain individuals, but left the deinstitutionalisation process untouched. Though these individuals must be held to account, we argue that the greater overarching process of deinstitutionalisation needs to be questioned. While the concept of deinstitutionalisation holds merit, it has been co-opted by a neoliberal agenda. Underlying the Life Esidimeni crisis are neoliberal tenets of economic prioritisation, self-responsibility and the removal of the state from service delivery

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INTRODUCTION

It is imperative for researchers to move beyond a mere "outsider or insider dichotomy" (Breen, 2007:163) when clarifying the personal motivation for their research, and to reveal their identities and social positions for the sake of greater transparency. Hence, to clarify their stance, researchers should position themselves as either insiders (part of a system) or outsiders (no affiliation with the system) to their research domain, or dissolve the traditional boundaries between researcher and subject (cf. Breen, 2007; Kerstetter, 2012). In this paper we position ourselves as both insiders and outsiders in order to argue that a neoliberal agenda leaves no room for the mentally ill. The first author provides an initial insider's view through a personal account of her experiences and insights in the deinstitutionalisation of mental health care in South Africa. After that we present an outsider's view on the timeline of the Life Esidimeni crisis, explore the emergence of deinstitutionalisation in mental health, and link its global consequences to underlying neoliberal currents. We furthermore contextualise this within South Africa today by blending our insider and the outsider views on the subject matter and conclude by arguing that we, as social service professionals and role players in mental health care, may potentially be facilitating our own demise.

A PERSONAL ACCOUNT (FIRST AUTHOR)

In the fourth and final year of my Social Work bachelor's degree, I was placed at a local state hospital in the Western Cape province to pursue the required practice education. With the capacity of the hospital extended beyond the 334 beds available, the social care staff – consisting of three full-time social workers, one part-time psychologist and a handful of medical students and practitioners – was hopelessly insufficient to meet the patients' needs. The hospital's small mental health ward was thus completely under-serviced. The team was already struggling to render basic services to the general hospital population, and hence the needs of mental health patients in the 72-hour observation ward were often left to the care of nurses and student doctors. Noticing this deficiency, and after a lengthy discussion with my practice supervisor, I began spending a few days working with patients in the ward. This soon became my central focus and it was not long before I moved into the ward nurse's office every day of my practice education. It was then that I became aware of the barrenness that was mental health service delivery and, moreover, that this was not an isolated issue.

The hospital's psychiatric ward consisted of a 10-bed, 72-hour observation unit, one of 36 dedicated emergency units in the country. In accordance with the Mental Health Act No. 17 of 2002 (Republic of South Africa, 2004), the ward was responsible for serving as a space for emergency observation, and to diagnose and de-escalate crisis patients before referring them to out-patient and community-based services. This was at a time when psychiatric facilities were fast beginning to shut down and long-term institutionalised mental health care was on the way to becoming non-existent (Petersen & Lund, 2011). Community reintegration and deinstitutionalisation were the catch phrases for the mass scaling down of mental health services. I had not heard of deinstitutionalisation until then, although the phenomenon had been moving slowly through the mental health sector, and in fact other social service areas in South Africa, since the late 1990s. The ward where I did my practice education, alongside 22 remaining psychiatric facilities and a few scattered specialised NGO groups, served an estimated population group of over 15 million people in South Africa (see the research report of Lund, Kleintjies, Campbell-Hall and colleagues, 2008). These wards had become known as "revolving doors" for mental health patients (Lund *et al*., 2008:16). I struggled to find adequate services to which I could refer discharged patients and often had them returning a few weeks later. Many of this group would spill over into public

hospitals, clinics, and child and family welfare NGOs, which were under-resourced and ill-equipped to provide the services or care for patients who needed to be fully reintegrated into society.

This gap I identified in my practice education propelled me to explore South Africa's commitment to the deinstitutionalisation process in my Master's study. I focused my thesis on the phenomenon of deinstitutionalisation and the role of social worker in the newly emerging community-based response to mental health care (Ornellas, 2014). The social workers whom I interviewed in my research, those on the frontline of mental health care across the Western Cape, warned me of the impending danger, as institutions were scaling down with little to no corresponding service development at the grassroots level. They advocated for the increased development of crisis centres and live-in community-based organisations for long-term treatment. They called for increased support for an NGO sector that was not adequately prepared for the task it was being forced to take up as the under-served mental health population began flooding the NGO field. These social workers criticised the South Africa government for adopting a mental health policy too speedily, based on international trends, without sufficiently exploring its long-term effects and potentially negative consequences. Even then, we did not duly question why deinstitutionalisation was a commitment South Africa had accepted in the first place. The criticism itself may have been deserved, but we did not explore and follow it up, and thus it was incomplete and ineffective.

In 2014, after completing my Master's degree, my co-author (who was the supervisor of both my Master's and PhD study) and I joined a global group of researchers in a Marie Skłodowska Curie European Union project that investigated the impact of economic policy on social welfare across a total of eleven countries (EU FP7-PEOPLE-IRSES, 2012). We soon began to realise that there was one recurring primary theme, one singular undercurrent, for much of the social welfare-based struggles we had been writing and reading about, including the crisis around mental health. We would come to understand that the conceptualisation and practice of deinstitutionalisation were not necessarily two sides of the same coin. Rather, the practice of deinstitutionalisation had been co-opted by a much bigger idea: a neoliberal economic agenda. This macroeconomic discourse (cf. Spolander, Engelbrecht & Pullen-Sansfaçon, 2016), which promotes a reduced state, privatisation, commodification of care, and the belief that social protection was a welfare burden, created the environment within which the practice of deinstitutionalisation would unleash destructive forces.

The predictions of the frontline social workers I had spoken to and the researchers I had referenced in my Master's thesis in 2014 would become a devastating reality when an estimated 141 mentally ill patients died in 2016 after being transferred from a mental health institution (Life Esidimeni health care centres) to several NGOs that were not ready to offer the care needed (Makgoba, 2016). It was evident that a neoliberal economic agenda would leave no room for the people from whom it could not derive any economic benefit, as I concluded in my doctoral thesis on the topic of social workers' reflections on the implications of neoliberal tenets for social work in South African non-governmental organisations (Ornellas, 2018).

In the following sections of this paper our aim is to shed light on the link between deinstitutionalisation and neoliberalism, and how, though we may be holding the Department of Health and certain persons to account for the Life Esidimeni crisis, we are still turning a blind eye to the bigger problem as our country continues on this neoliberal path of (in the words of Bond, 2006) talking left, while walking right.

THE LIFE ESIDIMENI CRISIS: A TIMELINE

In October 2015 the Department of Health announced that the contract between itself and the Life Esidimeni Care Centres was to be terminated and an estimated 2,000 people were scheduled to be moved out of the institution to their families, acute psychiatric hospitals or allocated NGOs. The motivation for this decision was relatively straightforward. The country's post-1994 social development approach, designed to tackle past inequalities and promote a localised rights-based approach to social security, had included a commitment to deinstitutionalisation in mental health care (Makgoba, 2016). Deinstitutionalisation refers to the shift from institutionalised psychiatric care to a localised community approach that would allow individuals with mental illness to be cared for and rehabilitated within and by society (Adato, Carter &

May, 2006). From the late 1990s South Africa proclaimed its commitment to the purposeful scaling down of psychiatric facilities with the promise of implementing a community-focused public health model influenced by international policy developments (Lund & Flisher, 2006). The termination of the Life Esidimeni contract was, therefore, one of many steps in the country's already embedded deinstitutionalisation process. Thus, in February 2015 a decision was taken by the members of the executive committee for health in Gauteng to deinstitutionalise mental health care at the Life Esidimeni centres (Mngadi, 2017). This action was conceptually judged to be humane and internationally approved, despite notable professional resistance (Makgoba, 2016).

More than 94 mentally ill patients died between 23 March 2016 and 19 December 2016 in Gauteng province after being transferred from Life Esidimeni Health Care Centres to 27 different NGO groups, many of which were later found to be operating under invalid licences (Makgoba, 2016). This number is said to have risen to 141 by October 2017 (Tau, 2017) and is still considered to be increasing. The Health Ombud Report (Makgoba, 2016) has estimated that, of the 141, at least 108 died from starvation or dehydration after being transferred to unlicensed NGOs. According to this investigative report, the decision to scale down Life Esidimeni centres was done in a hurry, with chaotic execution, in an environment with no or meagre experience of primary mental health care community-based services, framework and infrastructure:

> Mentally ill patients were transferred rapidly and in large numbers with a short timeframe from the structured and non-stop care environment of Life Esidimeni into an unstructured, unpredictable, sub-standard caring environment of the NGOs; this decision was not only negligent and a violation of the rights of the mentally ill patients, but also goes totally against the principle of health, i.e. the preservation of life and not the opposite (Makgoba, 2016: 1-2).

Reaction to the crisis has been significant. Public outcry and an on-going investigation resulted in the suspension and resignation of the Gauteng Health Department HOD and the Gauteng director of mental health, as well as a gruelling cross-examination of the former Gauteng Health Member of the Executive Council (MEC). Blame was cast and shifted around, government officials were publicly castigated, and there were profuse apologies (Makgoba, 2016) However, the broader system of deinstitutionalisation in which this crisis occurred has been left largely uninterrogated and untouched. The blame fell upon individuals rather than the structural framework within which they acted. Certainly, these people must be held to account for their role in the death of the patients. Nevertheless, we believe that in order to truly understand how these events happened and to ensure that more patients and families are not put through the same devastation, one must consider the Life Esidimeni crisis as reflecting a step in the deinstitutionalisation process. Furthermore, one must locate the deinstitutionalisation process within a broader neoliberal agenda. This tragedy forms part of a much bigger sequence of events.

To offer an understanding of the whole scenario, we will explore the emergence of deinstitutionalisation, and link its negative consequences globally to underlying neoliberal currents. We will then contextualise this process within South Africa today.

LINKING DEINSTITUTIONALISATION TO NEOLIBERALISM

Deinstitutionalisation did not emerge in isolation, but in many countries, including South Africa, it coincided with a socioeconomic shift to neoliberalism. This has impacted negatively on the deinstitutionalisation process and resulted in a co-opting of otherwise noble principles in a process of prioritising economic gain over social justice (Ornellas, 2018; Spolander *et al.*, 2014).

The deinstitutionalisation movement

The concept of deinstitutionalisation originated in the 1950s as a part of the US civil rights movement. The inhumane treatment of mentally ill patients in asylums and institutional settings was met with increasing resistance and criticism. Mental health practitioners began to question the dependency and stigma that institutionalisation created, and the isolation of mentally ill patients from normal societal functioning (Goffman, 1961; Shadish, 1984). Calls were made for the development of a policy that allowed for the care

of the patients closer to, or within, their home environment, minimising institutional dependence (Shadish, 1984). Advances made in medical care technology and pharmaceutical drugs at the time allowed for such shifts in thinking; mental health care could now be more easily administered in non-institutional settings (Crider, 1979). The shift, therefore, was to gradually scale down institutional health care and develop a community-based response. However, across several countries where deinstitutionalisation has been implemented, there has been poor synchronicity between this scaling down of institutions and the scaling up of community-based services; the resultant care has been less than humane (Ornellas, 2018; Spolander, Engelbrecht & Pullen-Sansfaçon 2016).

Early critiques of this approach by Kiesler (1982) and Bardach (1977) warned that the practice of deinstitutionalisation, despite its noble intentions, did more harm than good by removing existing care for patients, while lacking progressive alternative developments. Globally, deinstitutionalisation has resulted in the fragmentation of services, lack of quality assurance over available services, financial cutbacks and workforce shortages (Shen & Snowden, 2014). Reflecting on the discrepancies between the intentions and the consequences of deinstitutionalisation, Kiesler (1982) noted that instead of shifting care over to adequately equipped and resourced community-based services, it was in fact other institutional forms such as general hospitals which became the primary source of mental health care (Salize, Schanda & Dressing, 2008; Shen & Snowden, 2014). This has been referred to as trans-institutionalisation – transferring patients from psychiatric hospitals to other institutions such as shelters for the homeless, custodial institutions and prisons (Barbato, 1998; Lurie, 2005). In short, the scaling down of institutionalised care was implemented, while inadequate to no community alternative was put in its place. Yet despite these consequences and uncertainties, deinstitutionalisation continues to be a major component of transnational mental health policies, advocated for by groups such as the United Nations and the World Health Organisation (WHO, 2015) and thrust upon newly developing countries as the gold standard for mental health care.

It is necessary here to pause and make the distinction between deinstitutionalisation as a civil rights concept and deinstitutionalisation as it is actively practised. The concept of deinstitutionalisation has significant merit (Petersen & Lund, 2011). Yet the implementation of this concept is not what we have witnessed in practice throughout history. According to Salize *et al.* (2008: 533), in order to determine the success of deinstitutionalisation, one needs to analyse aspects such as the interaction among various health and social sectors, the extent of the patient shift between these sectors, and "whether potential shifts indeed correspond to the actual needs of the persons concerned, or whether referral patterns seem inappropriate, or there seems to be a potential systematic misuse of the referral or receiving sector." When reflecting on the Life Esidimeni crisis against this backdrop, it is worth asking whether the needs and wellbeing of the mental health patients were truly considered, or whether there was an alternative agenda.

Neoliberal co-opting of deinstitutionalisation

An extensive study undertaken by Shen and Snowden (2014), which mapped the adoption of deinstitutionalisation across 193 countries, from 1950 up to 2011, suggests that deinstitutionalisation, in practice, represents a neoliberal mode of emancipating people from psychiatric institutions, and that the adoption of this policy represents support for internationally sanctioned ideologies to maintain their regional presence. In this section we argue that the concept of deinstitutionalisation emerged during a time of socioeconomic policy shifts to neoliberalism and that the deinstitutionalisation process was co-opted by a cost-saving programme of a neoliberal nature.

Emerging as a dominant political framework in the 1970s, neoliberalism's core belief is that society is made up of rational actors, each seeking to be acquisitive and instrumental in their relations (Ornellas, 2018). Harvey (2007:22-23) defines neoliberalism as "a theory of political economic practices proposing that human well-being can best be advanced by the maximization of entrepreneurial freedoms within an institutional framework characterized by private property rights, individual liberty, unencumbered markets, and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices."

Neoliberalism is, however, a lot more nuanced in its infiltration and can appear in various forms, making it hard to define and, even more significantly, to resist. There are three key tenets of this socioeconomic model that are important when reflecting on its relationship with, co-opting of, and/or authority over the principles of deinstitutionalisation. These are: 1) the prioritisation of economics and the influence of market trends in government policy decisions; 2) the reduction of the state's role in service provision and the handing over of basic social services to the private sector, NGOs, the family unit and community-based organisations; and 3) the emphasis on individualism, self-care and self-responsibility for wellbeing (Henderson, 2005).

The prioritisation of economics

This neoliberal tenet argues for the prioritisation of economics and market principles in all spheres of governance and indeed human life. It is a means of reshaping society and personal life around the principles of enterprise, production and performance (Foucault, 2008). It is a mobilisation by the state to restore profit (Davies, 2014) and "[e]conomics becomes the defining discipline of effective governance and human behaviour is viewed as capable of being judged and understood within the context of economic theory" (Henderson, 2005: 243). Neoliberalism is thus largely concerned with the promotion of labour flexibility, the weakening of social welfare arrangements, the privatisation and commodification of care, and the generation of increased profit (Harvey, 2007). It prioritises economic arguments over and above impact on humans. Throughout its advancement, neoliberalism has infiltrated public utilities, services and welfare as new fields for capital accumulation (Spolander, Engelbrecht & Pullen-Sansfaçon, 2016).

Hence, mental health became a field for economic gain (Ornellas, 2018). The noble arguments in favour of the concept of deinstitutionalisation were co-opted for its identified neoliberal benefit: its cost-saving advantage. This hastened its initial public policy emergence under the neoliberal Reagan administration of the United States in the 1980s. Thomas (1998:12), when discussing the emergence of the deinstitutionalisation concept in the United States, asserted that "the policy shift had hardly anything to do with the mentally ill or the practitioners who treated them. It was designed to lower taxes and shift responsibility away from the federal government. Ironically then, the need for reform perceived by those involved and concerned with the mentally ill was co-opted by the interests of capital." This reference is as true for South Africa today as it was for the USA in the 1980s. Such sentiment was also echoed in other early implementing countries where neoliberalism has had a role in facilitating deinstitutionalisation, such as the United Kingdom (Mladenov, 2015), Italy (D'Avanzo, Barbato, Barbui, Battino, Civenti & Frattura, 2003), the Netherlands (Pijl, Kluiter & Wiersma, 2001) and Australia (Henderson, 2005), amongst others.

According to research in South Africa undertaken by Lund *et al*. (2008), the true concept of deinstitutionalisation is, in fact, not a cheaper option, but rather a costly process to implement initially when taking stock of the resources required for the establishment of appropriate community-based care. Where deinstitutionalisation has failed, it has been undertaken alongside poor budget allocation for community mental health services. Thus, a neoliberal practice of deinstitutionalisation as the cheaper alternative for mental health care may ostensibly hold up the banner of social progress and civil rights, while carrying out a neoliberal cutback of government and welfare-based expenses (Pillay, 2017; Talbott, 2004). This notion coincides with the second neoliberal tenet relevant for exploration, namely the reduction of the state's role in social care and welfare delivery.

The reduction of the state's role in service delivery

The neoliberal discourse argues for the reduction of the role of state and for a privatisation and decentralisation of services (Bond, 2000; Harvey, 2005). The argument here is based on the public burden theory of welfare (Pratt, 2006), which assumes that state spending on welfare services is responsible for broader economic recessions and downturns. The belief is that state intervention, in the form of welfare and safety nets, only serves to create a culture of dependence, a poor work

ethic, laziness and poverty. Instead, the generation of economic wealth, as a priority, will better serve the masses through a trickle-down effect more sustainable than government hand-outs (Spolander *et al*., 2016).

Within a neoliberal system, responsibility for wellbeing and related services is thus increasingly shifted from government to a combination of the private sector, NGOs, community-based services, family and the individuals themselves. Social services, including health care, have become subject to this corporatisation of service delivery disguised as a community-based model (Spolander, Engelbrecht, Martin, Strydom, Pervova, Marjanen, Tani, Sicora, Adaikalam, 2014). Hence, the deinstitutionalisation process is an exact reflection of such decentralisation and scaling down. However, as articulated by a South African frontline social worker, working for an NGO, this community response is largely non-existent. This extract, and others presented throughout this paper, are taken from Ornellas' empirical study as referred to earlier in the text and represents the views of frontline social workers within mental health service delivery:

> I think the policymakers don't consider the people with the [mental health] disease ... I clearly remember them putting people out [from institutions] who have been in hospital for fifteen to thirty years, [saying that] society must take care of them. But they never identified who society is (Frontline Social Worker; Ornellas, 2014: 131).

This narrative is in agreement with Gray (1998:25): "This raises the question as to whether a greater emphasis on development, with civil society having to carry the greater load of human need, is camouflaging an abdication of the state's responsibility for welfare". The shifting of care to society takes us to the third neoliberal tenet at play within the deinstitutionalisation argument, namely placing an emphasis on individuals as responsible for their own wellbeing.

The emphasis on individualism and self-help

The philosophy of neoliberalism rests on notions of individualism, freedom and choice. Here, as argued by Harvey (2005), neoliberalism promotes methodological individualism, which views society as a sum of rational individuals. Individual freedom can only be attained if there is freedom from the collective state, and self-reliance and moral responsibility have become preferable to a culture of dependence and, as Pratt (2006) argues, decency. The arguments related to individualism, self-responsibility and self-reliance are reflected in the deinstitutionalisation argument; these are similar to the arguments for the scaling down of welfare, social grants and state-provided social services. A neoliberal discourse promotes the "individual as enterprise" (Gordon, 1991:41), meaning that the individual is responsible for his/her own wellbeing and human capital (Henderson, 2005), and people are expected to be "experts of themselves" (Rose, 1996:59). Self-care, personal choice and responsibility are thus equated with ultimate freedom:

> The disadvantaged person, no longer the passive recipient of welfare support, is reconstructed as an active agent who is required to take responsibility for seeking expert support. The dominant model of service delivery becomes one based upon contractual arrangements rather than one based upon entitlement [which has become a dirty word] (Henderson, 2005: 244).

This promotes a culture of survival of the fittest and pulling oneself up by one's bootstraps that shifts blame for failure onto the individual and communities, rather than the state and the broader socioeconomic system in which individuals are ensnared (cf. Sewpaul & Holscher, 2004). In the following section we will argue that, based on the above commentary, South Africa's commitment to deinstitutionalisation need to be reviewed in the light of neoliberal influence.

THE SOUTH AFRICAN CONTEXT: THE POST-1994 VALUE CONFLICT

The section below shows how South Africa's post-1994 rights-based transition was quickly overrun by a neoliberal agenda; we locate the process of deinstitutionalisation and its impact on the country in this context.

From developmentalism to neoliberalism

After 1994 the African National Congress (ANC) championed a developmental and redistributive agenda for the newly democratic country that promised equitable and state-provided welfare and social protection for all citizens. This was reflected in documents such as the Reconstruction and Development Programme (RDP) (Republic of South Africa, 1994) and the Constitution (Republic of South Africa, 1996a). The overarching approach was people-centred and people-driven. A part of this new frontier was a shift towards rights-based approach to health care, which had already seen significant legislative developments in this direction. Four critical policy documents and pieces of legislation demarcated the boundaries and objectives of mental health care within the country: the National Health Policy Guidelines for improved mental health in South Africa (Republic of South Africa, 1997a), the White Paper for the transformation of the health system (Republic of South Africa, 1997b), the revised Mental Health Care Act of 2002 (Republic of South Africa 2004), which was promulgated in 2004, and the National Mental Health Policy Framework and Strategic Plan 2013-2020 (Republic of South Africa, 2009). All these policy documents are consistent with international human rights standards (WHO, 2005).

The focus of these documents was on dehospitalisation and the management of chronic patients within public health care settings (Petersen, Bhana, Campbell-Hall, Mjadu, Lund, Kleintjies, Hosegood & Flisher, 2009). This commitment was community driven with a vision of "a comprehensive and community-based mental health service … coordinated at the national, provincial, district and community levels, and integrated with other health services" (Republic of South Africa, 1997b:136). However, just as in other countries, the deinstitutionalisation process in South Africa, impacted by underlying neoliberal currents, has been implemented much too quickly and with little economic investment.

South Africa's redistributive commitments were soon compromised by an earlier (1993) IMF loan, which had required the country's commitment to market-driven principles (Bond, 2000). In particular, the loan defined socioeconomic parameters including a reduction of the government deficit, avoidance of tax increases, control of government expenditure, avoidance of genuine wage increases, monetary targeting, inflation control and industrial liberalisation (Sewpaul & Holscher, 2004). Thus, facing significant post-apartheid challenges politically, economically and socially, the ANC had little leverage to resist and with a global movement that promised incorporation into the global market, socialist redistributive policies such as the RDP were quickly replaced with competition, privatisation and reduced welfare, signalling a neoliberal advance.

The RDP (Republic of South Africa, 1994) was replaced with the Growth, Employment and Redistribution policy (GEAR) (Republic of South Africa, 1996b). As a consequence, the impact on the socioeconomic agenda of South Africa has been a value compromise that was caught between the rights-based promises of the RDP and the macroeconomic neoliberal-oriented commitments of GEAR. GEAR recommended, inter alia, financial discipline, strategies to increase public and private investment, commitment to rampant capitalism and the logic of the market (Sewpaul & Holscher, 2004). While the country maintains some elements of its social security provisions, a neoliberal discourse is evident, with an emphasis on the deserving poor, rather than collective and equal redistribution. Within this framework "social policy was given a residual role of coping with the consequences of socially blind macroeconomics" (Lund, 2006, p. vii) and the welfare system given over to the logic of the market (Sewpaul & Holscher, 2004). Ever since, the country has been committed to the principles of marketisation, deregulation and decentralisation (Spolander *et al.*, 2016); the result for the deinstitutionalisation process has been an institutional scaling down but without a community scaling up (Petersen *et al.*, 2009).

The impact of neoliberal deinstitutionalisation on South Africa

The impact of the deinstitutionalisation process on the country's mental health services is evident. The rapid scaling down along with poor alternative provisions, which has been more widely witnessed in the Gauteng province, has become known as the Gauteng Mental Health Marathon Project (GMMP) (Magoba, 2016). However, this is not an isolated issue. Concerns around the state of mental health care have been raised in

other provinces, with the South African Society for Psychiatrics (SASOP) indicating, for example, that mental health facilities in KwaZulu-Natal are in a critical and potentially disastrous situation after budget cuts, the freezing of key positions and a significant dearth of psychologists and treatment centres (Ndaliso, 2017). Across the country mental health care budgets have been cut in the name of deinstitutionalisation. The South African Depression and Anxiety Group (SADAG) has, for instance, referred to mental health as the orphan of the South African health care system (Tromp, Dolley, Laganparsad & Govender, 2014). This was echoed by a frontline social worker:

> From the government's viewpoint, the Department of Health and the Department of Social Development does not see mental health as a priority. This is evident when we look at mental health meetings, at forums, at NGO directory meetings and all that, it's clear that the government is not particularly interested in mental health. I stand to be corrected but I am basing this on government involvement, I'm basing this on stats, I'm basing this on the fact that we [mental health non-governmental organisations] receive very little funding from government departments (Frontline Social Worker; Ornellas, 2014:116).

In addition, it was estimated by Lund *et al.* (2008) that more than 16,5% of South Africans are suffering from depression, substance abuse, bipolar disorder or schizophrenia alone. However, provincial plans and budgets to implement national mental health policy and legislation remains inconsistent and inadequate. Lund *et al.* (2008) also reported that 53% of South Africa's state hospitals were listed as 72-hour observation units for psychiatric emergencies. Other reports have indicated that the majority of these hospitals are not equipped to offer such treatment (Petersen & Lund, 2011). Frontline social workers also report that hospitals are overcrowded with patients needing health care:

> Is there enough manpower in [government hospitals] to cater for all these areas? The issue is that these places become overpopulated and there's not going to be enough consultation … Many of the hospitals are full. Even though the client needs to be admitted, because there is no space, they will just turn them away … There are no beds available (Ornellas, 2014:111).

Petersen and Lund's (2011) study counted 22 psychiatric hospitals in South Africa and only 36 psychiatric wards in general hospitals. No new mental health care facilities have been built since 1994. Another study found that there are 320 practising psychiatrists in the country (Van Rensburg, 2013), which implies one psychiatrist for an estimated 15,000 people; 200 of the 320 psychiatrists are said to be working in the private sector, whilst an average of only 15% of the South African population belong to a medical aid: these patients are thus unlikely to access private psychiatric care. Moreover, a 2014 *Sunday Times* report suggested the number of psychologists in private practice to be around 85%, serving 14% of the population (Tromp *et al.*, 2014).

Additional adverse effects of the neoliberal process of deinstitutionalisation include, apart from limited access to mental health care across the country, an increase in the suicide rate of mentally ill patients, an increase in acute emergency *admissions and readmission relapse, and rising numbers in prisons and shelters for the homeless (Salize et al.*, 2008; Petersen & Lund, 2011). This caused a frontline social worker to ask in exasperation:

> But how do we advocate if government just closes their ears? Are we meant to build the community health centres [ourselves]? (Ornellas, 2014: 115).

This frustration expressed by a social worker ultimately points to the cutting of costs "effected with disregard for the evidence and the science" (Pillay, 2017:144) and instead motivated by a drop from R320 per patient per day at Esidimeni facilities to R112 at allocated NGOs. According to Makgoba (2016:22), "The NGOs were lured into what appeared to be a business opportunity not to be missed." The suspended head of the Gauteng Department of Health highlighted this, stating that the decision to terminate the long-standing contract with Life Esidimeni was taken to cut costs as a result of pressure from the national Treasury, and further acknowledged that NGOs took on more patients than they had

resources for in order to make more money. He acknowledged that patients were put at risk, as they were left in the care of people with no experience in mental health care (Makhubele, 2017).

Thus, much like other countries worldwide, South Africa adopted a policy shift in the guise of a humane response, presenting positive arguments for scaling down institutional care, while failing to review, or perhaps disclose, the evidence that shows that this process fails dismally without significant economic investment up front. What is glaringly apparent is that deinstitutionalisation in South Africa has been focused on the emergency management of patients through 72-hour observation facilities, with very little corresponding development of long-term, sustainable community-based care towards true rehabilitation and reintegration into society (as advocated by the theory on governance of deinstitutionalisation; see Talbott, 2004). As a result, mental health has become a wasteland of cost-saving and cutbacks, with the promised community-based alternative still to be realised.

CONCLUSION: WHY WE MAY BE FACILITATING OUR OWN DEMISE

Titmuss (1968: 106-107) postulated half a century ago within a North American context:

> We may feel righteous because we have a civilized mental act on the statute groups; but unless we are prepared to examine it ... at the level of concrete reality, what we mean by community care is simply indulging in wishful thinking … We are transferring the care of the mentally ill from trained staff to untrained or ill equipped staff, or no staff at all."

This postulation still holds true for us in South Africa. However, deinstitutionalisation is not necessarily an unjust concept, but it must be considered within the contemporary neoliberal context in which it is implemented. Talbott's (2004: 1112) "Ten Commandments" for the responsible governance of the deinstitutionalisation process, for example, hold valuable lessons for the provision of community-based care, appropriate funding and government involvement. The warnings and recommendations are striking when read today: "planning for community facilities and services must be improved, and funding for both institutional and community services must be provided during the phasing down of institutional services." Much of our Mental Health Act (No. 17 of 2002) (Republic of South Africa, 2004) outlines progressive and appropriate responses to the past failings of institutionalisation. If implemented adequately (and with the interests of the mental health patient duly in mind), the overall cost of the deinstitutionalisation process may equal that of institutional care; it is thus not a cost-effective initiative, but can be a more progressive and effective means of care (Pillay, 2017; Thornicroft, Deb & Henderson, 2016). However, the deinstitutionalisation process that we are witnessing now is not committed to this agenda, but is rather a neoliberal agenda with economic drivers.

The Life Esidimeni crisis is part of a much bigger scenario and the court procedures and actions taken against the Department of Health are futile in the long run, while the scaling down of mental health institutions endures. They are futile while privatisation continues to lay bare the social service sector in the guise of community development, social development and dignity. This is not just a Life Esidimeni crisis. This is not even just a mental health crisis. This is a neoliberal crisis. The concepts of neoliberal deinstitutionalisation and privatisation are at work in welfare, education, health, housing, and even land redistribution, inter alia. To hold government to account when its market commitments compromise our post-1994 developmental rights, we must call it what it is: the prioritisation of economic gain over social justice. Deinstitutionalisation, as it is implemented today, is nothing more than a neoliberal cost-saving exercise. After the arbitration hearing, trial, grief and soul-searching of the Life Esidimeni crisis, where we believe we have responded as a civilised country should, one thing remains: we are addressing the symptoms and not addressing the illness. Perhaps the immediate culprits responsible for such pain have been exposed, but not the conditions that afforded them the opportunity to grow and flourish. The fear is that, as a country, we may have slapped the individual or department we believe to be responsible on the wrist, but all the while leaving the neoliberal body intact. While the system remains, we will continue absurdly "punishing" the symptoms and congratulating ourselves for it.

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