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“Let’s manage the stressor today” exploring the mental health response to forced migrants in Johannesburg, South Africa

Rebecca Walker and Jo Vearey

Abstract

Purpose – *In South Africa, the majority of the population struggles to access care and support for mental health challenges. Drawing on challenges faced by asylum seekers and refugees in the urban margins of Johannesburg, this paper aims to explore the relationship between migration and mental health through a lens of heightened vulnerability, precarious urban spaces and unmet basic needs.*

Design/methodology/approach – *Remote interviews were conducted with respondents working in the mental health-care sector (public and private) and with migrant communities in Johannesburg. Respondents were identified via purposive sampling and interviews were conducted in English. Key findings were identified using thematic analysis.*

Findings – *Effective responses to asylum seekers and refugees facing mental health challenges are based on an understanding of context, of crisis and of the need to meet basic needs such as paying rent, finding employment and providing for families. These ‘‘daily stressors’’ not only compound ‘‘extreme traumatisation’’ but are a form of trauma in and of itself.*

Originality/value – *This paper shows how alternative responses determined by an understanding of context, of crisis and of the need to meet basic needs provide critical and potentially far-reaching interventions. Locating trauma in the unmet needs, precarious urban spaces and marginalisation opens up space to further question the ways that migration and mental health shape and reshape one another.*

Keywords *Migration, Well-being, South Africa, Refugees, Trauma, Mental Health, Health-care, Health systems*

Paper type *Research paper*

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Introduction

Johannesburg, a city built on and shaped by migration and mobility and often referred to as eGoli – the “City of Gold,” – is a place where many South Africans and non-citizens continue to move in search of better lives (Landau and Pampalone, 2018; Vearey, 2017). Yet few of its residents call the city home and many find themselves struggling to find employment and safe housing and to access public services including health care (Vearey, 2017). For some non-citizens – including asylum-seekers and refugees [1], the challenge of accessing and securing the necessary legal documentation required to stay and work in the country compounds these existing daily stressors.

Some asylum seekers (holders of a Section 22 permit) and refugees (holders of a Section 24 permit) and other forced migrants (which can include individuals who do not have documents but consider themselves to be asylum seekers) [2] find themselves living in densely populated urban areas that despite being diverse, and often vibrant, are

considered peripheral to the life of the city. This is due to the socio-economic desperation, high levels of violence (including gender-based, xenophobic and structural violence) as well as poor health and social welfare provision (Vearey and Nunez, 2011a, 2011b; Walker *et al.*, 2017).

The multiple barriers and exclusions experienced within and across urban spaces for many residents and, especially, non-citizens shape a precarious existence, requiring a balance between an ever-present threat of arrest, deportation and/or violence whilst findings ways to meet their basic needs and survive (Walker and Oliveira, 2020). Drawing from Butler's (2012) nuanced notion of precarious living, as "modes of "unliveability" (Butler, 2012, p. 12), the lack of sense of safety, trust and hope in these precarious urban spaces can, for many engender feelings of fear, anxiety, uncertainty and dislocation (Landau and Pampalone, 2018; Vearey, 2017; Walker, 2021).

Navigating precarious urban living can amount to daily life that is not only a struggle but also traumatic. And for those who may have already faced traumatic experiences back in their home countries and/or *en route* to South Africa the added layers of daily stress and anxiety which weave through marginalised spaces can compound and amplify trauma to reflect states of "complex trauma" (Wylie *et al.*, 2018) or what Becker refers to as "extreme traumatisation" (Becker, 2014).

While not all forced migrants are undocumented and not all undocumented forced migrants are traumatised, there are many who are – and they form part of the large percentage of individuals in South Africa who struggle to access quality health care including support for mental health challenges in the public sector (Nguse and Wassenaar, 2021; Vearey and Nunez, 2011a, 2011b). Classified as middle-income, South Africa is one of the most unequal places on the planet (World Bank, 2022) with 80%–85% of the population relying on state-funded health care (Health Policy Project, 2016). Yet with years of chronic underfunding, systemic weaknesses and a lack of political will the public health system is severely compromised in its ability to respond to the needs of citizens and non-citizens in South Africa. As a result, many struggling with mental health challenges are not only left without support but living in contexts in which these issues are exposed and further exacerbated (Walker, 2021).

The World Health Organisation (WHO) defines mental health as "a state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (WHO, 2018). Recognising the challenges of applying a simple definition to complex and fluid contexts and experiences, we also draw on the broader concept of well-being to capture the entanglement of vulnerability, precarity and poor health. Conceptualised as encompassing "community and social well-being (including safety satisfaction with public services and social connections), physical well-being and access to healthcare, career well-being (including employment and underemployment) and financial well-being" (Mazars, 2013, p. 6), well-being here is useful for referring to the many complex and intersecting issues which impact on the everyday lives and experiences of forced migrants can be considered. Equally, locating trauma, a concept that has been widely debated and contested over time within this understanding of well-being we work with the idea of "trauma-as-ongoing-lived-experience" (Lester, 2013, p. 755) [3]. In this way, trauma is variable and complex and does not have a prescribed process, response or form (Becker, 2014). Rather, it reflects those everyday experiences which can be simultaneously fulfilling and desperate; hopeful and depressing; mundane and exceptional (Walker, 2015).

Drawing from interviews with professionals working across the public and private mental health-care sector and in organisations supporting migrants, this paper explores the relationship between migration and mental health in Johannesburg through a lens of heightened vulnerability, precarious urban spaces and unmet basic needs. Based on research conducted towards the end of 2020 as South Africa battled the second wave of

COVID-19, the paper considers the many challenges faced in accessing mental health care and, critically, the ways in which these challenges are addressed by organisations (such as psychosocial non-governmental organisations [NGOs]) supporting migrants with the struggles of daily life in the city. In particular, we highlight the importance of a response determined by an understanding of context, of crisis and of the need to "manage the stressor today" including meeting basic needs such as paying rent, buying medicine, securing employment and being listened to – and heard. Such an understanding engages with unmet basic needs not only as "daily stressors" (Miller and Rasmussen, 2010) but as central to mental ill health and, therefore, central to any "effective" mental health-care response. Thus, to "manage the stressor today" is to directly respond to the lives of some of the most marginalised people in context and crisis living within the precarious urban spaces of Johannesburg.

Research in a time of inequality and COVID-19

Critical to the focus of this paper is an understanding of the context within which the research was carried out – both shaping the focus and impacting how the research could be done. The research is a part of a larger study led by the University of Edinburgh, Scotland in partnership with the African Centre for Migration and Society (ACMS) at the University of the Witwatersrand, South Africa and research partners in Somalia, the Democratic Republic of Congo (DRC) and Kenya [4]. This multi-sited study explores the relationship between displacement, gendered violence and mental health for Somali and Congolese refugees and asylum seekers who face multiple barriers to accessing health care.

While the study was planned with recognition of the sensitivities and ethical challenges of research in the areas of migration and mental health, the challenges of conducting an empirical study in the middle of a global pandemic could not have been anticipated. In South Africa, the arrival of the first case of COVID-19 in March 2020 was met with a strict nationwide lockdown including containment measures preventing travel outside of or within the country's borders, a curfew and restricted movement. Such restrictions created widespread and enduring challenges and heightened states of desperation for many of South Africa's poorest communities (Kihato and Landau, 2020; Mutambara *et al.*, 2021; Oliveira and Walker, 2021). In addition, the physical, emotional, psychological and financial challenges for all involved in the study researchers and respondents – cannot be ignored.

Some of the changes to the study such as interviews being conducted remotely were difficult but manageable. In fact, while acknowledging that much can be lost through remote interviews including the use of non-verbal cues, the rapport and the somatic responses to issues being discussed, we also became aware of the "new social intimacies" of online engagement "through which new and different discussions can be generated" (Rutherford, 2020). Distance can, for example, enable more in-depth discussions or provide a less-intimidating context in which people feel it is easier to open up. This seemed to be the case in our study, as we found key informants were willing to share their experiences, frustrations and particularly criticisms of health systems and socio-political contexts they were working in – perhaps more so than they might have done in-person. That said, this advantage did not override the intense pressures of the work situation for key informants working in the overwhelmed health system and trying to support migrant communities while also navigating the home-schooling of their own children, the threat of the virus itself and the many other challenges posed by the pandemic.

The issues we found ourselves navigating exposed some of the general ethical and moral questions that frame the "doing" of research in contexts of extreme pressure and/or crisis – a topic that is beginning to attract more attention and exploration and has been brought into sharper focus since the start of the pandemic (Rutherford, 2020). While a critical look at these questions is beyond the scope of this paper suffice it to say that there is an urgent

need to consider further what it means to conduct research under intense, unanticipated and fluid conditions; how we do research that is both about current contexts and also a part of the contexts while they evolve and confront the researchers and respondents with challenges and sometimes, crisis? (Rutherford, 2020) [5].

In our study, we had to balance our engagement with the intensity of what was happening around us. Overall, we conducted 25 interviews with psychiatrists, psychologists, nurses, doctors, social workers, community health workers and community volunteers working both in the public and private sector and, with organisations supporting migrants in accessing health care and addressing basic needs including mental health. Questions focussed on the general state of mental health care in South Africa, challenges faced in providing care and for those trying to accessing care, specific mental health challenges faced by different migrant groups and if and how these were responded to. We also looked at the impact of COVID-19 as not only exposing many of the normal pressures and challenges faced by the health and support sectors but also compounding them, adding a new layer of precarity, urgency and ultimately crisis to mental health care in South Africa.

Mental health crisis in South Africa

Research in South Africa suggests that the prevalence and burden of mental illness in South Africa are relatively high compared to other countries: one in six South Africans suffer from anxiety, depression, or a substance use disorder (SACAP, 2019), whereas nearly half of all citizens (47.5%) are at risk of developing a psychiatric disorder in their lifetime (Herman *et al.*, 2009). Data presented by The South African College of Applied Psychology (2019) suggest that around 40% of South Africans living with human immunodeficiency virus have a comorbid mental disorder, 41% of pregnant women are depressed and about 60% of South Africans could be suffering from post-traumatic stress. These figures provide just a glimpse of what is likely to be a far bigger and fast escalating mental health crisis in South Africa, further exacerbated by the impact of the COVID-19 pandemic (Burns, 2013; Herman *et al.*, 2009; SAHRC, 2019; Vearey, 2017; Vearey and Nunez, 2011a, 2011b).

While the long- and short-term impacts of COVID-19 pandemic are yet to be fully understood emerging research in South Africa suggests that there has been a considerable mental health impact, particularly amongst some of the most vulnerable populations who are also those who struggle to access adequate health care (Byrow *et al.*, 2020; Govender, 2020; Nguse and Wassenaar, 2021). The impact of "containment" (in terms of social distancing and isolation) in particular has been linked to increased anxiety and depression, particularly for those with a pre-existing mental health illness and, living in non-rural areas (De Man *et al.*, 2021). In addition, the fear of infection, loss of family members, friends and community and the impact of the lockdown on already high unemployment levels, food insecurity and social disruption have also led to negative mental health outcomes. While links between the pandemic, lockdowns and poor mental health are being documented globally (Vigo *et al.*, 2020a; Zhang and Zheng, 2020), studies have particularly highlighted the impact on low - and middle-income countries (LMIC) where the economic paralysis and lack of government support for those on low incomes and in informal work combined with a lack of access to health care generally and COVID-19 testing, protective equipment and vaccines specifically have been described a leading to "a perfect storm" (Vigo *et al.*, 2020 b). In South Africa, the pre-existing high rates of mental ill health and the increasingly precarious everyday lives of many in urban city spaces points not only to an escalating crisis but also to the urgent need for widespread and accessible mental health support.

However, even prior to the pandemic mental health-care access and usage in South Africa was reported to be "severely limited" with figures suggesting that only 27% of South Africans with severe mental disorders receive treatment (Herman *et al.*, 2009). The extent of the neglect of mental health within the health system has been well documented. October (2019), for example, reports that mental health is allocated 5% of the national

health budget, whereas only 50% of public hospitals offering mental health services have a psychiatrist, and about 30% do not have a clinical psychologist. Thus, despite critical pressure to expand to meet the needs of the 84% of the country's population who rely on the public health sector the state of mental health in South Africa has been characterised by "[…] chronic and systemic neglect, coupled with mismanagement and a dire lack of resources" (SAHRC, 2019).

The concerning state of the mental health-care system as described by those working within and alongside it exists despite the fact that South Africa has taken some critical steps in prioritising mental health as an integral part of health through legislation and policy reform including The Mental Health Care Act of 2002 and the National Mental Health Policy Framework and Strategic Plan 2013–2020. With the inclusion of mental health in the 2015 Sustainable Development Goals (SDGs), South Africa also responded to the global commitment to recognise mental health among the highest priorities for investment as a health, humanitarian and development priority through the adoption of the National Health Insurance Policy (2017) to promote equity in health service delivery towards Universal Health Care (Docrat *et al.*, 2019 b; World Health Organization *et al.*, 2010; WHO, 2018). Yet such commitments thus far appear to be mostly cosmetic with very little evidence of actual change on the ground (Docrat *et al.*, 2019a, 2019 b; Nguse and Wassenaar, 2021). The disconnect between policy and practice is further highlighted by the absence of any sustainable plans to implement inclusive and accessible mental health care, especially for the most vulnerable, including migrants and those who are undocumented in South Africa (Vearey, 2017; Vearey and Nunez, 2011a, 2011b).

Putting out fires

Speaking of the limitations of the public health system in providing care for South Africa's most vulnerable a clinical psychologist based in inner-city Johannesburg noted, "most people won't ever get to see a psychiatrist or psychologist even if they want to – it is seldom those in the profession who help them." While this comment highlights the role played by those external to the state system – something we return to later – it also underlines what many of the health-care professionals we spoke to focussed on: that the mental health system in South Africa is only able to respond to extreme cases or, as a psychiatrist working in one of Johannesburg's busiest hospitals stated "constantly having to put out fires." (Psychiatrist, Johannesburg). Such a system confines mental health responses to "a predominantly vertical (disease focused, as opposed to integrated) model of care" (Docrat *et al.*, 2019 b). Thus, while the WHO proclaims that "there is no health without mental health" (Prince *et al.*, 2007), the impact of chronic under-funding and systemic failures means that mental health in South Africa is not only alienated from mainstream health care but is prevented from developing a care model that locates mental health as dependent on health and well-being in general (Docrat *et al.*, 2019 b).

Reflecting the view of many of the key informants we interviewed, a professional nurse working for a University in the Province of Gauteng (within which Johannesburg is located) described the mental health care services as "a disaster":

> It's just the total lack out there of actual services available, whether you're a South African or not, you know the whole mental health scene in South Africa is just a disaster, so I think you need to bear that in mind as well when trying to look at services available for migrants is that there's just a total lack of services generally (Professional nurse, Gauteng).

Explaining the pressure placed on nurses working in the public health system to deal with every patient that comes through the clinic doors including those who are mentally unwell a medical doctor working in the public sector noted that the nurses ended up diagnosing mental health conditions without the specific knowledge or ability to prescribe the correct medication or refer for further treatment. Even if referred, patients often have to wait months,

sometimes years for an appointment. For those living in precarious conditions such as many migrants, these appointments can be hard to keep. Some migrants are forced to regularly change accommodation and area of residence due to rent challenges, xenophobia and other stresses; some are fearful of going to public health-care facilities due to previous experiences of discrimination, while others, especially those working in the informal sector, cannot afford to take time off work (Chekero and Ross, 2017; Misago, 2017; Walker, 2015). While many of these issues can also affect citizens, who rely on public health care and are poor, for non-nationals – especially those without documentation – the risks of being turned away or worse (arrested and detained) shape help-seeking behaviours and (constrained) choices. Accordingly, one doctor argued that the mental health sector in South Africa needs a "radical reimagining" in which responses are built around the contexts in which people are located – including the dynamics and disparity of precarious urban spaces in Johannesburg.

Johannesburg and precarious urban spaces: exclusions, stigma and mental ill health

The context for many migrants, especially those who have crossed borders in South Africa, is one of an increasingly restrictive immigration regime and an overwhelmed and under resourced Home Affairs Department (even before the closures owing to the pandemic increased the backlog of applications). This means that many asylum seekers and other migrants spend years batting to access documents and waiting for a resolution on their status (Amit, 2015; Amit and Kriger, 2014). Although popular discourse (including by government officials and ministers) often present South Africa as burdened by the numbers of non-nationals in the country, data suggests that they only constitute a small proportion of the population: around four million, out of a total population of approximately 56 million (Statistics South Africa, 2015; UNDP, 2017). Far more numerically significant in fact is internal migration, which is unevenly distributed across South Africa's nine national provinces (Statistics South Africa, 2015). Yet, despite the relatively small number of foreign-born migrants, they are often blamed for South Africa's struggling education and public health-care system, and for its lack of affordable housing and formal work opportunities (Hassim *et al.*, 2008; Misago *et al.*, 2015). These xenophobic myths have given rise to unrelenting discrimination, hostility and harassment towards foreign-born nationals when dealing with law enforcement and Home Affairs officials and, in public clinics and hospitals (Crush and Peberdy, 2018; Hassim *et al.*, 2008), turning places where people seek care into places of struggle and, sometimes trauma.

As a member state to the World Health Assembly (WHA), South Africa is constitutionally mandated to ensure access to health care for internal and cross-border migrant populations in line with the 2008 WHA resolution (Walls *et al.*, 2016). In addition, The Government of the Republic of South Africa (1996), as interpreted within the National Health Act (Walls *et al.*, 2016), guarantees rights to health care for everyone in South Africa and also provides for the right to dispute resolution (H. Walls *et al.* access, 2016). Yet, the variation in how this legislation is interpreted both regionally and locally within specific facilities not only creates space for discrimination but also places health-care practitioners and facility staff at the frontline as gate keepers and critical mediators of policy implementation (Vearey, 2017). Thus, the range of protective legislations, policies and international declarations ensuring access to primary health care for all in South Africa, in practice become empty words, particularly within health facilities in urban spaces where the challenges of managing the long queues of patients, often few resources and support mean that people get turned away. For migrants, especially those without documents, the risks of being turned away are further exacerbated with arbitrary charges for treatment that should not carry costs and discrimination and, sometimes, abuse within the system (Chekero and Ross, 2017; Human Rights Watch, 2009; Walker, 2021).

The challenges faced by migrants in terms of accessing health care and in particular the impact of the lack of documentation or an "unauthorised status" on experiences of health, well-being and mental-health in South Africa and globally have received considerable attention (Andrade *et al.*, 2014; Castañeda *et al.*, 2015; Chekero and Ross, 2017; Gonzales *et al.*, 2013; Keller *et al.*, 2006; Sangaramoorthy and Carney, 2021; Walker, 2021; Willen, 2012, 2012a). As Willen reminds us in the context of the multiple levels of exclusion faced by migrants due to insecure documentation status and the associated lack of rights:

> [. . . .] unauthorised migrants face yet another form of exclusion. They are excluded not only from the political community, but also from the moral community of people whose lives, bodies, illnesses, and injuries are deemed worthy of attention, investment, or concern (Willen, 2012a).

Mental ill health can therefore be compounded by the very system in which help is sought not least due to the discrimination against and, sometimes, stigmatisation of those with mental health challenges. As a psychologist at a local trauma centre in Johannesburg argued, "we cannot have a system that harms those who are so fragile [. . .] we need a different conversation around this and around "us" and "them" (Clinical Psychologist, JHB). This view is reflected in an incident recounted by a legal advisor working for a law clinic in a local NGO in Johannesburg, who described how a client a Congolese man was laughed at by nurses when trying to attend an appointment in a public hospital with a psychologist. The man who had taken time to build up courage to go to the hospital had returned to the NGO feeling humiliated and deflated. He vowed never to return to the hospital, leaving the legal adviser reflecting on the gaps in sensitisation of health-care workers to mental health issues: "It's a big thing- knowing what to do with people who come and say they need those [mental health] services, obviously not laughing at them, not sending them away etc." (Legal Advisor, Johannesburg).

Stress cycles and unmet basic needs

Julia (not her real name), a clinical psychologist and director of an organisation in inner-city Johannesburg providing psychosocial support to the surrounding communities noted:

> You cannot separate the symptoms from the external environment [. . .] people are hungry, they need nutritious food, they need to know they can pay the rent – that is responding to mental health in context not just responding to symptoms (Clinical Psychologist, Johannesburg).

Julia therefore describes a key problem in the mental health-care approach in South Africa as the failure to respond to context, that mental health care needs to be about understanding the context within which migrants are located and recognising where best to target help, which is meeting basic needs. She gave an example of a client of hers – a Congolese mother of four called Katherine for whom Julia had managed to get an appointment with a psychiatrist in the private sector, following months of failed attempts to be seen within the public system). Despite Julia's detailed report provided prior to the appointment mapping out Katherine's past and current circumstances the psychiatrist showed what Julia referred to as "a complete lack of understanding." After two sessions with her he concluded that Katherine was "deceitful" based on the fact that some of her stories did not add up.

Katherine and her husband had been political activists supporting their local community in the DRC before she was forced to flee in 2010 after she had been raped and her husband killed. Dropped off by a truck driver with her four young children outside a church in Johannesburg in the middle of winter, Katherine had to find a way to start a new life supporting her family while dealing with anxiety, depression and high-levels of trauma she had and continued to face. Although Katherine managed to find work as a hairdresser, which helped pay the rent and cover school fees, she had lost this job as a result of the COVID-19 lockdown and since then had been unable to make even the most basic ends

meet since. This desperation, Julia noted, was enough to leave anyone at risk let alone someone who was already dealing with so much. Thus, while Katherine was looking for someone to listen to and perhaps engage with her story (rather than judge the validity of it) she also needed recognition of her immediate plight: the stress, the anxiety and the fear of not knowing where the next meal will come from, how rent will be paid at the end of the month, and how she will be able to keep the children in school.

Reflecting on how the psychosocial organisation works with clients like Katherine who are traumatised and facing many struggles in their everyday lives, Julia talked about a cycle of stress: stress would rise and fall from the beginning of the month to the end, following the pressures of when rent and other expenses were due. In the middle of each month, there was a small window after rent had been paid ("through some means, somehow") and just before it was due again. At this time Julia noted, "stories would emerge" as clients felt the physical and emotional space to be able to go beyond the immediate stressors. Julia noted however, that these stories had to be "handled with care" because they were not being shared in a vacuum and soon clients would again be in states of extreme stress and anxiety "leaving them unable to go beyond these immediate stresses." This view reflects similar experiences documented in a study exploring mental health care with immigrants and refugees in transcultural contexts. Explaining the need for assessments for immigrants and refugees prior to starting trauma work one health-care professional emphasised the importance of a "screening checklist": "Who's at home? What are the resources available to you? Who's working? Who's not working? Are there kids? Did you eat today? What did you eat today?" (Wylie *et al.*, 2018).

Responding to context

The need to balance what can be addressed now and what can wait (as described by Julia) is based on an assessment of context and crisis; whether there is space to ask questions and talk about what came before, or after, or is happening now (and sometimes these do not separate out neatly), or whether there is only space to address immediate needs and "manage the stressors today". This approach also opens up space to see trauma as "ongoing-lived-experience" (Lester, 2013, p. 755) through which loss, marginalisation, vulnerability as well as agency and survival are entangled. Basic needs here are central as they not only confirm a way of keeping going but for some confirm an existence – a recognition of being here and belonging through the security of knowing where you are sleeping, that you have food and that when you need support – including for health – that you will be listened to – and heard.

In line with this view, a medical doctor working in an NGO's mental health programme described some of the consequences of failing to understand and respond to context. Karabo described how often, if they are finally able to get a client an appointment with a psychiatrist at a public hospital they are treated and prescribed medication that is inappropriate for the precarious urban environment in which the patient lives:

> So, the patient may not default [on their medication] but they are high risk because [. . .] like prescribing medication that is a sedative to someone who is sleeping on the street or in informal housing [. . .] there is no support, safety etc. [. . .] or telling someone they must take medication regularly with meals when they do not know when they will next eat [. . .] it doesn't work like that (Medical Doctor, NGO, Johannesburg).

Many of the experiences of asylum seekers and refugees recounted by respondents attested to the importance of meeting basic necessities both material and non-material in order for clients to address mental health challenges. This reflects research that has identified structural barriers, including lack of financial means to pay for treatment or even to travel to hospitals/clinics, language challenges and a lack of documentation, as salient in preventing help-seeking amongst refugees and other migrants (Andrade *et al.*, 2014;

Kleber, 2019; Miller and Rasmussen, 2010; Sareen *et al.*, 2007; Vearey and Nunez, 2011a, 2011b). Byrow *et al.* (2020) highlight the more pressing priorities for refugees as "meeting basic needs such as obtaining financial security or food security and securing stable housing" over help-seeking for mental ill health.

Extreme traumatisation

Katherine's experiences as well as the many other experiences described by the key informants' echo those of many cross-border migrants in Johannesburg who are burdened by multiple layers of trauma in a context where they feel regularly misunderstood and/or rendered invisible (Walker and Oliveira, 2020). These experiences reflect the enduring and continuous forms of suffering that Becker (2014) refers to as "extreme traumatisation" (p. 3). Becker locates "extreme traumatisation" within specific cultural and political contexts, noting the different conceptualisations of trauma and growth of work on trauma at an individual, collective and social level. Here the emphasis is on the "destruction of the individual, of his sense of belonging to society and of his social activities" (2001, p. 5) and applies particularly to those who have experienced prolonged exposure to violence – which can be in many forms including refugees. An understanding of trauma in this sense, therefore is about well-being in constantly changing experiences and precarious environments rather than being an identified state or condition, as is more common with traditional and medicalised approaches to health (Walker, 2021).

Paul, a community health worker running a mental health and well-being programme for young people in inner-city Johannesburg, described how the impact of these protracted struggles – to survive, to make ends meet and to feel safe and supported – ultimately exacerbate trauma:

> Many of those who are trying to manage here are dealing with an internal sense of being shackled because the world around them is not tame and they are scared. The problem is that there's a lot of people who then have to maintain the hypervigilance and it seems to be the kind of somatic, or the overdrive because it's what you need to survive (Community Health Worker, Johannesburg).

Similarly, Ernest explained:

> In terms of my experience working with refugees and migrants, mental health is the first thing that you pick up through frustration [. . .] here we are dealing with an already traumatised person who arrived into traumatic situations that are adding to the trauma and causing an escalation, or rather degenerating further their mental health (Ernest, Legal Advisor, Johannesburg)

This idea of ongoing fear and trauma is exacerbated by the challenges to access mental health care and by the failure of mental health care to respond to "extreme traumatisation". In the same way that Miller and Rasmussen argue that daily stressors – in the form of poverty, social isolation and poor housing – "may gradually erode people's coping resources and tax their mental health" (Miller and Rasmussen, 2010) – the inability to meet basic needs not only compounds "extreme traumatisation" but is a form of trauma in and of itself. For many this is the key issue impacting their mental health in those moments within the cycles of stress described by Julia.

"Plugging gaps" and a parallel system

A number of key informants described the different strategies they had developed based on the failures of the public health system. Describing how her organisation had developed an approach based on what they were hearing and seeing from their clients about their experiences trying to access mental health-care in the public system, Vanya noted:

> You know clients with mental health issues, you're also facing clients that have a high level of distrust. And so, building a new relationship, it's like they will tell us "I went but I didn't say anything. I'm not going again because I don't like it." And we notice when we say okay, I really want you to go for psychiatric assessment, and the psychiatrist works here and she's coming here next week [. . .] it's a world of difference where they're opening up faster (Clinical Psychologist, Johannesburg).

For Vanya and the trauma centre then an alternative response lay in ensuring the clients did not have to go to the public hospitals and instead received the higher levels of care they needed in the same space where they had initially been seen. Based on the recognition of distrust, fear and experiences of exclusion this system consolidates services into one space to draw on familiarity and safety. Yet at the same time Vanya acknowledged that this approach risks circumventing the public system in a way that increases the pressure on non-state services and those working within them rather than "fixing" the failures of the public services. As she explained:

> It's definitely, you know; you are setting up a parallel system. I think the frustration [. . .] so when we have our conversations with our funders, we're having these conversations around 'we need a physio, you know we need a doctor here. And it is, it is setting up a parallel system [. . .] but what other choice do we have? (Clinical Psychologist, Johannesburg).

Other respondents described similar responses which they described as "plugging the gaps" (Social Worker, Johannesburg) and "working with what you can" (Clinical Psychologist, JHB). There was widespread acknowledgement that the response needed was too immediate to wait for changes within the public system. As Julia noted:

> We don't give up, we keep trying but those days of being able to get people in [to the public health system] don't exist now [. . .] it's too desperate and too damaged, which is why we have to make a plan and form our own response of care.

Vanya, however, spoke about how they still tried to access the public mental health-care system for their clients – many of whom were migrants and undocumented – through keeping a list of the health-care providers within the system that they knew would try and assist based on previous and current relationships between the organisation and health-care provider. Karabo referred to a similar approach that included figuring out how best to get people into the system. For example, she described how they ensured that clients they saw during the COVID-19 lockdown who were suffering from mental health challenges exacerbated by the pandemic were able to get into the public system; "we managed that mainly through admission to hospital rather than trying to go via the clinic system because we realised that was not working" (Medical Doctor JHB).

In this way, the responses developed by organisations working for and with cross-border migrants in South Africa are based on circumventing the public system, which is largely rendered as failed and another source of trauma for clients, containing complex situations and contexts.

Conclusion: fixing a response rather than the system

When asked what would be an "ideal" public health-care system in South Africa, a social worker in Johannesburg suggested there should be a three-pronged approach. First it would be an approach that "comes in at the beginning not at the end" and is "based on recognition that for good mental health people need a place to go: a starting point, access to support and services, interventions as they enter." Second, the approach needs to recognise that everything can impact mental health be it "challenges meeting basic needs, protracted trauma and/or the impact of Covid-19" and that the it responds to situations that are fluid. Finally, that any approach must work to "restore dignity, not strip it." (Social Worker, Medical NGO, JHB).

Yet the key informants that we interviewed working both within the mental health-care system and with and for organisations supporting migrants recognised that deeply embedded structural and systematic weaknesses of the public mental health system could not be "fixed" any time soon. As such they worked with the reality that instead they needed to "fix" a response; a response that focuses on immediate context and crisis with the hope of longer-term consequences. Therefore, "lets manage the stressor today" could be looking at how to cover rent, the next step in accessing documentation or putting food on the table for individuals and their families. As Julia described, working with and responding to the cycles of stress means being able to locate those spaces and moments where talking is possible and those where it is not. Paul, supported this view in arguing "If I can help with nutritious food now – then I can help a child to feel more able to think and get through the day – and the next [. . .] that's mental healthcare right there."

In other words, being able to pay the rent, put food on the table and support dependents based on "managing the stressor today" should be seen as an in-context mental health response itself rather than solely as factors that impede access to care and prevent interventions from helping. Or, as Vigo et al aptly put it:

> "We know that there is no health without mental health, we now highlight that there is no mental health without survival, and that the lives of large swaths of the population in LMIC [lower and middle income countries] are at stake" (Vigo *et al.*, 2020a, p. 1208).

While this comment was made in reference to the impact of the Covid-19 pandemic specifically, it also applies more generally to the lives of marginalised populations such as forced migrant's dependent upon, and yet made the more vulnerable by the urban spaces in which they are trying to survive. While there was widespread recognition amongst the key informants that due to funding challenges and pressures on the non-state system a more sustainable approach was yet to come there was a clear argument for responding to context and crisis through basic needs and with understanding of precarious urban spaces as the first step to an alternative approach. Whether these needs are a result of trauma, of unemployment, of physical sickness, the impact of COVID-19 or all of these factors combined, what is significant here is that by missing the context and failing to contain crisis mental health-care risks exacerbating the very challenges that shape the mental health of many of the most vulnerable, including cross-border migrants.

Notes

1. An asylum seeker is a person who has left their country and is seeking protection from persecution and serious human rights violations in a country but has not yet been legally recognised as a refugee. A refugee is a person who has received this legal recognition and is afforded a right to international protection (Gandar, 2019).
2. In South Africa, many asylum seekers and migrants with work visas become undocumented as a result of the slow, inefficient and corrupt Home Affairs system (Amit, 2015; Gandar, 2019).
3. See for example: (Burstow, 2003; Byrow *et al.*, 2020; Ellis *et al.*, 2019; Keller *et al.*, 2006; Kleber, 2019; Miller and Rasmussen, 2010).
4. The support of the Economic and Social Research Council (UK) is gratefully acknowledged.
5. See also de Gruchy *et al.* (2022).

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Further reading

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