

**IMPLEMENTATION OF THE MENTAL HEALTH CARE ACT IN PSYCHIATRIC
HOSPITALS**

**Eva Nkeng Mulutsi
Student Number: 515897**

**Supervisor:
Professor Laetitia C. Rispel**

**A thesis submitted to the School of Governance,
Faculty of Commerce, Law and Management,
University of the Witwatersrand, Johannesburg, in fulfilment of the requirements
for the degree of
Doctor of Philosophy**

**Johannesburg, South Africa
23 September 2017**

DECLARATION

I, Nkeng Eva Mulutsi, declare that this thesis is my own work and is being submitted for the degree of Doctor of Philosophy at the University of Witwatersrand, Johannesburg. The data collection in this thesis was undertaken in 2013 while I was a full-time employee of the national Department of Health. I confirm that I have undertaken all fieldwork. I declare that no part of this thesis has been submitted before for any degree or examination at this or any other University.



NE MULUTSI

Date: 23 September 2017

DEDICATION

I dedicate this work to:

The legacy of my late father and brother

My wonderful mother and supportive sister

My loving and understanding husband

My children Katlego, Tshegofatso, and Ororiseng

Education is power!

ACKNOWLEDGEMENTS

This PhD would not have been possible without the support, guidance, encouragement and motivation of my supervisor, Professor Laetitia Rispel. I would like to express my deepest appreciation and gratitude to her for instilling in me a sense of empathy, patience, hard work, discipline and dedication, which will continue to shape my life. Your belief in me is highly appreciated. Thank you also to Professor Rispel for the financial assistance provided to enable the transcription of the interviews, and for going beyond the call of duty to ensure that I completed this thesis.

I wish to thank the National Department of Health for permission to conduct the study, for facilitating access to the key informants in all nine provinces, and for financial assistance. My colleagues at the Mental Health and Substance Abuse Directorate in the National Department of Health, and Professor Melvyn Freeman, are thanked for the invaluable support provided. I acknowledge Janine White and associate Professor Nicola Christofides for serving as a “sounding board” on many occasions, and Dr Thomas Achia for assistance with data analysis.

The PhD forums of the School of Governance and the KITSO sessions at the School of Public Health, added great value during my PhD journey.

I thank my husband, mum and sister for their understanding, encouragement and support.

Last, but not least, I thank God for the wisdom and opportunity to complete this PhD. My sincere hope is that the study findings will contribute to the improvement of mental health services in South Africa.

ABSTRACT

Introduction

Mental illness is prevalent in all regions of the world and contributes significantly to premature mortality, high morbidity and loss of economic productivity (Baxter, Whiteford, Vos, & Norman, 2011; Charlson, Baxter, Cheng, Shidaye, & Whiteford, 2016). In South Africa, the Mental Health Care Act (No 17 of 2002) was promulgated in 2004 in response to the high burden of mental illness and to improve mental health service delivery, within a human rights framework.

Aims and Objectives: The overall aim of this PhD study was to examine the implementation of the Mental Health Care Act in psychiatric hospitals in South Africa. The specific objectives were to: explore stakeholders' involvement in the implementation of the Act; examine the policy processes followed in the implementation of the Act; determine whether Mental Health Review Boards execute their prescribed roles and functions; examine the implementation of legal procedures for involuntary admissions of psychiatric patients; and identify factors that influenced the implementation of the Act.

Methods: The study was approved by the Human Research Ethics Committee of the University of Witwatersrand, Johannesburg. Sixteen psychiatric hospitals were selected in nine provinces, through stratified random sampling. Using an adapted conceptual framework with policy implementation theory as its foundation, the overall study approach was qualitative in nature, complemented with a record review of involuntary patient admissions in the selected hospitals. The qualitative component consisted of 35 in-depth interviews with: the drafter of the Act (n=1); provincial mental health coordinators (n=9); a psychiatrist at each of the selected hospitals (n=16); and the chair of a Mental Health Review Board in each of the provinces (n=9). At each selected psychiatric hospital, five patient records were selected randomly (n=80), focusing on compliance with the legal procedures for involuntary admissions. The qualitative data were analysed using thematic content analysis and MAXQDA® 11 while STATA® 12 was used to analyse the data from the record reviews.

Results: South Africa's political transition created a window of opportunity for the implementation of the Act. Wide-spread stakeholder support for the spirit and intention of the Act, advocacy for human rights, the broader transformation of the health system, and the need for enhanced governance and accountability in mental health, facilitated the implementation of the Act. However, implementation was hindered by: the relatively low prioritisation of mental health; stigma and discrimination; poor planning and preparation for implementation; resource constraints; and suboptimal stakeholder consultation. The study found that the majority of involuntary psychiatric patients admitted during (the year) 2010 were single (93.8%), male (62.5%), and unemployed (85%), predominantly black African (80%), with a median age of 32.5 years. The primary diagnoses were schizophrenia (33/80), substance-induced psychosis (16/80), bipolar mood disorders (15/80) and acute psychosis (9/80). There was poor compliance with the prescribed procedures for involuntary psychiatric admissions, exacerbated by suboptimal governance by, and functioning of, the Mental Health Review Boards, thus resulting in *de facto* illegal detention of patients.

Conclusion and Recommendations: The Mental Health Care Act is an important policy lever to address the burden of mental illness and ensure quality mental health service delivery in South Africa. However, the enabling potential of the Act can only be realised if the following issues are addressed: improved, and dedicated resources for mental health; training and capacity building of health professionals and hospital managers on key aspects of the Act; improved governance, leadership and accountability through well-functioning Mental Health Review Boards; and improving mental health infrastructure and community-based services.

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average Length of Stay
ART	Antiretroviral Treatment
BOD	Burden of Disease
CPD	Continuing Professional Development
CSDH	Commission on Social Determinants of Health
DESA	[United Nations] Department of Economic and Social Affairs
DOH	Department of Health
ECOSOC	[United Nations] Economic and Social Council
GBD	Global Burden of Disease
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Syndrome
HODs	Heads of Departments
HSRC	Human Science Research Council
HST	Health Systems Trust
ICD	International Statistical Classification of Diseases and Health Related Problems
KITSO	Knowledge, Information and Training Support Opportunities
MDGs	Millennium Development Goals
MECs	Members of Executive Councils
MHaPP	Mental Health and Poverty Project
MHCA	Mental Health Care Act
MhGAP	Mental Health Gap Action Programme
MHRBs	Mental Health Review Boards
NDP	National Development Plan
NHC	National Health Council
NGOs	Non-Governmental Organisations
NHI	National Health Insurance
PHC	Primary Health Care
RDP	Reconstruction and Development Plan
SAFMH	South African Federation of Mental Health
SAHR	South African Health Review
SASH	South African Stress and Health Survey
SDH	Social Determinants of Health
SDGs	Sustainable Development Goals
StatsSA	Statistics South Africa
UN	United Nations
UNCRPD	United Nations Conventions on the Rights of Persons with Disabilities
YLDs	Years of Life lost due to Disability
WHO	World Health Organization
WHO-AIMS	World Health Organization's Assessment Instrument for Mental Health Systems

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CHAPTER 1 : INTRODUCTION AND BACKGROUND

1.1 Introduction

Mental health is an integral part of health and well-being, defined by the World Health Organization (WHO) as “a state in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO, 2001c, p. 1). The positive dimensions of mental health are emphasised in the WHO’s definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2001a, 2003a, 2013a, 2013c). At an individual level, important attributes of mental health include emotional processing, self-management skills, self-esteem, environmental intelligence and the ability to manage thoughts and behaviour (WHO, 2003a, 2013a).

Mental health enables people to have healthy relationships, make good life choices, maintain physical health and well-being, and realise their full potential (WHO, 2001a, 2001c). Mental health promotes good behavioural choices and reduces the need for medical interventions. In the work environment, mental health is associated with enhanced performance and fewer workplace accidents (WHO, 2003a, 2013a). Mental health is also linked to a range of development outcomes, which include improved health status, higher educational achievement, enhanced productivity and improved quality of life (Okpaku, 2014; WHO, 2010a, 2010b, 2013a).

However, mental illness is prevalent in all regions of the world and contributes significantly to premature mortality, high morbidity (Chisholm et al., 2016; WHO, 2001c) and loss of economic productivity (Baxter et al., 2011). Mental illness or mental disorder is characterised as a clinically significant behavioural or psychological pattern that occurs in an individual and is usually associated with distress, disability or increased risk of suffering that is not expected as part of normal development or culture (American Psychiatric Association, 2013).

Poor mental health is both a cause and a consequence of poverty, poor education, gender inequality, ill-health and violence (WHO, 2010a). Hence, investing in mental health yields valuable economic, health and social returns (WHO, 2003a, 2010a, 2016).

The social and economic impact of mental disorders is diverse and far reaching (WHO, 2013b). Mental disorders incur high indirect costs associated with morbidity, loss of employment, absenteeism, poor performance at work, and early retirement (McDaid, Knapp, & Raja, 2008; WHO, 2009a). In 2010, the global cost for mental disorders was estimated at US\$ 2.5 trillion, with a projected increase to over US\$ 6 trillion in 2030 (WHO, 2016, p. 7). The World Economic Forum estimated that between 2010 and 2030, mental disorders will account for approximately US\$ 16 trillion in lost Gross Domestic Product (GDP) globally, pushing millions of households further into poverty (Bloom et al., 2011).

The reduced income and employment by those suffering from mental disorders further entrench poverty, which in turn, increases the risk of mental disorders (Miranda & Patel, 2005; WHO, 2009a, 2010a). Poor people are disproportionately affected by mental disorders (WHO, 2013b), with the risk for mental illness among poor communities being eight times greater than among those with high incomes (Holzer et al., 1986; Lund et al., 2011). The social impact of mental disorders includes: homelessness; higher rates of imprisonment (Fazel & Danesh, 2002; Henry, Boyer, Belzeaux, & Baumstarck-Barrau, 2010); poor educational opportunities and outcomes (Knapp, King, Healey, & Thomas, 2011); lack of employment; and limited income generating opportunities (Funk, Drew, & Knapp, 2012; Ssebunya, Kigozi, Lund, Kizza, & Okello, 2009; WHO, 2010a). The social impact of mental disorders is exacerbated by the treatment gap for people suffering from mental disorders and human rights violations (Alem, 2000; Schneider et al., 2016; WHO, 2009a).

In South Africa, mental disorders also account for significant morbidity, with an estimated life-time prevalence of mental illness of 30.3% (Herman et al., 2009; Seedat et al., 2009; Williams et al., 2008). The country's policy response to the burden of

mental illness includes expansion of mental health programmes, health sector reforms, development of progressive health policies and promulgation of specific legislation. In 2004, South Africa promulgated a new Mental Health Care Act, 2002 (No. 17 of 2002) (Republic of South Africa, 2002). However, despite the extensive provisions of the Act, mental health services were found lagging behind the needs of the population (Burns, 2008, 2014; Flisher et al., 2007; Lund, Kleintjies, Flisher, & MHaPP, 2010; Petersen et al., 2016; Petersen, Hancock, Bhana, Govender, & PRIME, 2013; Ramlall, 2012; van Rensburg, 2011). Furthermore, there is a dearth of research studies on the implementation of the Act in South African psychiatric hospitals, particularly of studies using policy implementation theories (Fixsen et al., 2005; Proctor & et al, 2009; Thom, 2004). This is despite the fact that policy development and implementation facilitate improved health systems, which in turn, contribute to optimal population health outcomes (Kihuba, Gheorghe, Bozzani, English, & Griffiths, 2016; WHO, 2001c, 2003a, 2010a).

This study draws from policy implementation theory to analyse the implementation of the Mental Health Care Act (No. 17 of 2002) in psychiatric hospitals in South Africa. The study brings together three important issues at both conceptual and methodological levels, namely mental health, mental health care services and policy implementation. Although these issues overlap, each is discussed separately for the sake of clarity.

The purpose of this chapter is to provide the study background and to set the scene for the research that was conducted in this doctoral study. The chapter begins with the global context, focusing on the burden of disease, social determinants of health, and important policy developments in mental health and provides an overview of mental health systems. The second section of the chapter summarises the South African context, with focus on the country's burden of disease and mental disorders, mental health systems, the key developments in mental health since 1994 and service provision. The third section provides an overview of the 2002 Mental Health Care Act, as it constitutes the core policy that is being analysed in this study. The importance of psychiatric hospitals is highlighted in this section, as these constitute the study setting.

The chapter concludes with the problem statement, the study rationale, aim, scope, objectives and research questions and the structure of the thesis.

1.2 Global Context

1.2.1 *Global burden of disease*

The 2010 Global Burden of Disease (GBD) study indicated a shift in the GBD from communicable, new-born, nutritional and maternal diseases in 1990 to a predominance of non-communicable diseases (NCDs) (Institute of Health Metrics and Evaluation, 2013; Malherbe, Aldous, Woods, & Christianson, 2016; WHO, 2014a, 2014b). The WHO defines NCDs as medical conditions that cannot be transmitted from one person to another and these include mental disorders (Ivbijaro, 2011; O'Neil et al., 2015; WHO, 2009a).

The high contribution of NCDs to the burden of disease is driven by an ageing population, an increase in the risk factors and prevalence of chronic and degenerative diseases, and changes in lifestyle and diet (Collins, Musisi, Frehywot, & Patel, 2015; Institute of Health Metrics and Evaluation, 2013; National Institute on Aging, National Institute of Health, U.S. Department of Health and Human Services, & WHO, 2011).

In 2010, mental, neurological and substance abuse disorders ranked among the top 20 conditions worldwide (WHO, 2016) and accounted for 10.4% of global total number of years lost to illness (DALYs) (Collins et al., 2015; Whiteford, Ferrari, Degenhardt, Feigin, & Vos, 2015). According to the 2015 GBD data, 4.4% of the global population is estimated to suffer from depressive disorders and 3.6% from anxiety disorders (WHO, 2017). Although the prevalence of mental disorders is underestimated in many countries, scholars have found that the prevalence of these disorders increased by 41% between 1990 and 2010 (Atun, 2014; Gomez, 2016; Patel et al., 2016; Patel, Chisholm, Dua, Laxminarayan, & Medina-Mora, 2015; Vigo, Thornicraft, & Atun, 2016; Whiteford et al., 2015; WHO, 2016).

Mental disorders are also associated with chronic conditions, such as cardiovascular disease, cancer, hypertension and diabetes mellitus (Charles., Lambert, & Kerner, 2016; Mayosi et al., 2009; O'Neil et al., 2015; Prince, Patel, Saxena, & et al, 2007). They also feature prominently in the high level of co-morbidity with infectious diseases such as HIV & AIDS, tuberculosis (TB) (Prince, Patel, Saxena, & et al, 2007; Tola et al., 2015; Tola et al., 2016), maternal and childhood illnesses (Chopra, Daviaud, Pattinson, Fonn, & Lawn, 2009; Hassan, Werneck, & Hasselmann, 2016; Orta, Gelaye, Qiu, Stoner, & Williams, 2015; Satyanarayana, Lukose, & Srinivasan, 2011). Research has found that a person living with HIV is 36 times more likely to commit suicide than a person in the general population (Dabaghzadeh, Jabbari, Khalili, & Abbasian, 2015; Gurm et al., 2015; Schlebusch & Govender, 2015).

The leading mental disorders vary among adults and children. The most common mental and behavioural disorders in adults are depressive disorders, anxiety disorders and substance-induced disorders, which account for 76% of the burden of these disorders (Haroz et al., 2016; Institute of Health Metrics and Evaluation, 2013; Vos, Flaxman, Naghavi, & al, 2012). The WHO predicted that depression will rank as the number one condition by 2030, surpassing cardiovascular disease and cancer (Hidaka, 2012; WHO, 2011a). Other common mental disorders among adults include post-traumatic stress disorders and suicide (Atwoli, Stein, Koenen, & McLaughlin, 2015; Institute of Health Metrics and Evaluation, 2013; Schlebusch & Govender, 2015).

Worldwide, mental disorders such as mood disorders, schizophrenia and other psychotic disorders are the most prevalent (Heslin & Weiss, 2015). These conditions account for long stays in psychiatric hospitals and readmissions within 30 days of discharge (Babalola, Gormez, Alwan, Johnstone, & Sampson, 2014). Research evidence shows that compared to hospital stays for substance abuse disorders, stays for mood disorders were 39% longer and stays for schizophrenia were more than twice as long (Heslin & Weiss, 2015). This represents high hospital costs and negative clinical outcomes for patients with severe mental disorders, which have been partly attributed to poor self-care, limited community-based services and challenges with adherence to

medication (de Almeida & Killapsy, 2011; Heslin & Weiss, 2015; Johnstone & Zolese, 2000).

Worldwide, about 20% of children and adolescents are affected by mental disorders (Patel et al., 2016; Patel, Chisholm, Dua, et al., 2015; Patel, Chisholm, Parikh, et al., 2015). The main mental disorders in children and adolescents are depression and anxiety, as well as autism and attention-deficit disorders (Erskine et al., 2016; Institute of Health Metrics and Evaluation, 2013).

1.2.2 *Social determinants of mental health*

The conditions in which people live, work and age are shaped by political, social, economic and environmental factors (Commission on Social Determinants of Health, 2008; WHO and Calouste Gulbenkian Foundation, 2014). Known as the social determinants of health (SDH), these factors have assumed increasing global importance because of the persistent and unacceptable inequities that continue to exist in societies, affecting people's health, their functioning and quality of life across all stages (Commission on Social Determinants of Health, 2008).

These SDH influence mental health and outcomes (Compton & Shim, 2014; Freeman, 2016; Patel et al., 2016; WHO, 2013a), but also shed light on the ways that mental illness can be prevented and mental health promoted through policy rather than treatment alone (Compton & Shim, 2014). Central to the SDH of mental health are the social injustices and inequities such as prejudice, discrimination, social exclusion, unemployment, housing, instability, food insecurity, unhealthy behaviours, limited access to care and education (Compton & Shim, 2014; Lund, Breen, et al., 2010; Lund et al., 2011; Patel, Araya, De Lima., Ludermit, & Todd, 1999; WHO and Calouste Gulbenkian Foundation, 2014). Scholars have described mental illness as both a cause and a consequence of poverty (Cooper, Lund, & Kakuma, 2012; Flisher et al., 2007; Frenk & Moon, 2013; Lund, Breen, et al., 2010; Lund et al., 2011; Lund, Myer, Stein, Williams, & Flisher, 2013; Sylvia et al., 2013; WHO, 2010a).

1.2.3 Key global developments in mental health

The last two decades have been characterised by a recognition of the importance of mental health to overall human development (Patel et al., 2016; WHO, 2010b); the shift in the GBD from infectious diseases to NCDs (Institute of Health Metrics and Evaluation, 2013; Malherbe et al., 2016; WHO, 2016); and a re-emphasis on the SDH (Compton & Shim, 2014; Patel, Chisholm, Parikh, et al., 2015). In response, there have been a number of global developments, the most important of which are summarised in Table 1.1.

Table 1.1: Key global developments in mental health, 1993 to 2015

Year	Key developments	Overview	Source
1993	World Bank Report: Investing in mental health: World Development Indicators	<ul style="list-style-type: none"> Mental health is an essential part of health Emphasis on the need to invest in mental health services for development 	WHO (1993)
2000	White Paper by the International Society of Psychiatric-Mental Health Nurses: Responding to the Global Burden of Disease	<ul style="list-style-type: none"> Emphasis on the importance of enhancing knowledge and understanding on psycho-social-physical-spiritual care of people with mental illnesses, their caregivers, families and communities 	International Society of Psychiatric-Mental Health Nurses (2000)
2001	WHO World Health Report	<ul style="list-style-type: none"> Mental health is a global public health issue 	WHO (2001d)
	WHO Mental Health Atlas	<ul style="list-style-type: none"> Assists countries to identify areas that need urgent attention. It also provides comparisons of strengths and weaknesses across countries 	WHO (2001b)
2003	WHO: Mental Health Policy and Service Guidance Package: Human Rights and legislation	<ul style="list-style-type: none"> Guidance on the development and implementation of mental health legislation within a human rights framework 	WHO (2003b)
2005	WHO: Mental Health Policy and Service Guidance Package: Mental health policy, plans and programme	<ul style="list-style-type: none"> Guidance on the development and implementation of mental health policies, plans and programmes across countries 	WHO (2005c)

Year	Key developments	Overview	Source
	WHO Mental Health Atlas	<ul style="list-style-type: none"> Assists countries to identify areas that need urgent attention. It also provides comparisons of strengths and weaknesses across countries 	WHO (2005a)
2006	Adoption of the Convention on the Rights of Persons with Disability	<ul style="list-style-type: none"> Focus on protection of the rights of mentally-ill persons 	United Nations (2006)
2007	WHO: Mental Health Policy and Service Guidance Package: Monitoring and Evaluation of mental health policies and plans	<ul style="list-style-type: none"> Guidance on how to monitor and evaluate mental health policies and plans across countries 	WHO (2007c)
	WHO Mental Health Atlas	<ul style="list-style-type: none"> Assists countries to identify areas that need urgent attention. It also provides enabling comparisons of strengths and weaknesses across countries 	WHO (2007a)
	The Lancet Series on Global Mental Health	<ul style="list-style-type: none"> Documented the evidence base for global mental health with focus on lo- and middle-income countries. Motivated for scaling up of services and financing for mental health services 	Prince, Patel, Saxena, Maj, et al. (2007); Jacobs et al. (2007); Patel, Araya, and Chatterji (2007); Saraceno et al. (2007); Saxena, Thornicroft, Knapp, and Whiteford (2007)
2008	WHO report: Integrating mental health into primary care: A global perspective	<ul style="list-style-type: none"> Focus on integration of mental health into primary care 	WHO/WONCA (2008)
2009	Ministerial Declaration on implementing the internationally agreed goals and commitments with regard to global public health	<ul style="list-style-type: none"> Emphasis on integration of mental health into the implementation of MDGs and other development goals 	United Nations Economic and Social Council (2009)

	Year	Key developments	Overview
	Report of the Secretary-General: 63rd session of the General Assembly, United Nations(Resolution A/RES/63/150	<ul style="list-style-type: none"> Realising the MDGs for persons with disabilities through implementation of the World Programme of Action concerning disabled persons and the Convention on the Rights of Persons with Disabilities 	United Nations General Assembly (2009)
	ECOSOC high level ministerial roundtable breakfast meeting	<ul style="list-style-type: none"> Addressing non-communicable diseases and mental health 	WHO (2009b)
2010	UN Department of Economic and Social Affairs (DESA)-WHO Policy Analysis	<ul style="list-style-type: none"> Focus on mental health and development: Integrating mental health into all development efforts including MDGs 	WHO (2010d)
	WHO and UN-DESA High level meeting	<ul style="list-style-type: none"> Focus on mental health as an emerging development issue and the need to integrate mental health into efforts to realise MDGs and beyond 	WHO (2010d)
	WHO report: Mental health and development: Targeting people with mental health conditions as a vulnerable group	<ul style="list-style-type: none"> Highlighted the urgent need to redress the situation as people with mental disorders are vulnerable yet they fall into the cracks of development aid and government action 	WHO (2010b)
2011	WHO Mental Health Atlas	<ul style="list-style-type: none"> Assists countries to identify areas that need urgent attention. It also provides comparisons of strengths and weaknesses across countries 	WHO (2011b)
2012	65th World Health Assembly: Resolution WHA 65.4	<ul style="list-style-type: none"> Acknowledge the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors 	WHO (2012a)
	WHO Quality Rights Tool Kit	<ul style="list-style-type: none"> A practical tool for assessing and improving quality and human rights standards in mental health and social care facilities 	WHO (2012b)
2013	WHO: Mental Health Action Plan 2013-2020	<ul style="list-style-type: none"> A comprehensive mental health action plan 2013-2020 focusing on effective leadership, governance, integrated services, community care, mental health promotion and prevention 	WHO (2013a)

	Year	Key developments	Overview
2014	WHO: Mental Health Atlas	<ul style="list-style-type: none"> Provides updated information in countries on areas that need urgent attention Provides comparisons of strengths and weaknesses across countries 	WHO (2014a)
2015	UN: Sustainable Development Goals (SDGs)	<ul style="list-style-type: none"> SDGs highlight importance of mental health and the need to address the growing burden in all countries 	United Nations (2015)
	MhGAP Forum launch	<ul style="list-style-type: none"> Focus on mental health innovations and their uptake into policy and practice 	WHO (2015b)

Notwithstanding these global developments, the 2000 millennium development goals (MDGs) were silent on mental health and the growing problem of NCDs. Furthermore, several authors have highlighted the gaps between laudable policy development and implementation (Ahuja et al., 2016; Ashipala, Wilkinson, & van Dyk, 2016; Awenva et al., 2010; Bakari & Frumence, 2013; Bhuyan, Jorgensen, & Sharma, 2010; Burke et al., 2012; de Boer & Bressers, 2011; Ditlopo, Blaauw, Rispel, Thomas, & Bidwell, 2013; Ditlopo., Blaauw, Bidwell, & Thomas, 2011; Hupe, 2016; Kaitlin, 2012; Rispel, 2015b, 2016; Rispel & Moorman, 2010). This thesis contributes to the global discourse on strategies needed to address these gaps, which are even more pronounced in mental health.

In the next section, an overview is given of mental health systems, in order to set the scene for the focus on psychiatric hospitals.

1.2.4 Global mental health systems

A health system can be defined as the sum total of all the organization, institutions and resources whose primary purpose is to improve health (WHO, 2007b, 2010c). A health system provides preventive, curative and rehabilitative interventions which includes efforts to address the SDH. A well-functioning health system should deliver quality services to all people when required and should protect the right to health for all, including for people with mental disorders (WHO, 2010c). However, around the world, the response of health systems to the burden of mental disorders has been suboptimal. As a result, the gap between the need for treatment and the provision of mental health

services is large (WHO, 2013a), especially in LMICs (Patel, Chisholm, Parikh, et al., 2015).

According to the WHO, there are six building blocks for a well-functioning health system (WHO, 2010c). The desirable outputs from these building blocks in a health system include improved health outcomes, financial and social risk protection and responsiveness to community needs (WHO, 2007b, 2010c). The health system building blocks and the desirable attributes are shown in Figure 1.1.

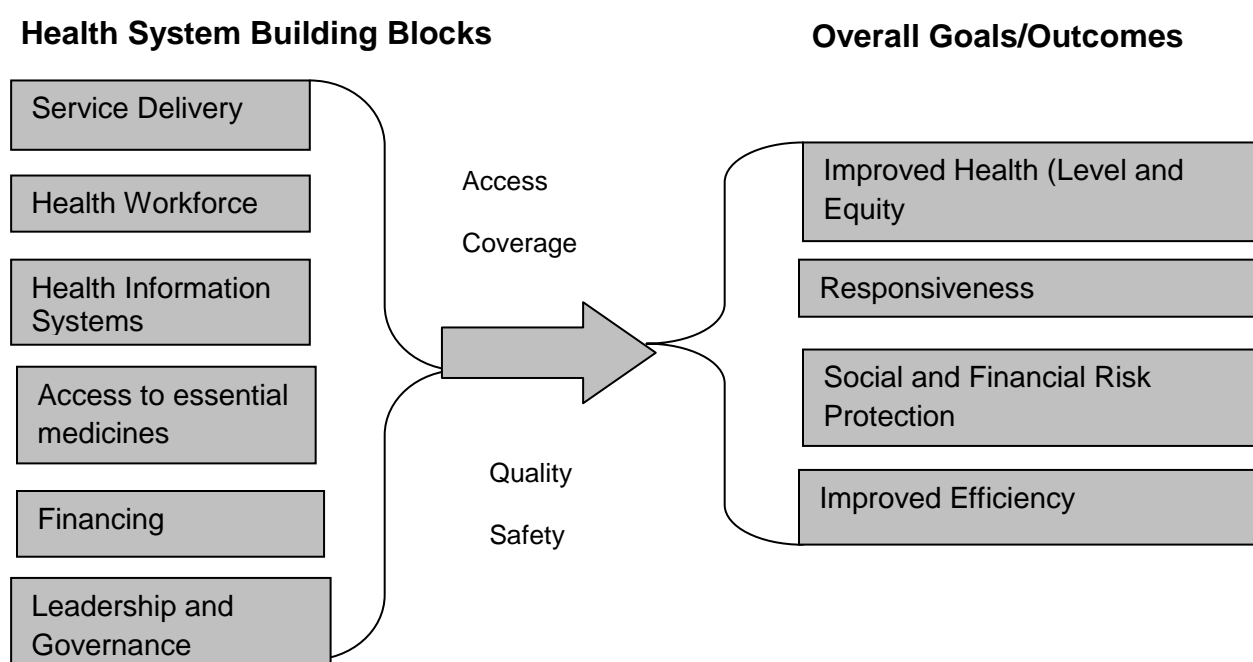


Figure 1.1: The six building blocks of a health system: Aims and desirable attributes
Source: WHO (2010c)

The building blocks are interrelated and contribute to a well-functioning health system in different ways (WHO, 2010c). Leadership and health information systems provide a basis for policy and regulation, while financing and health workforce serve as key inputs to a health system (WHO, 2010c). The medical products and technologies including service delivery components, are the immediate outputs of the inputs into a health system such as the health workforce, procurement, supplies and financing. Therefore, increased inputs should lead to improved service delivery and access to health services

(WHO, 2010c). These health systems building blocks provide a comprehensive framework for describing mental health services (WHO, 2013a)

Mental health leadership and governance: Mental health policies and legislation are key components of good governance in mental health. This is reflected in the human rights protection for people with mental disorders, exceptional conditions for involuntary admissions, and treatment and service structures that reflect the protection of rights (WHO, 2015a). In mental health policies, good governance is reflected as service delivery improvement, accessibility and stakeholder engagement (WHO, 2015a). The Global Comprehensive Mental Health Action Plan 2013-2020 also emphasise good governance in mental health and encourage countries to update and align their mental health policies and legislation with international human rights instruments such as the Convention on the Rights of Persons with Disabilities (WHO, 2010c, 2013a, 2015a). However, these requirements are often not met in all countries (WHO, 2013a), particularly in the majority of low-and middle-income countries (LMICs) where mental health policies and legislation are either non-existent, out-dated or non-operational (Flisher et al., 2007; WHO, 2014a).

The 2015 Mental Health Atlas showed that only 15% of the WHO's 194 member states reported full implementation of mental health policies, while 14% had policies in place but not implemented. About 10% of countries did not have policies at all (WHO, 2014a, 2015a). The lack of policies was found in many African countries (WHO, 2005d, 2015a). In Ghana, Zambia and Uganda studies found weak implementation of mental health policies and plans (Bird et al., 2011; Faydi et al., 2011; Sibanyoni & Maritz, 2016; Ssebunnya, Kigozi, & Ndyabangi, 2012). The same applies to mental health legislation. Where mental health policies and legislation exist, their implementation is suboptimal (Chapell, 2013). In 2010, only 59% of countries had dedicated mental health legislation (WHO, 2010a, 2011b), which increased to 63% in 2014 (WHO, 2015a). The majority (70%) of these countries are in the European and Western Pacific Regions compared to 50-55% of African and American Regions (WHO, 2015a) and 36% in low income countries (WHO, 2013a). Of concern is that only 18% of the countries had up-

dated their legislation in 2010, and the majority were still using out-dated mental health legislation dating back to the 1960s (WHO, 2010a, 2011b). Another challenge is that only 16% of countries had mental health legislation, but this was not implemented in 10% of the 16% countries. In 2015, the WHO found that few countries have their mental health legislation aligned to the international human rights provisions such as procedures for involuntary psychiatric admission (WHO, 2015a). There were also differences among countries in the same region. For example, Denmark had very strict provisions for involuntary psychiatric admissions in terms of their Mental Health Act compared to the other in countries in the European region (Jepsen, Lomborg, & Engberg, 2010).

Out-dated mental health policies and legislation may not reflect the recent developments in international human rights standards and evidence-based practice (WHO, 2013a), while compromising, at the same time, the enforcement of protection against discrimination, economic marginalisation, abuse and exploitation of mentally ill people (Alem, 2000; Bateman, 2012; Drew et al., 2011; Freeman, Patlhare, & World Health Organization, 2005; Jakubec & Rankin, 2014).

Scholars have pointed out that the development and implementation of the mental health policies and legislation across countries are influenced by: the low prioritisation of mental health; inadequate resource allocation; and competition with other health priority programmes (Ahuja et al., 2016; Fekadu et al., 2016; Frasheri & Dhamo, 2016; Freeman, 2016; Hanlon et al., 2014; Kakuma et al., 2011; Nicaise, Dubois, & Lorant, 2014; Sibanyoni & Maritz, 2016).

Mental health financing: Adequate financing for mental health services enhances the capacity of mental health systems to respond to the mental health needs of societies (WHO, 2014a). However, the investment in mental health is limited and resources to treat and prevent mental disorders remain insufficient and inequitably distributed (Reuter, McGinnis, & Reuter, 2016; Simpson & Chipps, 2012; Sweetland et al., 2014; Thomlinson & Lund, 2012). According to the 2015 WHO Atlas report, public expenditure

on mental health in low-and middle-income countries was less than US\$ 2 per capita, of which a large proportion was spent on in-patient care in psychiatric hospitals (WHO, 2015a). The situation in African countries is worse, where less than 1% of the health budgets is spend on mental health (WHO, 2005a, 2014a).

Mental health care service delivery platform: The platform comprises three interlinked service delivery channels (Bucci, Roberts, Danquah, & Berry, 2015; Lee et al., 2014; Shidaye, Lund, & Chisholm, 2015; WHO, 2007b), namely; self-care which includes care by family members, informal health care by community structures, primary health care and specialist health care (Lee et al., 2014; Shidaye et al., 2015). These main delivery channels are commonly referred to as *Service Organization Pyramid for an Optimal Mix of Services for Mental Health* developed by the WHO (WHO, 2007d), shown in Figure 1.2.



Figure 1.2: WHO optimal mix of services for mental health

Source: WHO (2007)

According to the WHO model shown in Figure 1.2, self-care is a fundamental health care delivery platform in collaboration with families and health workers. Informal community care involves community structures such as traditional healers, faith-based healers, village elders and family and user organisations (Dube & Uys, 2016; Lee et al.,

2014; WHO/WONCA, 2008). The community care platform is used in East Asia, Pacific, Latin American and Sub-Saharan Africa (Shidaye et al., 2015). The PHC platform is the backbone of the health system and is the first level of contact within the formal health system (WHO, 2007d; WHO/WONCA, 2008). Mental health services rendered in PHC are accessible, affordable and acceptable to the community (Dube & Uys, 2016). Effective primary mental health care services reduce referrals for specialist care in psychiatric hospitals. A minority of people with mental disorders would require specialist care beyond the primary health care level (Dube & Uys, 2016; Goodrich, Kilbourne, Nord, & Bauer, 2013). Others may require on-going community-based residential care due to the chronic nature of their mental conditions (de Almeida & Killapsy, 2011; Wilson, Lavis, & Guta, 2012).

However, around the world, mental health services remain inequitably distributed (Dube & Uys, 2016; Patel et al., 2013; WHO, 2003c). In many countries, in-patient psychiatric care is the dominant mode of service delivery, which results in the concentration of resources in specialised psychiatric hospitals (WHO, 2003c). According to the 2014 WHO report, there has been a modest decrease in the number of mental health beds from 2005 to 2014, but about 63% of beds in low-income countries are still located in psychiatric hospitals. High-income countries have a far higher number of hospital mental health beds than lower-income countries (WHO, 2014a). For example, there are 35 beds per 100 000 population in the European Region compared to fewer than 10 beds in all other Regions. The same applies to the admission rates, which exceeded 200 per 100 000 population in the European region compared to less than 50 per 100 000 population elsewhere and more than one in ten of these admissions was on an involuntary basis. The follow-up levels for patients discharged from psychiatric hospitals is very low in American, Eastern Mediterranean and African Regions (WHO, 2015a). In an attempt to reduce the burden on psychiatric hospitals and use resources efficiently, countries established psychiatric wards attached to general hospitals. Globally, there are 2.1. psychiatric beds per 100 000 population attached to general hospitals, which is still three times less than psychiatric hospital beds (WHO, 2015a).

Community-based mental health services are limited in many countries (Sibanyoni & Maritz, 2016). These services can be rendered in the community, residential and out-patient care facilities, serving stable and chronic mental health care users (Dabelko-Schoeny, Anderson, & Guada, 2013). The 2015 Atlas data show that there are 10 per 100 000 population residential beds globally and the majority are in the European Region (WHO, 2015a). Only 44% of the countries globally, had some kind of community mental health care services rendered (WHO, 2014a). The limited beds attached to general hospitals, poor follow-up systems in place and the limited community mental health care services may lead to relapse of patients and frequent re-hospitalisation in specialised psychiatric hospitals, which bears significant costs in the health system due to expensive medication and specialists' services rendered in these hospitals (WHO, 2003c).

However, there are encouraging developments on mental health service delivery in some countries. Brazil has made significant progress in reorganising their mental health services in accordance with the WHO pyramid framework (Brazil Mental Health Reform, 2016). Between 2002 and 2014, psychiatric hospital beds in Brazil were reduced by 58% and the Psychosocial Healthcare Network coverage quadrupled in 2015 through the *Going Back Home Programme* which benefited about 4 349 people. The reduction of hospital beds in Brazil resulted in increased funding dedicated to community-based services, which tripled between 2012 and 2014 (Brazil Mental Health Reform, 2016).

Mental healthcare workforce: Mental health human resources are limited and disproportionately distributed across countries (Reuter et al., 2016; Thomlinson & Lund, 2012). About half of the world's population resides in countries where on average, there is one psychiatrist or less to serve 200 000 people (WHO, 2014a). In low-income countries, there are 0.5 psychiatrists per 100 000 population, compared to 6.6 in high-income countries (WHO, 2015a). The disparity is also pronounced in the number of psychologists, with the distribution of psychologists 100 times greater in high-income countries compared to low-income countries (WHO, 2014a). Other gross shortages have been reported in professional groups, such as social workers and occupational

therapists (WHO, 2014a). Nurses are the single largest group, comprising 40-60% of mental health professionals globally, but there are also shortages (WHO, 2015a). The staff constraints compromise the provision and the quality of mental health care rendered (WHO, 2013a).

User/consumer and family associations: These organisations play a critical role in mental health advocacy and awareness programmes against stigma, discrimination and prevention of mental disorders. However, users, consumer and family organisations are limited, especially in LMICs (WHO, 2014a). Only 49% of the countries had consumer groups and 39% had family groups (WHO, 2003c).

Supply of psychotropic drugs: Despite the availability of low cost treatment, the supply of psychotropic medication is limited, especially in LMICs (WHO, 2014a). The WHO estimates that the median expenditure on psychotropic medication is US\$ 6.81 per person per year globally and that the cost of medicines in low-income countries is 340 times greater than in high-income countries. The high costs of psychotropic drugs contribute directly to non-availability of the drugs, particularly in low-income countries (WHO, 2013a). It is estimated, in these countries, that about 76% to 85% of people with severe mental disorders do not receive treatment (WHO, 2016). The treatment gap predisposes people with mental disorders to high morbidity and premature mortality, as well as human rights abuses, stigma and discrimination (Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009), diminished quality of life and disability (Kebede et al., 2005), and poverty (Saraceno et al., 2007; WHO, 2016). This occurs in the face of research evidence suggesting that mental disorders are both preventable and treatable (Beaglehole et al., 2008; WHO, 2009a).

1.3 The South African context

1.3.1 Demographics

South Africa is divided into nine provinces. In 2016, the country had an estimated population of 55.6 million people, 51% of whom are women and 80.5% black Africans (Statistics South Africa, 2016). A third of the population is under the age of 15 (Statistics South Africa, 2016). The population is ageing, with a population growth of those

individuals aged 60 years and above growing from 6.6% in 2002 to 8% by June 2016 (Statistics South Africa, 2016). As indicated earlier, ageing is one of the factors that influence NCDs, including mental disorders (National Institute on Aging et al., 2011; O'Neil et al., 2015).

South Africa has one of the largest economies on the African continent, and is ranked as upper-middle-income by the World Bank (Statistics South Africa, 2016). The proportion of the health budget as a percentage of GDP was 8.8% in 2016 (National Treasury, 2016). The unemployment rate in the country is high at 24.9% (Statistics South Africa, 2016).

1.3.2 Burden of disease and mental disorders

South Africa's quadruple burden of disease has been well described, consisting of HIV and AIDS, TB and other communicable diseases; a rise in NCDs; violence and injuries; and maternal and perinatal health problems (Day & Gray, 2016; Department of Health, 2015; Department of Monitoring and Evaluation, 2010; Institute of Health Metrics and Evaluation, 2016; Malherbe et al., 2016).

Nonetheless, between 2002 and 2016 there has been an overall increase in the life expectancy at birth from 55.2 to 62.4 years, infant mortality declined from 48.2 to 33.7 per 1000 live births and the under 5 mortality from 70.8 to 44.1 deaths per 1000 live births (Statistics South Africa, 2016). The treatment and management of the HIV epidemic has resulted in a gradual decline in AIDS-related deaths from 48% in 2006 to 28% in 2016, and has enabled HIV positive people to live longer and healthy lives (Gray & Vawda, 2016).

The leading causes of years lived with disability (YLDs) in South Africa and the changes from 2005 to 2016 are shown in Table 1.2 below.

Table 1.2: Leading causes of YLDs in South Africa

Condition	2005 ranking	2016 ranking	% change between 2005-2016
HIV/AIDS	1	1	-9.6%
Low back & neck pain	3	2	22.8%
Sense organ diseases		3	13.6%
Skin diseases	2	4	6.9%
Depressive disorders	5	5	14.2%
Migraine	6	6	34.1%
Diabetes	8	7	5.3%
Anxiety Disorders	7	8	48%
Iron deficiency anaemia	9	9	-4.2%
Asthma	10	10	0.9%

Source: Adapted from (Institute of Health Metrics and Evaluation, 2016, p. 2)

As can be seen, mental disorders are among the top ten leading causes of disability in South Africa. In 2016, depressive disorders (rank 5) and anxiety disorders (rank 8) contributed significantly to the burden of disease in South Africa (Gray & Vawda, 2016; Institute of Health Metrics and Evaluation, 2016; Schneider et al., 2016).

The high burden and prevalence of mental disorders in South Africa is driven by the legacy of apartheid, which created huge inequalities and adverse socio-economic conditions, especially for black African people (Eagle, 2014; Schneider et al., 2016). Historical factors such as poor living conditions, racial discrimination, and childhood trauma, social, political and economic alienation are associated with mental disorders in the country (Eagle, 2014). Furthermore the on-going racial tensions; inequalities, stigma and discrimination associated with mental illness, and the treatment gap (Joska, Stein, & Grant, 2014; Lund et al., 2013) in the post-apartheid era continue to predispose many South Africans to mental disorders (Eagle, 2014; Lund et al., 2011).

The first and only reliable representative national research on the prevalence of mental disorders was conducted between 2002 and 2004 through the South African Stress and Health (SASH) study, as part of the World Mental Health (WMH) Survey Initiative (Herman et al., 2009; Stein, Herman, & et al, 2008; Williams et al., 2008). The SASH study showed that one in six adults (16.5% of the adult population) suffered from common mental disorders over a 12-month period. The most prevalent mental disorders

were anxiety disorders, substance abuse disorders and mood disorders (Herman et al., 2009; Stein et al., 2008). It was further estimated that one in three South African adults will suffer from common mental disorders once in their life time (Herman et al., 2009; Williams et al., 2008). The study further showed that the prevalence of mental disorders in South Africa was more than twice that in Nigeria (12.0%) and China (13.2%) but lower than in Columbia, France, Ukraine and New Zealand (47.4%). However, the differences in the prevalence data on mental disorders among countries must be interpreted with caution due to the possibility of underreporting as a result of stigma and the varying diagnostic criteria for mental disorders used across cultural contexts. The 12-month prevalence of adult mental disorders in South Africa for 2009 is shown in Table 1.3.

Table 1.3: 12-month prevalence of adult mental disorders in South Africa, 2009

Mental disorder	% prevalence
Anxiety	8.1
Substance Use	5.8
Mood	4.9
Impulse	1.9

Source: Herman et al. (2009, p. 4)

Smaller studies have yielded important information on the burden of mental illness in different geographical areas of South Africa. In the Western Cape Province, the 2007 project on reduction of the BOD found that mental disorders was the second among the five major high ranking diseases in the province and estimated that 30% of adults would develop mental illness in their life time (Bradshaw, Nannan, Laubsher, & et al, 2004; Corrigall et al., 2007). Thomas, Cloete, Kidd, and Lategan (2015) also reported a high prevalence of mental disorders in the Western Cape Province. Another study conducted in KwaZulu-Natal Province in 2014, found that 956 000 adults were living with mental disorders but only 20% received mental health care treatment (Burns, 2014). In the Eastern Cape Province, it was estimated that 15.2% of the population suffered from depression with a lifetime prevalence of depression of 31.4% in 2012 (Andersson et al., 2013).

Regarding children and adolescents, nationally representative prevalence data on mental disorders is lacking (Jack et al., 2014; Kabiru, Izugbara, & Beguy, 2013; Merikangas, Nakamura, & Kessler, 2009; Paula et al., 2014). A study conducted by Kleintjies and colleagues in 2006 found a 17% unadjusted 12-month prevalence of child and adolescent mental disorders in the Western Cape Province (Kleintjies et al., 2006). The most common mental disorders found in children and adolescents were generalised anxiety disorders (11%), depression (8%), attention deficit hyperactivity disorder (5%) and post-traumatic stress disorder (8%) (Kleintjies et al., 2006).

The impact of mental disorders in South Africa is significant. Although data on the economic impact of mental disorders in South Africa is limited, it has been estimated conservatively that in 2005 the lost household income due to depression and anxiety disorders alone was nearly 2.2% of the GDP (Lund et al., 2013).

1.3.3 Social determinants of mental health in South Africa

The historical and political context, notably the legacy of apartheid, predisposes South African communities to an increased risk of mental illness (Eagle, 2014; Schneider et al., 2016). Many people in the country experienced severe human rights violations in the form of violence, exclusion and racial discrimination under the apartheid government (Lund et al., 2011; McCrea, 2010). The mental and psychological trauma endured by the victims of apartheid has been well documented in the 2000 Truth and Reconciliation report (Truth and Reconciliation Commission, 2000).

Although a supportive childhood environment, opportunities for learning and work have proved to be effective protective factors against mental illness (WHO, 2013b), these are not favourable for many South Africans. Many people are living in poor social conditions, characterised by unemployment, lack of proper housing, limited access to health and education, which increases the risk of many South Africans to mental disorders (Flisher et al., 2007; Lund, Breen, et al., 2010; Lund et al., 2013). A country report released by Statistics South Africa revealed a 32.7% food poverty line (Statistics South Africa, 2011) and 45.5% upper-bound poverty line in 2011 (Statistics South

Africa, 2014). In 2014, 5.2% of South Africans had no schooling (Statistics South Africa, 2014) .

Substance abuse (including alcohol, tobacco and illicit drugs) is another risk factor for mental illness in South Africa, in addition to the risk factors of crime, and violence. In Western Cape Province only, the most common primary drug of use was methamphetamine (35%) followed by cannabis (22%), alcohol (21%), heroin (14%), mandrax (4%) and cocaine (1.0%) in 2015 (Dada et al., 2015). Regarding smoking, 15.9% of South Africans 18 years and above reported to be frequent smokers in 2012 (Reddy et al., 2013) while 32.8% of males and 10.15% of females aged 15 years and above reported to have smoked cigarettes (Reddy, Zuma, Shisana, Jonas, & Sewpaul, 2015).

1.3.4 Key developments in mental health in South Africa

Developments following democracy in 1994 aimed to redress the unacceptable inequities in mental health systems inherited from the apartheid. The main developments are summarised in Table 1.4.

Table 1.4: Key policy developments in South Africa

Year	Policy Development	Overview	Sources
1993	Correctional Services Amendment Act	<ul style="list-style-type: none"> • Makes provision for State patients (persons who allegedly committed an offence but are not criminally responsible and also cannot stand trial due to mental illness, declared as such by the Courts) and mentally ill prisoners 	(Republic of South Africa, 1993)
1994	The Reconstruction and Development Programme (RDP): A policy framework	<ul style="list-style-type: none"> • Recognition of the importance of mental health to overall well-being • Policy framework to address the socio-economic problems inherited from the apartheid regime, to alleviate poverty and addressing shortfalls in social services and basic needs such as health care, nutrition, housing, education among others 	(The African National Congress (ANC), 1994)(1994)
	A policy for the development of a district health system	<ul style="list-style-type: none"> • District health system based on the Primary Health Care Approach as enunciated at Alma Ata in 1978 • Emphasis on prevention, health promotion, early intervention, rehabilitation in response to the community health needs. It includes mental health services through health districts 	(Department of Health, 1994)

	Policy development	Overview	Sources
1996	Constitution of the Republic of South Africa and the accompanying Bill of Rights	<ul style="list-style-type: none"> • The supreme law of the country designed to respect promote, protect and fulfil the rights of all • Contains the Bill of Rights 	(The Republic of South Africa, 1996)
1997	White Paper for Transformation of the Health System in South Africa	<ul style="list-style-type: none"> • Restructuring of health services post-apartheid in South Africa towards a unified national health system. Chapter 12 is dedicated to mental health and delineates responsibilities for policy development and implementation at national, provincial, district and community level 	Department of Health (1997d)
	Draft National Health Policy Guidelines for improved mental health in South Africa	<ul style="list-style-type: none"> • Development of community-based mental health services, downsizing psychiatric hospitals, integration of mental health services, advocacy 	(Department of Health, 1997b)
	Child and adolescent mental health policy guidelines	<ul style="list-style-type: none"> • Guidance on service requirements and plans for the mental health needs of children and adolescents 	Department of Health (1997a)
	National integrated disability strategy	<ul style="list-style-type: none"> • Framework for inclusion of the needs of the disabled including mental disability at work 	(Republic of South Africa, 1997)
2004	Mental Health Care Act	<ul style="list-style-type: none"> • Promulgation of the legal framework for mental health services with emphasis on a human rights approach to care, treatment and rehabilitation of mental health care users 	Republic of South Africa (2002)
2005	Children's Act	<ul style="list-style-type: none"> • Provides for the well-being of children and support to intellectually and mentally disabled children 	(Republic of South Africa, 2005)
2006	Guidelines on the roles and responsibilities of members of the Executive Council, Director-General, Heads of Health Establishments in terms of the Mental Health Care Act No 17 of 2002	<ul style="list-style-type: none"> • Clarifies roles of members of the Executive Council, Director-General, and Heads of Health Establishments as prescribed in the Mental Health Care Act No 17 of 2002 • These roles include, among others, appointment of Mental Health Review Boards, designation of psychiatric hospitals, involuntary psychiatric admissions and admission for State patients. 	(Department of Health, 2006)
2007	Ratification of the Convention of the Rights of disabled persons which includes mentally disabled persons	<ul style="list-style-type: none"> • South Africa became signatory to the Convention on the Rights of Disabled Persons that seeks to promote and protect the rights and dignity of persons with disabilities. 	(Department of Health, 2007a)

	Policy development	Overview	Sources
	Norms manual for severe psychiatric conditions	<ul style="list-style-type: none"> • Guidance on service plans for adult severe psychiatric disorders • Provides a framework for determination of beds and human resource requirements according to population size and prevalence rates 	(Department of Health, 2007c)
2012	Policy guidelines on 72-hour assessment of involuntary mental health care users	<ul style="list-style-type: none"> • Provides guidance on models for provision of 72-hour assessment in general hospitals including infrastructure and human resource requirements. 	(Department of Health, 2012a)
	Policy guidelines on seclusion and restraint of mental health care users	<ul style="list-style-type: none"> • Provides guidance on criteria for seclusion and restraint and the related care in terms of the Mental Health Care Act No 17 of 2002. 	(Department of Health, 2012b)
	National and provincial mental health summits	<ul style="list-style-type: none"> • All 9 provincial health departments held summits followed by the national summit to consult stakeholders, review mental health services, identify best practices and to generate a roadmap for improving mental health services in South Africa 	Department of Health (2013b)
	The Ekurhuleni Declaration on Mental Health	<ul style="list-style-type: none"> • The Declaration by the Department of Health to improve mental health services and service requirements. • The Declaration commitments include promoting mental health as a development objective, full implementation of the Mental Health Care Act, integration of services, collaboration with other sectors and improved resourcing for mental health 	Department of Health (2013b)
2013	National Health Amendment Act	<ul style="list-style-type: none"> • Provides a framework for a unified health system in South Africa, a system for cooperative governance and management of health services 	Republic of South Africa (2013)
	National Mental Health Policy Framework and Strategic Plan 2013-2020	<ul style="list-style-type: none"> • Aimed towards improved mental health services by 2020 in the country, with focus on key objectives for action: District-based mental health services, institutional capacity building, research, infrastructure, human resources, technology, intersectoral collaboration and advocacy 	Department of Health (2013b)
2015	White Paper on National Health Insurance System	<ul style="list-style-type: none"> • A significant change in health systems financing based on the principles of health for all, equity, social solidarity and effective and efficient health system • Among other objectives, the NHI aims to restructure provision of occupational health, mental health, disability and emergency medical services 	Republic of South Africa (2015)
	Ministerial Technical Advisory Committee on Mental Health	<ul style="list-style-type: none"> • Among others, the Advisory Committee provide advice to the Department of Health on mental health care and other appropriate interventions 	Department of Health (2013b)

As can be seen from Table 1.4, there have been a plethora of policy initiatives with the aim of redress, equity, social justice and addressing the complex BOD. As is the case at

the global level, many South African authors have highlighted the disjuncture between policy and implementation gaps, which continue to affect poor people disproportionately and undermine the equity and human rights intentions of policy and legislation (Ditlopo et al., 2013; Ditlopo. et al., 2011; Mabena., 2010; Mthethwa, 2012; Petersen et al., 2016; Ramlall, 2012; Ramlall, Chipps, & Mars, 2010; Rispel, 2015b; Rispel & Moorman, 2010; Sibanyoni & Maritz, 2016; van Rensburg, 2011, 2012).

The next section summarises seminal aspects of the South African mental health system.

1.3.5 South African mental health system

The WHO building blocks for health systems are used to discuss the mental health system and service provision in South Africa.

The legislative and policy environment in South African mental health systems

The Mental Health Care Act, 2002 (No. 17 of 2002): Prior to democracy in South Africa, mental health services were provided in terms of the Mental Health Act No 18 of 1973, referred to as the “1973 Act” in this study (Republic of South Africa, 1973). The human rights of patients was not a priority under this legislation (McCrea, 2010), as the main focus was to control and treat psychiatric patients so as to ensure “protection of the welfare and safety of society” (Burns, 2008; Republic of South Africa, 1973). Only a reasonable degree of suspicion was sufficient under the 1973 Act for a person to be certified and detained at a mental health institution. There were many reports where people were admitted unfairly in mental health institutions based on prejudice, jealousies and political vendettas (Department of Health, 1996). Mental health care users, or psychiatric patients were often alienated, disempowered and stigmatised, assaulted and traumatised (Burns, 2008). The legislation also condoned discrimination in service provision on the basis of race, with black Africans having the least access to care (Republic of South Africa, 1973). Furthermore, mental health services were curative, fragmented, and inequitably distributed among different racial groups, with

limited focus on preventive and promotive approaches to care (Burns, 2008; McCrea, 2010; Republic of South Africa, 1973).

Following the democratic transition and alignment with the Constitution of the country and the Bill of Rights, South Africa replaced the 1973 Mental Health Act with the new Mental Health Care Act, 2002 (No. 17 of 2002), (Republic of South Africa, 2002). The key goals and provisions of the Act relevant to this study are discussed in section 1.4 below.

The National Mental Health Policy Framework and Strategic Plan 2013-2020

Until 2013, South Africa had no official mental health policy. However, there was a review of the mental health policy in 1997 and the national health policy guidelines for improved mental health in South Africa were produced, but not approved (Department of Health, 1997c). The components of the 1997 policy guidelines included: community mental health; downsizing large mental hospitals; integrating mental health into primary health care; protection of human rights, advocacy, financing and quality improvement (Department of Health, 1997c; Lund, Kleintjies, et al., 2008; WHO and the Department of Psychiatry and Mental Health, 2007).

In 2013, government introduced the National Mental Health Policy Framework and Strategic Plan 2013-2020. The main aim of this policy framework and strategic plan is to give guidance on mental health priorities and action (Department of Health, 2013b). The policy outlines eight catalytic objectives that aim to improve mental health services in the country while also facilitating implementation of mental health legislation (Department of Health, 2013b). The objectives outlined in the policy framework are to: develop district based mental health services and primary health care; build institutional capacity across the national, provincial and district levels; ensure surveillance, research and innovation; improve the infrastructure and capacity of facilities; improve mental health technology and medicines; ensure inter-sectoral collaboration; improve human resources for mental health; and promote advocacy, mental health promotion and prevention of mental illness (Department of Health, 2013b).

The National Mental Health Policy Framework and Strategic Plan 2013-2020 requires each province to develop strategic plans for mental health with clear plans, activities, targets and costs (Department of Health, 2013b). However, no province has complied with this requirement. Even in the provincial strategic plans, mental health has received limited prominence as part of non-communicable diseases. Mental health is only articulated to as part of provincial hospital services as specialised psychiatric facilities. Although there has been limited policy implementation research, there is emerging evidence on the challenges in the implementation of this policy framework, exacerbated by poor communication and resource limitations (Petersen et al., 2016).

Mental health service organisation and delivery platform: In the public sector, the national Directorate: Mental Health and Substance Abuse, provides policy oversight on mental health services in the country. In each province, a mental health directorate or sub-directorate coordinates service provision, led by mental health coordinators.

The pyramid framework on the organisation of mental health services proposed by the WHO is inverted in South Africa despite the emphasis by the Act and the National Mental Health Policy Framework and Strategic Plan 2013-2020 on improved access to mental health care, closer to where people live and work and a recovery model focusing on psychosocial rehabilitation and community services (Department of Health, 2013b; Republic of South Africa, 2002). Mental health services still remain largely hospital-based in this country with a ratio of 18 beds per 100 000 population in psychiatric hospitals, compared to 2.8 beds per 100 000 in general hospitals (WHO and the Department of Psychiatry and Mental Health, 2007).

It has also been argued that mental health services in South Africa have been modelled on institutional care and lack elements that promote social inclusion, empowerment and independence (Rural Health Advocacy Report, 2015).

There are limited community-based mental health services (day care and residential mental health facilities) (Lund et al., 2011; Petersen et al., 2016; Ramlall, 2012; Sibanyoni & Maritz, 2016). The WHO-AIMS project found 80 day care facilities in the country, half of which were provided by non-governmental organisations (NGOs), the South African Federation for Mental Health (SAFMH) as well as 63 community-based residential facilities (WHO and the Department of Psychiatry and Mental Health, 2007). This hampers efforts to enhance knowledge and understanding of mental illness among families and communities (Rural Health Advocacy Report, 2015). Tragically, the lack of community-based mental health facilities in the public health sector in Gauteng Province resulted in 100 deaths of chronic psychiatric patients who were cared for in unlicensed facilities run by NGOs (Makgoba, 2017).

Researchers have documented challenges encountered in psychiatric hospitals in South Africa (Lund, Kleintjies, et al., 2010; Ramlall, 2012; Ramlall et al., 2010; Sukeri, Alonso-Betancourt, & Emsley, 2014b). Although these facilities should not provide chronic mental health services to stabilised psychiatric patients, the situation in South Africa is unavoidable due to the limited community-based mental health services (Dube & Uys, 2016). As a result, the psychiatric hospitals in South Africa remain full to capacity (Sukeri et al., 2014b). The Act provides for the provision of mental health services in psychiatric units attached to general hospitals (Republic of South Africa, 2002). However, limited progress has been made in this area due to infrastructure, human and financial resource constraints. Infrastructure challenges are a prevailing problem, also in specialised psychiatric hospitals in the country (Freeman, 2016; Petersen et al., 2016; van Rensburg, 2012). This is against the historical background of these hospitals in South Africa, some of which were condemned buildings; some were old leprosy hospitals while some were barracks in prison facilities. The design and layout of these facilities were not meant for mental health service, and this predisposed patients and staff to safety risks (van Rensburg, 2012).

Mental healthcare workforce: The shortage of mental health human resources is a critical barrier to the provision of accessible, effective high quality mental health services

in South Africa. In 2016, the public sector had only 1.2 psychiatrists, 2.6 occupational therapists, physiotherapists and psychologists for every 100 000 population (Gray & Vawda, 2016). Data on psychiatric nurses and social workers is not available despite these professionals being the foundation of mental health care (Gray & Vawda, 2016). This is in contrast to seven times more psychologists, five times more physiotherapists and three times more occupational therapists in the private sector (Rural Health Advocacy Report, 2015). The WHO found that the total number of health professionals working in mental health facilities in the Department of Health and NGOs in South Africa was 9.3 per 100 000 population. The majority of health professionals in the country were working in the private sector, which serves around 17% of the population. About 70% of medical practitioners, 60% of specialists and half of professional nurses continue to work in the private sector. Although 40 to 45% of South Africans live in rural areas, very few health professionals work in these areas. About 12% of doctors and 19% of nurses work in rural areas (Rural Health Advocacy Report, 2015; WHO, 2014a). Information systems for monitoring the location of mental health personnel and their continuing professional development after qualification are inadequate. The limited available information shows limited exposure to mental health during the training of medical doctors (Emsley, 2001; Shields et al., 2016).

Financing for mental health services: Despite the high prevalence and the associated economic impact of mental illness in South Africa, investment in treatment and prevention programmes is relatively low (Rural Health Advocacy Report, 2015). There has never been a systematic tracking of budget allocation for and expenditure on treating mental disorders in the country, and limited information is available on mental health budget allocations and costs (WHO and the Department of Psychiatry and Mental Health, 2007). The 2004 WHO country report showed that only four provinces (Gauteng, North West, Northern Cape and Mpumalanga Provinces) spent about 5% of their total health budget on mental health services, and that the bulk of the budget was spent in specialised psychiatric hospitals (WHO, 2005a). The available data on the proportion of the provincial mental expenditure on mental hospitals in 2007 is summarised in Table 1.5.

Table 1.5: Proportion of provincial mental health expenditure in psychiatric hospitals in 2007

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

Source: (WHO and the Department of Psychiatry and Mental Health, 2007)

The figures above exclude mental health expenditure in the private sector. In 2012, one medical scheme, Discovery, reported to have paid about R494.6 million for mental health care services (Bateman, 2015).

The limited articulation of mental health in provincial strategic plans results in limited provincial budgets for mental health. The only available expenditure on mental health in the public sector is from specialised psychiatric hospitals (Lund, Kleintjies, et al., 2010). The budget for mental health services provided in general and primary health facilities is not known because it is integrated within the health budget (Rural Health Advocacy Report, 2015). In the 2015/16 financial year, provinces spent on average 2.9% of their total budgets in psychiatric hospitals. The expenditure varied from 4.6% in North West, 3.96% (Limpopo), 3.87% (Western Cape), 3.37% (Free State), 3.17% (Eastern Cape), 3.10% (Gauteng), 2.42% (KwaZulu-Natal), 1.19% (Northern Cape) and 0.37% in Mpumalanga Province (Rural Health Advocacy Report, 2015).

User/consumer and family associations: The South African Federation for Mental Health is funded by the Department on an annual basis for mental health promotion and mental illness prevention programmes (Lund, Kleintjies, et al., 2008; Lund, Kleintjies, et al., 2010). Consumer associations in the Western Cape, Gauteng, Free State and Mpumalanga Provinces were also funded by government. About 33 NGOs countrywide were involved with counselling, housing and support groups (Rural Health Advocacy Report, 2015). No data was available on family organisations in the country (Lund, Kleintjies, et al., 2008; van Rensburg, 2012; WHO and the Department of Psychiatry and Mental Health, 2007).

Availability of psychotropic drugs: The availability of medication for mental disorders is another challenge in the South African mental health system (Sunkel, 2013). Reports indicate that the country has frequent stock-outs of psychiatric medication at clinics (Rural Health Advocacy Report, 2015), which result in the deterioration of mental illness and relapse of patients. The Rural Mental Health Campaign reported that 10% of the medication stock-outs reported in South Africa between January and July 2015 were psychiatric medications. These were exacerbated by long distances to the facilities, logistical and human resource constraints (Rural Health Advocacy Report, 2015). For the users that pay out of pocket for generic psychotropic medication in South Africa, the cost is as high as 24 cents per day, which is 0.7% of the minimum wage (Lund, Kleintjies, et al., 2008).

Access to health care in South Africa is dependent on the individual's income and where they live, with rural populations being disproportionately affected. People living in rural populations carry a double burden from high out-of-pocket expenses for transport costs to access services from hospitals that are mostly located in cities (Rural Health Advocacy Report, 2015). This was also found in the SASH study which found that only 28% of people with severe mental disorders and 24% of people with mild mental disorders received treatment (Herman et al., 2009).

The next section expands on key aspects of the 2002 Mental Health Care Act relevant to this thesis and provides a background on psychiatric hospitals in the country, the setting for the PhD study.

1.4 The Mental Health Care Act and psychiatric hospitals

The 2002 Mental Health Care Act (referred to as the Act in this study) is based on the principles of respect for human rights, accessibility, equity, and quality care, treatment and rehabilitation (Republic of South Africa, 2002). The main objectives of the Act are to transform and regulate mental health service delivery from the historical custodial approach through enhancement of accountability, governance, coordination and

community-based care and efficient mental health services across all levels of the health system (Republic of South Africa, 2002).

In order to achieve the intended objectives, the Act transformed the mental health services platform and introduced new terminology, classifications, and procedures. For example, psychiatric patients are referred to as mental health care users, defined as a person receiving care, treatment and rehabilitation or using a health service at a health establishment aimed at enhancing their mental health state (Republic of South Africa, 2002). The Act also introduced new legal classifications of voluntary, assisted and involuntary users. The new procedures include designation or “accreditation” of psychiatric hospitals to render mental health care; and 72-hour assessments for further involuntary care (Republic of South Africa, 2002). The Act further introduced new governance structures, called the Mental Health Review Boards.

1.4.1 Legal classifications of mental health care users

The Act refers to psychiatric patients as mental health care users, and they are further classified as voluntary, assisted or involuntary. A voluntary user is a person who gives consent voluntarily for mental health interventions; an assisted user is a person who is incapable of making an informed decision due to their mental health status and does not refuse health interventions. Involuntary user is person who is incapable of making informed decision due to their mental health status and refuses health interventions, but requires such for their own protection or for the protection of other people. Mental health care users can move across these legal classifications based on their mental health status (Republic of South Africa, 2002). In this study, the concepts of psychiatric patients and mental health care users are used interchangeably.

The Act has special provisions on involuntary psychiatric admissions, because of its abuse under the 1973 Act (Freeman et al., 2005). Drawing on a broader human rights approach, the Act stipulates three conditions for involuntary admission in South African psychiatric hospitals: (a) that the user is likely to harm self or others; (b) care, treatment and rehabilitation of the user is necessary for the protection of their financial interests or

reputation, (c) the user is incapable of making an informed decision on the need for intervention at that time. A summary of procedures prescribed in the Act for involuntary psychiatric admission (Republic of South Africa, 2002) is presented in Table 1.6.

These procedures are used in the study to examine the implementation of the Act in psychiatric hospitals.

Table 1.6: A summary of the procedures for involuntary psychiatric admission

1. The application must be made under oath by the spouse, next of kin, partner, associate, parent or guardian of the mental health care user on Form 4 of the Act
2. The applicant must have seen the mental health care user within seven days before making the application
3. If the designated persons are not available, a health care provider can make the application, but must state the reasons why they are applying and the steps they took to locate the relatives of the mental health care user
4. On receipt of the application, the head of the health establishment (hospital CEO) must ensure the examination of the mental health care user by two mental health care practitioners
5. If the hospital CEO concurs with the assessment reports (on two Form 5s) and the recommendation for further involuntary mental health care, he or she must inform the applicant in writing about the decision and reasons for such admission in Form 7
6. The mental health care user must then be admitted to undergo a 72-hour assessment of their physical and mental health status by a medical practitioner and another mental health care practitioner
7. If the assessment report warrants further involuntary care, treatment and rehabilitation, the hospital CEO must within seven days of expiry of the 72-hour assessment period, submit a written request to the MHRB for approval of the involuntary admission
8. The MHRB must within 30 days of receipt of the application consider the request and submit a written response to the CEO
9. If the MHRB approves the involuntary admission, they must submit the request to the Registrar of a High Court, which must grant a final order authorising the involuntary admission in Form 16 within 30 days after receipt of application from the MHRB
10. The mental health care user, spouse, next of kin, partner, associate, parent or guardian of the mental health care user may appeal against the involuntary psychiatric admission to the MHRB within 30 days after being informed of the admission

11. If the user's estimated property value is R200 000 or more, or their annual income is R24 000 or more, an application may be made to the Master of a High Court to appoint an administrator to take care of the mental health care user's property or their annual income
12. The Act makes provision for a change in the involuntary legal classification subject to the mental health user's ability to make informed decisions

Adapted from the Republic of South Africa (2002)

The salient features of the procedures for involuntary psychiatric admission prescribed in the Act include the requirements for application; procedure for assessment of the user's physical and mental status; approval and authorisation of the application, appeal against the admission; protection of the user's property and annual income whilst involuntarily admitted at a psychiatric hospital; and finally, change of the user's involuntary mental health status to assisted or voluntary mental health care user upon recovery of the capacity to make informed decisions (Republic of South Africa, 2002). In terms of the application process, the Act requires a written application by the designated people to be made under Oath in Form 4. Provision is made where the designated applicants are not available and allows the health care provider to apply, but must indicate the reasons for making such an application and the steps that were taken to locate the relatives (Republic of South Africa, 2002).

The Act further introduced a stringent assessment procedure of the user, where the first must be conducted by two mental health practitioners. This is followed by another assessment by a mental health practitioner and medical practitioner during a period of 72-hours where the initial assessment recommended involuntary psychiatric admission. Reports from these assessments must be compiled and submitted to the hospital CEO, who must issue a notice to the applicant if she or he concurs with the recommendation for involuntary psychiatric admission. The application must be further submitted to the MHRB for approval and to the High Court for final authorisation on Form 16 of the Act. Additional procedures include lodging an appeal by the applicant to the MHRB against the involuntary admission or processes followed; care for the user's property and annual income. When the user's mental status improves and he/she regains capacity for making informed consent, the Act allows for the change in the involuntary legal

classification to an assisted or voluntary status (Republic of South Africa, 2002). The researcher could not find any study in South Africa that has examined compliance of psychiatric hospitals with the legal procedures prescribed in the 2002 Act on involuntary psychiatric admissions. The findings from this study begin to fill this knowledge gap.

1.4.2 Designation of psychiatric hospitals

Under the 1973 mental health legislation in South Africa, mental health services were centralised in specialised stand-alone psychiatric hospitals (Republic of South Africa, 1973). As a result, mental health services in the country were inaccessible, fragmented and not effective (McCrea, 2010). The 2002 Act intended to improve accessibility by integrating mental health services into the general health service environment. In order to achieve this objective, the Act decentralised mental health services to district and regional hospitals (Republic of South Africa, 2002). The provincial head of the health department would identify a suitable district and/or regional hospital in the public sector and, in concurrence with the national Director-General of Health, designate or 'accredit' part of the hospital to serve as a psychiatric hospital. In terms of the Act, a wing or ward of the hospital that has been designated to serve as a psychiatric hospital is referred to as a designated psychiatric hospital, although it is located at a general hospital (Republic of South Africa, 2002). The concept of designation in the Act is applied only to public hospitals (both self-standing specialised psychiatric hospitals and units attached to general hospitals), and licensing is used for private psychiatric hospitals.

The designation or licence of a public or private psychiatric hospital may be revoked or varied by the national Director-General of Health with the concurrence of the relevant provincial health department, if the conditions at the hospital are not satisfactory according to the norms and standards set by the national Department of Health. Due to the urgency and importance of decentralised mental health care, the Act prescribed that designation of public psychiatric hospitals be undertaken within 120 days of the commencement of the Act (Republic of South Africa, 2002).

In this thesis, the term psychiatric hospitals include all designated psychiatric hospitals, whether self-standing specialised psychiatric hospitals and units attached to general hospitals.

1.4.3 The notion of 72-hour assessments

There have been numerous reports of ill-treatment and suboptimal care of patients in psychiatric hospitals in the past (Department of Health, 1996). These included misdiagnosis, limited attention to physical or medical conditions of psychiatric patients and abuse of involuntary psychiatric admission (Burns, 2011). The notion of 72-hour assessment was introduced in the Act with the intention of improving the physical and mental health assessments of patients before being admitted involuntarily in psychiatric hospitals (Moosa & Jeenah, 2008). Partly, the Act also intended to redress the legacy of the past in mental health, but generally, to uphold the rights of patients and to promote their wellbeing. During the assessment period, mental health treatment is also initiated, which has proven to be effective and reduced a significant number of involuntary psychiatric admissions (Moosa & Jeenah, 2010). As indicated above, this assessment is conducted by two professionals, namely the mental health care practitioner and a medical practitioner in order to ensure a holistic assessment of the patient (Republic of South Africa, 2002). Hence the 72-hour assessment is the main determinant of the need for involuntary psychiatric admission at a psychiatric hospital.

1.4.4 Improving governance through the Mental Health Review Boards (MHRBs)

MHRBs have been established in the Act to promote the human rights of people with mental disorders (Department of Health, 2007b; Freeman et al., 2005). These MHRBs have a clearly specified legal role to oversee the human rights of mental health care users through considering applications for assisted and involuntary admissions; review periodic reports of these users including discharges, investigate complaints and consider appeals by users or their families (Department of Health, 2007b; Republic of South Africa, 2002). One critical role of these boards is to ensure that all involuntary psychiatric admissions are authorised by the High Court in accordance with the Act as shown in Table 1.6. The powers and functions of the MHRBs prescribed in the Act

(Republic of South Africa, 2002) are shown in Table 1.7. The functioning of the MHRBs is examined in this study against these powers and responsibilities, but limited to involuntary psychiatric admissions.

Table 1.7: Powers and functions of the MHRBs as stipulated in the Act

- Consider appeals against decisions of the head of a health establishment
- Make decisions with regard to assisted or involuntary mental health care, treatment and rehabilitation services
- Consider reviews and make decisions on assisted or involuntary mental health care users
- Consider 72-hour assessment made by the head of health establishment and make decisions to provide further involuntary care, treatment and rehabilitation
- Consider applications for transfer of mental health care users to maximum security facilities; and
- Consider periodic reports on the mental health status of mentally ill prisoners

Source: (Republic of South Africa, 2002)

The MHRBs are appointed by the MECs in provinces (Republic of South Africa, 2002) who should provide a favourable working environment and resources for the execution of their legal mandates. This includes offices where they hold regular meetings and appraise applications for involuntary admissions and conduct hearings on appeals lodged. Other resources includes equipment such as fax machines and telephones to facilitate correspondence of application documents to and from the hospitals and the High Court (Department of Health, 2007b). The Act purposefully locates the Board in the MECs offices to ensure their independence and quasi-judicial role with respect to mental health care provision (Department of Health, 2005, 2007b, 2009, 2013a).

The MHRBs determine their own systems in conducting their business, such as frequency of meetings and procedures, review mechanisms of applications, and hearings on appeals. However, it is critical that the MHRBs have annual strategic plans in order to source adequate resources, such as budgets and equipment for their functioning (Department of Health, 2007b). A number of local studies as well as audits conducted by the national DOH have highlighted challenges in the functioning of the MHRBs in some provinces (Department of Health, 2005, 2009, 2013a; Moosa & Jeenah, 2010; Ramlall, 2012; Ramlall et al., 2010). This study generates empirical information on the functioning of MHRBs in all provinces in South Africa.

1.5 Problem statement

South Africa faces a high burden of mental disorders across all age groups, gender and race, which contributes significantly to the BOD (Herman et al., 2009; Petersen et al., 2016; Petersen et al., 2013). However, despite the existence of progressive mental health legislation in South Africa, anecdotal evidence suggests that the mental health system still carries the characteristics from the previous apartheid regime (Burns, 2014; Jackson et al., 2010; Sukeri, Alonso-Betancourt, & Emsley, 2014a). This includes stigma and discrimination, under-resourcing, fragmentation of services with minimal integration, lack of community-based mental health services, a curative hospital-based approach to care and inhabitable infrastructure (Ahuja et al., 2016; Breuer et al., 2016; Burns, 2011, 2014; Jackson et al., 2010; Lund, Kleintjies, et al., 2010; Ramlall, 2012; Ramlall et al., 2010; Sibanyoni & Maritz, 2016; Sukeri et al., 2014a).

Importantly, there has been limited research on the implementation of the Act in psychiatric hospitals (Breuer et al., 2016; Lund, Kleintjies, et al., 2010), with knowledge gaps on the progress made, challenges and barriers encountered, and any unintended consequences from the implementation of the Act. Policy implementation studies can increase our understanding of the relationship between laudable policies, and actual implementation, and provide insights as to how to improve the implementation process (Gilson & Raphaely, 2007; WHO, 2003a). Furthermore, the field of policy implementation in mental health remains underdeveloped. The existing body of published mental health policy implementation research in South Africa is small, and tends to be mostly descriptive case studies, rather than analytical in approach (Lund, Kleintjies, et al., 2010; Thom, 2004).

In consort with a human rights approach, the Act introduced new procedures for involuntary psychiatric admissions in general and specialised psychiatric hospitals (Republic of South Africa, 2002), but to date, no nationally representative study has been conducted to determine the compliance of health care facilities with the prescribed procedures.

Mental Health Review Boards are important governance structures introduced by the Act in the South African mental health system (Republic of South Africa, 2002). However, little is known about their functioning, progress made, and challenges encountered, which may influence their performance.

1.6 Study rationale

There were several reasons for undertaking this study, particularly in psychiatric hospitals. These are discussed here:

Limited scholarly focus on psychiatric hospitals: There is a dearth of studies on the implementation of the Act in psychiatric hospitals in South Africa. The majority of studies are focused on the need for community-based mental health services and also in primary mental health care (Dube & Uys, 2016; Petersen et al., 2016; Ramlall, 2012; Rural Health Advocacy Report, 2015). This is despite the significant investments of financial and human resources in psychiatric hospitals. As described in the previous section, the bulk of the mental health care expenditure was in psychiatric hospitals. This makes it imperative to generate new knowledge on the implementation of the Act in psychiatric hospitals in South Africa, through the lens of policy implementation theory.

Secondly, focusing on psychiatric hospitals allows the researcher to answer the study research question on compliance with procedures for involuntary admissions, which would not have been possible with a focus on PHC or community-based care.

Lastly, there is limited empirical information on the functioning of the MHRBs as new governance structures introduced by the Act, which are applicable only to psychiatric hospitals.

Contribution to the body of knowledge: This study begins to fill the gaps and contributes to the body of knowledge on the implementation of the Mental Health Act in psychiatric hospitals, by exploring the progress made, identifying problems in implementation and the reasons behind those problems. Given the fact that the theory

of policy implementation remains an under-utilised tool in mental health, this is one of the first studies to use policy implementation theory in the field of mental health. The findings determine whether the factors that influence the implementation of mental health policy are similar or different to other aspects of social or public policy implementation. Furthermore, the study expands the commonly applied WHO framework on mental health policy implementation by developing an adapted conceptual framework underpinned by policy implementation theory.

Generating additional research questions: The findings and lessons from this study will generate additional research questions in the field of mental health legislation and psychiatric hospitals, both in South Africa and with relevance for other LMICs.

Contribution to enhanced mental health policy and practice: The study contributes to improvements in mental health policy and practice, as well as service delivery by analysing the progress and challenges, and by identifying bottlenecks in the implementation process, thereby providing lessons for future implementation and improved legislative compliance.

1.7 Aim of the study

The overall aim of this study was to analyse the implementation of the Mental Health Care Act in designated psychiatric hospitals for the period from 2005 to 2010.

1.8 Scope of the study

This study was restricted to psychiatric hospitals and focused on the following components of the implementation of the 2002 Act:

- 1.8.1 Involvement of mental health policy actors/ stakeholders in the implementation of the Act in psychiatric hospitals
- 1.8.2 Planning processes that were followed in the implementation of the Act in psychiatric hospitals
- 1.8.3 The functioning of Mental Health Review Boards in executing their prescribed roles

- 1.8.4 Compliance of the psychiatric hospitals with the procedures for involuntary psychiatric admissions

1.9 The specific objectives of the study

In light of the above rationale and scope of the study, the specific objectives of the study were to:

- 1.9.1. Explore the extent and nature of involvement of mental health policy actors or stakeholders in the implementation of the Act in psychiatric hospitals
- 1.9.2. Describe the processes and planning followed in the implementation of the Act in designated psychiatric hospitals
- 1.9.3. Examine whether Mental Health Review Boards in designated psychiatric hospitals execute their prescribed roles and functions
- 1.9.4. Examine compliance of psychiatric hospitals with prescribed procedures in the Act on involuntary admissions
- 1.9.5. Explore the factors that influenced the implementation of the Act

1.10 Research questions

1.10.1 The main research question of the study

Using the theory of policy implementation, how has the Mental Health Care Act, 2002 (No 17 of 2002) been implemented in psychiatric hospitals for the period, 2005 to 2010?

1.10.2 Sub-questions of the study

- 1) Were the different stakeholders in mental health consulted in the development of the Act?
- 2) To what extent were stakeholders in mental health involved in the implementation of the Act in psychiatric hospitals?
- 3) Were there differences among stakeholders in the interpretation of the different provisions of the Act?
- 4) What were the narratives of different stakeholders on the planning and preparatory processes for implementation of the Act in psychiatric hospitals?

- 5) Did MHRBs execute their roles and functions as prescribed in the Act? What were the factors that influenced their functioning?
- 6) To what extent were psychiatric hospitals compliant with the procedures prescribed in the Act on involuntary admissions?
- 7) What were the factors that influenced the implementation of the Act?

1.11 Structure and outline of the thesis

Chapter 1 introduces the study topic and locates the study within a global and national context, and outlines the study rationale and objectives.

Chapter 2 reviews the literature on policy, policy implementation, conceptual models and theories of policy implementation that provide the framework of analysis on the implementation of the Mental Health Care Act in psychiatric hospitals.

Chapter 3 focuses on the research approach and methodology. Ethical considerations and issues of validity and trustworthiness in the study are also discussed in this chapter.

Chapter 4 presents the qualitative research findings of this study, in line with the study objectives and the conceptual framework.

Chapter 5 is a discussion of the qualitative research findings, in light of the existing literature.

Chapter 6 presents the findings from the record review of involuntary admissions in the selected hospitals, with specific focus on compliance with the prescribed legal procedures outlined in the Act.

Chapter 7 is a discussion of the findings from the record review, in light of the existing literature.

Chapter 8 is a discussion of the study's findings and recommendations. It provides an integrated discussion and conclusion that brings together all the elements of the thesis; it highlights the scholarly contributions of this thesis and recommends areas for future research.

CHAPTER 2 : LITERATURE REVIEW

2.1 Introduction

This chapter is a brief review of the theoretical and empirical literature on policy implementation, with particular focus on the concepts of: policy and public policy, policy processes, policy implementation theories and empirical studies on mental health policy implementation. The literature review is informed by Gornitzka, Kogan and Armalar's proposition that "studying implementation of a policy without looking at *how* those policies come about and divorcing our understanding of implementation from our understanding of the *processes* that generate policies may be a fruitless exercise" (Gornitzka, Kyvik, & Stensaker, 2007, p. 43).

2.2 The meaning of policy and public policy

Policy is a broad and complex phenomenon, which lacks a standard definition (de Coning, 2006, p. 4). The variations in the definition of policy illustrates the multidimensional nature of policies, the complexity of interrelationships involved in the policy process (Hjern & Hull, 1982; Patmisari, 2014), and the differences in ideological perspectives, and disciplinary backgrounds of policy scholars (de Coning, 2006; Easton, 1990; Lasswell & Kaplan, 1970).

Within the discourse on policy, some scholars have focused on the notion of *public policy*. In general, public policy refers to a set of laws, mandates, or regulations (Howlett, 2009) and has its origins in political decisions to implement programmes in order to achieve societal goals (Chochran & Malone, 2005). Public policy provides a mechanism by which governments address the needs of citizens or give effect to their Constitutions, where relevant (Lasswell & Kaplan, 1970), and is a powerful building block towards systems reforms and maintenance of any changes made (Davies, Yelton, Katza-Leavy, & Lourie, 1995).

There is substantive literature on the definitions and descriptions of policy and public policy. The first group of scholars that defined policy focused on the notion of policy as a

statement of intent that reflects societal goals and values, and the subjectivity of these values enunciated by the policies (Lipsky, 1980; O'Toole, 1997; Pressman & Wildavsky, 1973; Sabatier & Mazmanian, 1980). The subsequent group of scholars included in the definition, the role of actors, notably government, and behaviours of these actors. These definitions also included programmatic aspects of policy (Wandersman & et. al, 2008). In the preceding two decades, the definitions of policy have combined the earlier emphasis on values, ethics with programmatic aspects of action or inaction, policy outcomes and quality (Benoit, 2013; de Boer & Bressers, 2011; Meyers et al., 2012). These various definitions are summarised in Table 2.1.

Table 2.1: A summary of policy definitions

Definition of policy	Source
Declaration and implementation intent	Ranney (1969)
A projected programme of goals, values and practices	Lasswell and Kaplan (1970)
A course of action or inaction rather than specific decisions or actions	Heclo (1972)
A standing decision characterised by behavioural consistency and repetitiveness on the part of both those who make it and those who abide by it	Eulau and Prewitt (1973)
A mechanisms employed to realise societal goals and to allocate resources	Baker, Michaels, and Preston (1975)
A guide that delimits action	Starling (1985)
Policy is a distinction among various proposals, programmes, decisions and effects	Charles (1984)
"A series of patterns of related decisions to which many circumstances and personal, group and organizational influences have contributed"	Hogwood and Gunn (1984, pp. 23-24)
The authoritative allocation of values for the whole society	Easton (1990)
"Whatever governments choose to do or not to do"	Dye (1995, p. 4); (Dye, 2002)
The programmatic activities formulated in response to an authoritative decision	(Matland, 1995)
"Authoritative statements made by legitimate public institutions about the way in which they propose to deal with policy problems"	Fox and Meyer (1995, p. 107)
Purposive course of action or inaction undertaken by an actor or a set of sectors in dealing with a problem or matter of concern	Anderson (1997)
Authoritative decisions made in the legislative, executive or judicial branches of government intended to direct or influence the actions, behaviours or decisions of others"	Longest (1998)
A proposed course of action of government or guidelines to follow to reach goals or objectives, which is continuously affected by environmental changes	Roux (2002)

Definition of policy	Source
Policy is “a statement of intent, specifying the basic principles and values to be followed in attaining specific goals”. This definition emphasises ethics, principles and intention as key elements	de Coning (2006, p. 6)
An idea that we use in both analysis and the practice of the way we are governed	Colebatch (2009)
Policy involves behaviours and intentions, action and inaction as well as the outcomes that may or may not have been foreseen	Hill and Hupe (2009); Hupe (2016)
Public policy is purposive, goal-oriented action taken by government to deal with societal problems	Scott and Baehler (2010)
Public policy is a set of interrelated decisions taken by a political actor or group concerning the selection of goals and the means to achieving them in a specified situation	Jenkins, Mussa, et al. (2011)
Public policy can take the form of law, rule, statute, regulation or order	Howlett (2009)

There has also been increasing scholarly attention on the definition of *health policy*, as a sub-set of general policy. Gauld defined health policy as the ‘course of action proposed or taken by government to improve the provision of health services (Gauld, 2005). A more comprehensive definition of health policy is proposed by Buse, Mays, and Walt (2005, p. 8) which states that:

“Health policy embraces courses of action (or inaction) that affect the set of institutions, organizations, services, and funding arrangements of the health care system. It includes policy made in the public sector (by government) and in the private sector. It goes beyond health services, however, and includes actions or intended actions by public, private and voluntary organizations that have an impact on health” (Buse et al., 2005, p. 6).

Mental health policies, the focus of this study, define the vision for mental health of the population, and are designed to improve mental health outcomes. Such policies specify the framework for the prevention of mental illness, the promotion of mental health, management of mental disorders, and the quality, accessibility and organisation of mental health service delivery (WHO, 2005b). Flowing from the definition by Buse, Mays and Walt and emphasised by the WHO, mental health policies include “actions or intended actions by public, private and voluntary organizations that have an impact on

[mental] health”, such as community care activities (Buse et al., 2005, p. 8; WHO, 2005b). For the purpose of this thesis, mental health policy is defined as the official statement of [the South African] government conveying “a set of values, principles and objectives for improving mental health, reducing the burden of mental disorders in the South African population and ensuring the provision of quality, accessible mental health services” (WHO, 2005c, p. 2).

2.3 Policy Processes

Policy implementation, the focus of this study, is an integral part of policy processes. In practice, policy processes do not have clear-cut beginning and end features (Jann & Wegrich, 2007). Nonetheless, various authors have defined common stages or steps of: problem identification, policy formulation, adoption, implementation and evaluation (Anderson, 2011; Buse et al., 2005; Dubnick & Romzek, 1999; Howlett & Ramesh, 1998; Lasswell & Kaplan, 1970; Sabatier & Jenkins-Smith, 1999; Sutcliffe & Court, 2005). Some scholars have suggested that these policy stages should not be seen as “absolutes, but rather as a useful, simplified, interpretative lens to understand or explain complex policy processes (Benoit, 2013; Patmisari, 2014). These policy processes are shown in Figure 2.1.

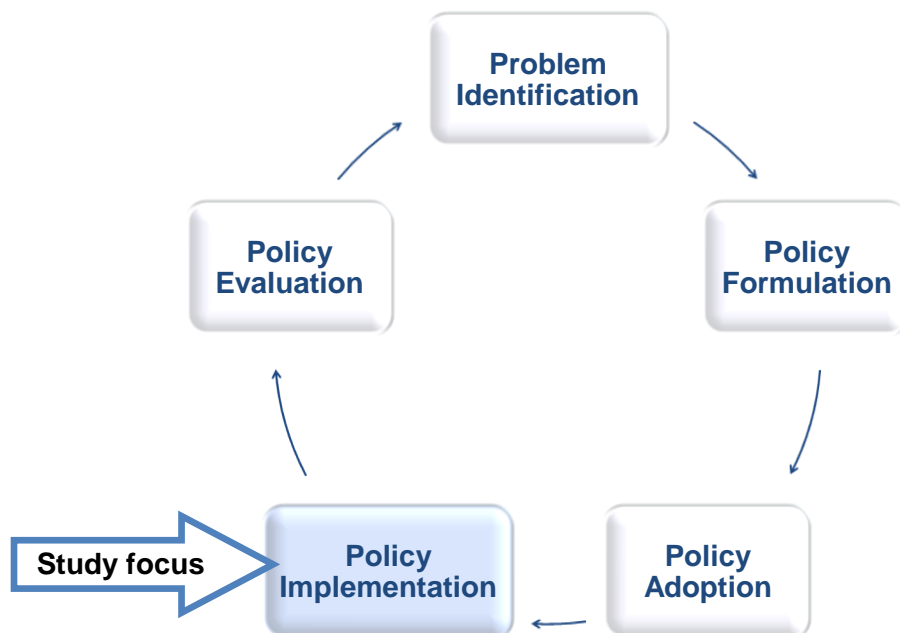


Figure 2.1: Generic policy processes

Source: Adapted from Buse, Mays, and Walt (2005)

Policy implementation is the third stage in the policy process (Buse et al., 2005; Howlett, 2009) and is discussed in detail in the following section, as it is the main focus of this study.

2.4 Defining policy implementation

Although policy implementation is concerned with turning policy objectives into practice (Fixsen et al., 2005), there is relative neglect at both practice and scholarly levels (Buse et al., 2005; Cerna, 2013, p. 388; Headley, 2017; Lawrence & O'Toole, 2017; Sandfort & Moulton, 2015, p. 388). Academic opinion on the definition of policy implementation is also divided (Cloete, 2000; Cloete., Wissink, & Coning, 2006; Lawrence & O'Toole, 2017), because of different contexts and the varying disciplinary backgrounds of policy scholars (Cerna, 2013; Hill & Hupe, 2009; Paudel, 2009).

Notwithstanding the voluminous literature on the definitions of policy implementation, there is consensus that implementation implies executing or carrying out certain activities to achieve the stated policy objectives (Colebatch., 2009; De Leon & De Leon, 2002; De Leon & Varda, 2009; Fixsen et al., 2005; Hill & Hupe, 2014; Hupe, 2016; Mazmanian & Sabatier, 1983, pp. 20-21; O'Toole, 1997; Paki. & Ebienfa, 2011; Pressman & Wildavsky, 1973, pp. xxi-vviii; Van Meter & Von Horn, 1975, p. 447).

For purposes of this study, mental health policy implementation is defined as the processes and actual execution of tasks that are aimed at achieving the stated policy intentions and objectives of the 2002 South African Mental Health Care Act (Colebatch, 2009).

This thesis draws on policy implementation theory as its underpinning theoretical framework, hence an overview of these theories are presented in the next section.

2.5 Policy implementation theories

Barker (2003, p. 434) has defined a theory as “a set of interrelated hypotheses, concepts, constructs, definitions and propositions that presents a systematic view of a

phenomenon based on facts and observations, with the purpose of explaining and predicting the phenomenon”.

There are several theories of policy implementation, the evolution and timeline of which are shown in Figure 2.2.

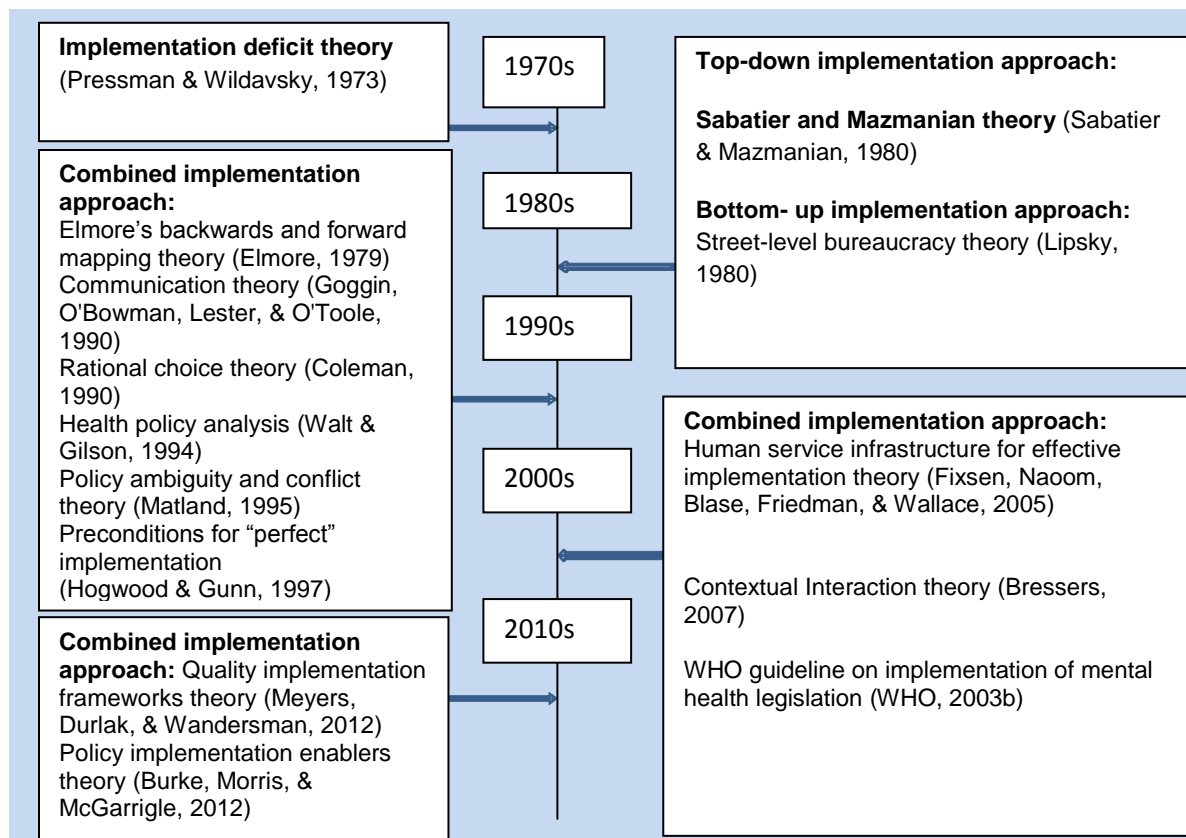


Figure 2.2: The timeline and evolution of policy implementation theories

Source: Adapted from Burke, Morris, and McGarrigle (2012)

The first generation of policy implementation theories emerged from 1970s to the 1980s, focusing on systematic efforts to understand factors that facilitate or constrain policy implementation (Sabatier & Mazmanian, 1980). The main assumption by scholars of the first generation of theories was that proclamation of the adoption of policies do not translate automatically into implementation (Goggin et al., 1990). Pressman and Wildasky systematically explored the gap between policy and its implementation, referred to as the “implementation deficit”. They argued that effective implementation

depends on good linkages between levels of government and organisations at the local level (Pressman & Wildavsky, 1973).

The second generation of policy implementation theories emerged from the 1980s to the 1990s, focusing on the relationship between policy and practice (Paudel, 2009). The debate during this era culminated in the development of two policy implementation approaches, namely the top-down and bottom-up approaches (Winter., 1999; 2003, p. 213), discussed briefly below.

2.5.1 Top-down policy implementation approach

The top-down approach represents a “classical single authority” view of policy implementation as a ‘scientific, rational, predictable and “machine like” process (Hjern & Hull, 1982; Saetren, 2014), rather than a political process (Grindle & Thomas, 1991). Implementation is based on a well-grounded theory of cause and effect, a perfect line of authority, communication, sufficient time, resources and perfect obedience by subordinates (De Leon & De Leon, 2002; De Leon & Varda, 2009; Saetren, 2014). In the government sector, this approach posits that policies are made at the top by the elected politicians and implementation operates in a ‘command-comply’ mode and a ‘principal-servant’ relationship between policy makers and bureaucrats, assuming that subordinates know how to implement policies (Hogwood & Gunn, 1984, pp. 23-24; Mazmanian & Sabatier, 1983; Van Meter & Von Horn, 1975) and that policy goals are well specified (Palumbo & Calista, 1990). The assumptions in this approach distinguish policy-making from policy implementation processes (Mazmanian & Sabatier, 1983; Van Meter & Von Horn, 1975) which are inseparable processes in practice (Hjern & Hull, 1982). The top-down approach examines a government’s decision and the extent to which the policy objectives have been implemented. This approach helps to determine if the policy was modified or adapted by implementers in response to the contextual factors and lessons learned. The top-down approach suggests that although policies may fail because of the policies themselves, they also fail because of the problems with how they are diffused down to the implementation level (De Leon & De Leon, 2002).

One of the most widely quoted top-down implementation theories in the literature is Sabatier and Mazmanian's analytical policy implementation theory. This theory examines policy implementation according to three characteristics, namely; tractability of the problem, ability to structure implementation and the non-statutory variables affecting implementation (Sabatier & Mazmanian, 1980). Tractability refers to how manageable the issue is to policy-makers based on four variables: availability of valid technology, diversity of target group behaviour, target group as a percentage of the population and the extent of behavioural change required. Sabatier and Mazmanian argue that the less tractable problems, i.e. those that are difficult to deal with, do not get the necessary attention from implementers and policy makers as they are not clearly comprehended and the solution to these problems is not easy to find. Tractability of the problem poses a significant impact on the implementation of policies and legislation (Sabatier & Mazmanian, 1980).

The second feature of Sabatier and Mazmanian's framework is the ability of the statute to structure implementation. This implies that policy must be based on a clear cause and effect relationship and the policy directives are unambiguous with adequate financial resources and clear decision-rules for implementation. The last feature in this theory is the non-statutory variables essential for effective policy implementation. These factors include socio-economic conditions, media attention to the problem, attitudes and resources, support, commitment and leadership of implementing officials (Hill & Hupe, 2014; Sabatier & Mazmanian, 1980). Lack of these non-statutory factors may result in poor implementation of the policy.

The top-down policy implementation approach has been criticised for disregard of the context of implementation and the assumption that the implementers are well-skilled in policy implementation (Lipsky, 1980; Nakamura & Smallwood, 1980; Winter., 1999), which is not always the case.

2.5.2 Bottom-up policy implementation approach

The bottom-up approach gained traction in the field of policy implementation when it became clear that implementation was far more complex and political and that policy formulation and implementation are inseparable. The bottom-up generation of scholars recorded the magnitude of policy implementation complexities and showed why it was faulty to assume that policy in place ensures its implementation (Hill & Hupe, 2014; Hjern & Hull, 1982; Hupe, 2016). Theorists argued that a more realistic understanding of implementation can be gained by looking at a policy from the view of the target population and service deliverers (Hill & Hupe, 2014; Hjern & Hull, 1982; Hupe, 2016; Lipsky, 1980; Matland, 1995). Birkland highlighted the importance of understanding the goals, motivation and capabilities of the lower level implementers and further argued that policy cannot always mandate the outcomes at the local level (Birkland, 2011).

Contextual factors were found to be influential and dominated the rules from the top of the implementing pyramid, making it difficult for policy designers to control the implementation process as was highlighted by the top-down proponents (Matland, 1995). Researchers therefore argue that a policy implementation theory that is context free is unrealistic (Hupe, 2016) because implementation arises from the interaction of policy, context and actors (Palumbo, Maynard-Moody, & Wright, 1984; Walt & Gilson, 1994), and a strategic balance between pressure and support for the implementers on the ground (Birkland, 2011).

Scholars generated various policy implementation theories under the bottom-up policy implementation approach. The most commonly cited under this approach is Michael Lipsky's "street-level bureaucracy" theory. He recognised the critical role of frontline implementers in policy implementation, referred to as 'street-level bureaucrats' and their influence on policy implementation (Lipsky, 1980, 2010). Focusing on public services, front line workers, according to Lipsky's theory are typically nurses, doctors, teachers or policemen, as they are in direct interaction with the public for government services (Erasmus, 2014). A key argument of this theory is that the actions and decisions of street-level bureaucrats represent the policy because citizens experience policy as the

decision that street-level bureaucrats take about their need for the service. Their actions and decisions also heavily influence the direction of policy implementation as they may decide to render or sanction the required service according to their discretion (Roh., 2012). Partly this discretion comes from the fact that they are professionals in their field of expertise and therefore are expected to exercise their own judgement when rendering the services. Also they tend to be somewhat removed from managerial oversight and authority, and performs complex tasks that cannot be measured with a simple formula (Erasmus, 2014). They face on-going dilemmas and duality between being responsive to the needs of the clients and the pressure of ensuring that the policies are properly implemented during service delivery (Lipsky, 1980, 2010). Other challenges they may encounter is when their perspectives and attitudes differ from others in the organisation, including their managers or when the resources for implementation are limited, which forces street-level bureaucrats to adopt reactionary strategies, such as rationing resources (Erasmus, 2014; Lipsky, 2010), going on strike, absenteeism or apathetic attitudes towards the policy and clients, which may also affect the way the policy is being implemented (Yvonne, 2000). The unlimited discretionary power of street-level bureaucrats based on freedom from organisational authority opens room for non-implementation of policies and negative outcomes for the clients, which is contrary to the policy objectives (Lipsky, 1980). The fact that the theory underplays the role of management and accountability in the public sector and the unlimited ability by street-level bureaucrats to interpret and implement policies assumed in this theory has been the main criticism levelled against Lipsky's theory (Linder & Peters, 1987). Ideally, implementers often require oversight from authority structures in the organisation and some guidance in the interpretation and implementation of policy objectives (Yvonne, 2000).

Table 2.2 presents a summary of the differences between top-down and bottom-up policy implementation approaches (Paudel, 2009).

Table 2.2: Comparing the top-down and bottom-up policy implementation approaches

Variables	Top-down approach	Bottom-up approach
Policy decision-maker	Policy makers	Street level bureaucrats
Starting point	Statutory language	Social problems
Structure	Formal	Both formal and informal
Process	Purely administrative	Networking including administrative
Authority	Centralisation	Decentralisation
Output/Outcomes	Prescriptive	Descriptive
Discretion	Top-level bureaucrats	Bottom-level bureaucrats
Scope of change	Incremental	Radical and large
Validity of technology	Certain	Uncertain
Goal conflict	Low	High
Institutional setting	Tightly coupled	Loosely coupled
Environment stability	Stable	Unstable and dynamic

Source: Adapted from Paudel (2009)

The third generation of policy implementation evolved from the 1990s onwards, during which the combined policy implementation approach emerged. The combined approach represents an analytical approach to policy implementation (McLaughlin, 1987, p. 173) and focuses on the interaction of policy makers from the top and the implementers who are the frontline of service delivery during the implementation process. This implementation approach is discussed briefly below.

2.5.3 The combined policy implementation approach

Scholars identified many commonalities between the bottom-up and top-down policy implementation approaches. For example, there is a general agreement between the two approaches that implementation is a complex, dynamic, multilevel and multi-actor process that is influenced by the policy context (Cloete. et al., 2006). However, one of the differences between the two approaches is about which actors are the most relevant and their importance in the implementation process.

The combined policy implementation approach synthesises the major features (Scaccia et al., 2015) and assumptions from both perspectives (Quah, 2016; Saetren, 2014). The theories, frameworks and guidelines that emerged from the combined policy implementation debate includes Elmore's backwards and forward mapping theory

(Elmore, 1979), communication theory (Goggin et al., 1990), rational choice theory (Coleman, 1990), ambiguity/conflict policy implementation processes theory (Matland, 1995), pre-conditions for “perfect” implementation theory (Hogwood & Gunn, 1997), human infrastructure for effective implementation in practice and programme theory (Fixsen et al., 2005), contextual interaction theory (Bressers, 2007), quality implementation frameworks for multiple practice domains theory (Meyers et al., 2012) and policy implementation enablers theory (Burke et al., 2012). These theories are discussed briefly below.

Elmore’s theory describes policy implementation in two ways, referred to as “forward mapping” and “backward mapping” (Elmore, 1979). Forward mapping is a hierarchical approach in the implementation process starting from policy makers at the top, with a clear statement of intent, proceeding downward through an organised system to define the rules and procedures for implementation. Forward mapping is based on the assumption that the ability to address complex problems depends on clear lines of control and authority from the top (Elmore, 1979). It posits that the closer one is to the source of policy, the greater one’s influence and authority. Backward mapping begins at the bottom from the implementers and operates under the notion that the closer one is to the source of the problem, the greater the ability to influence behaviour and solve complex problems. Of interest is that backward mapping seeks to disperse rather than centralise control, to strengthen the knowledge capacity of lower level implementers and to use funds strategically to influence discretionary choices of implementers. Elmore recommended four factors that facilitate effective policy implementation. These include the clear mandates and rules governing the behaviour of individuals; inducements for implementers in return of good performance; capacity building and transfer of authority among individuals (Elmore, 1979).

Goggin, Bowman, Lester, O’Toole, and Laurence’s (1990) communication theory describe policy implementation as a sub-system full of messages, messengers, channels and targets operating within a broader communications system (Goggin et al., 1990). The communication theory focuses on acceptance or rejection of messages

between layers of government. This system is affected by inducements and constraints from the top (federal level), from the state and local levels (Goggin et al., 1990). The interpretation and perception of messages depends on the contextual factors in which they are received, which further influence the implementer's decision to act (Goggin et al., 1990; Matland, 1995).

Walt and Gilson introduced a model for health policy analysis, which focused attention on four related variables critical to policy implementation. These are actors, contextual factors, content and process (Walt & Gilson, 1994). The contextual factors highlighted in this model include the situational, structural and cultural factors. In the context of actors, these include the involvement and power of key stakeholders and interest groups in the implementation process. Regarding processes, these involve stages, strategies and interaction with the actors during the implementation process. Lastly, this model argues that the content of the policy such as the objectives, the implementation plan and implementation strategies are critical to the implementation of policies. Effective policy implementation, according to this model, requires attention to all four variables. For instance, focus only on the policy content diverts attention from the context, processes and actors in the implementation process, which may result in failure to achieve the policy outcomes (Walt & Gilson, 1994).

Rational-choice theory is another policy implementation theory that falls within the combined policy implementation approach. Policy implementers, according to this theory, possess a fixed set of preferences and they act rationally in order to maximise the attainment of their preferences and choices. Where cooperation of the implementers is lacking, policy implementation becomes affected (Hall & Taylor, 1996). Two models in this theory were developed, namely, the game theory and the agency theory (Cerna, 2013). According to the game theoretical model, policy implementation depends on how rational implementers act in conflict situations introduced by the policy in order to achieve their individual preferred objectives (Firestone, 1989). Policy implementation is seen as a continuation of a political game, commencing from the adoption stage in pursuit of their own interest, which may distort policy implementation (Winter., 2003).

The agency theory, on the other hand, focuses on how the principals delegate implementation to state agents. The implication of this theory is the emphasis on monitoring and evaluation of the implementation process in order to detect challenges to implementation on time (Kiser, 1999).

Matland introduced the Ambiguity/Conflict policy implementation process model which shows how conflict and ambiguity affects decision making (Matland, 1995). Both rational and bureaucratic policy models assume that goals are agreed upon and conflict can be controlled through situational factors. It is however, known that it is difficult to find one best way to attain an agreed goal. However, a conflict will ensue when there is interdependence of actors, incompatibility of objectives and incongruent views on the policy goals (Matland, 1995). Placing policy where there is conflict, few resources and little support leads to implementation failure. Matland also argues that it is possible to manipulate conflict by providing remunerative incentives for the implementers. However, certain policies are inevitably controversial and it is not possible to adjust them to avoid conflict (Matland, 1995). Policy ambiguity arises from unclear goals, which leads to misunderstandings, uncertainty and ultimately, implementation failure (Matland, 1995). In some cases, the actors form coalitions which can impact on the implementation of policies (Matland, 1995).

Other proponents of the combined policy implementation approach are Hogwood and Gunn, who introduced a framework of ten pre-conditions necessary for “perfect” policy implementation. This framework differentiates non-implementation from unsuccessful implementation in that non-implementation is when policies are not put into effect because the implementers were not efficient or they could not overcome the obstacles to the implementation process. Unsuccessful implementation, on the other hand, is when the policy is fully implemented but fails to produce the intended objectives (Hogwood & Gunn, 1997).

The pre-conditions proposed in Hogwood and Gunn’s framework on the pre-conditions for “perfect” implementation are shown on Table 2.3.

Table 2.3: Hogwood and Gunn’s framework on the pre-conditions for “perfect” policy implementation

Pre-conditions	Description
1. External constraints	Consideration must be given to external factors that have an impact on the implementation process
2. Time and resources	Adequate time and sufficient resources are made available for the programme
3. Resource combination	Required combination of resources is about the availability of combined resources such as human resources, budgets and infrastructure to facilitate implementation. If one of the required resources is inadequate or not available, implementation is likely to be unsuccessful
4. Theory-based policy	The policy to be implemented is based on a valid theory of cause and effect. This requirement emphasises the importance of scientific evidence-based policy objectives that are acceptable to stakeholders in the field
5. Cause/effect relations	The relationship between cause and effect is direct and there are few, if any intervening links. It is critical, according to this theory, that a clear link between the policy objectives exists
6. Dependency relationships	This theory recommends an independent implementing agency or minimal dependency among implementers, where they exist
7. Agreements of objectives	There is agreement of, and among, stakeholders on the policy objectives and intention
8. Events sequencing	Sequencing of events implies that the agreed objectives and sequence of events and tasks to be performed by each stakeholder are clearly outlined and understood
9. Communication/coordination	Communication and coordination is important in the implementation process
10. Total compliance	Total compliance is about the need for monitoring of the implementation process and the ability of those in authority to secure compliance with the legislative and policy mandates during the implementation process

Source: Hogwood and Gunn (1997)

Fixsen et al. (2005) explain policy implementation from a human resource point of view in their theory on human infrastructure for effective implementation in practice and programmes (Fixsen et al., 2005). They argue that personnel involved in policy implementation must be well-orientated in the field and be supported by their managers in the organisation through coaching and performance management throughout all stages of the implementation process (Fixsen et al., 2005). Many writers have set out stages for policy implementation as exploration and adoption; programme installation; initial implementation, full implementation; expansion and sustainability (Ahuja et al.,

2016; Ashipala et al., 2016; Bhuyan et al., 2010; Burke et al., 2012; Cerna, 2013; Fixsen et al., 2005; Howlett, 2009; Nilsen, 2015). During the exploration stage, the need for change is identified and the likely innovative practices are explored. The capacity systems for implementation are built in selected sites in the installation stage followed by the initial implementation of the programme. The programme is expanded to other implementation sites in the last stage of policy implementation (Ashipala et al., 2016; Fixsen et al., 2005). Although the implementation process does not necessarily logically follow these stages in practice, they provide a systematic approach to capture the multiplicity of reality during implementation. Each stage relates to the specific context in which policy implementation occurs (Hill & Hupe, 2014; Hupe, 2016).

However, policy implementation is often subverted by contextual factors (Ahuja et al., 2016; Scaccia et al., 2015) such as lapses in planning, specification and control (Elmore, 1979); unclear and inconsistent objectives, unstructured implementation process, unskilful and uncommitted implementers, limited political support, unfavourable socio-economic conditions (Bakari & Frumence, 2013; Carey, Landvogt, & Barraket, 2015); the value of the policy (Moore, 2003; Suggett, 2010); the will of implementers (Matland, 1995); contending priorities and competing centres of authority (Hanlon et al., 2016; Hanlon et al., 2014; Matland, 1995); bad planning and inadequate resources (Jordans, Luitel, Pokhel, & Patel, 2016; Meyer & Cloete, 2006). Wandersman and et. al (2008) categorised these factors into individual, organisational and community factors that influence implementation in practice settings. The individual factors include the implementer's education, experience, attitude and motivation. The organisational factors include leadership, goals and vision of the organisation, commitment, size, skills for planning and implementation, support for the implementers and evaluation of the implementation process. Community level factors include capacity, competence, and readiness, collective efficacy of the community for implementation of the policy. Edwards., Jumper-Thurman, Plested, Oetting, and Swanson (2000) argued that preparing the system adequately for implementation of policies is one way of mitigating implementation barriers.

Hans Bresser, on the other hand, described policy implementation from a contextual perspective in his Contextual Interaction Theory (CIT) which highlights three key factors in the implementation process, namely; mutual relationships between policy making and implementation; the learning process inherent in implementation; and the adaptation of the implementation processes to the local situation and experience (Bressers & O'Toole, 2000; de Boer & Bressers, 2011). This theory posits that policy implementation is an interactive multi-actor process and the relationship among implementers determines the course and outcome of implementation (Bakari & Frumence, 2013). Furthermore, the characteristics of the actors, such as motivation, information, and power are crucial in that they drive the actions of actors and contribute to their ability to interpret the situation and decision making capacity and power in the implementation process (Bressers, 2009; de Boer, Bressers, & Kuks, 2011).

Meyers et al. (2012) introduced the notion of quality in their description of policy implementation. They introduced the quality implementation frameworks for multiple practice domains theory, also founded on the principle of the combined policy implementation approach (Meyers et al., 2012). In this theory, various implementation frameworks were synthesised to generate a conceptual overview of the critical phases necessary for a quality implementation process. These phases include assessment of the context, collaboration and negotiation with stakeholders, monitoring of the implementation process and self-reflection for potential bias by the implementers. This theory assumes that compliance with these phases enhances the likelihood of achieving the desired policy goals (Meyers et al., 2012).

A framework closer to the quality implementation theory discussed above is the Burke et al. (2012)'s framework on policy implementation enablers, which identified a set of factors that facilitate policy implementation.

Organised in no order of significance, these factors are presented in Table 2.4 and discussed below.

Table 2.4: Framework on enablers of policy implementation

Enablers of policy implementation
• An explicit implementation plan
• Enhanced staff capacity
• Efficient organisational support
• Organisational culture
• Adequate communication with staff
• Effective monitoring and evaluation mechanisms
• Comprehensive implementation teams
• Sufficient resources
• Strong leadership
• Adequate stakeholder involvement
• Learning from experience

Source: Burke et al. (2012)

The above framework by Burke et al. (2012) posits that a systematic and structured implementation plan with clearly defined objectives, specific tasks, agreed timelines, process inputs, outputs and outcomes including a proper risk management, are essential for effective implementation of policies. Another important factor highlighted in this framework is a well-structured mechanism for monitoring and evaluation of the implementation process, which builds a culture of learning from “early wins” and lessons derived from the implementation process in the organisation. Regarding personnel, the enabling factors for implementation include adequate capacity, involvement, team work and communication across all levels of the organisation. Other implementation enabling factors includes effective leadership and adequate resources (Burke et al., 2012).

Burke et al. (2012)’s implementation enablers were integrated with the WHO guideline on the implementation of the mental health legislation to develop a conceptual framework for this study, presented in Chapter 3 of this thesis.

The WHO guideline on the implementation of mental health legislation is not explicitly a theory but a guideline that has been developed specifically to guide the implementation

of mental health legislation. It has been used in the majority of mental health policy studies and it provides an approach consisting of essential steps for the implementation of the mental health legislation. These steps are briefly discussed below (WHO, 2005d).

Step 1: Appoint a body to oversee implementation. A body with a focused mandate is necessary to oversee and coordinate the implementation process. This may be an independent body, an agency or government itself, which put procedures in place to monitor and facilitate effective implementation through an explicit implementation plan.

Step 2: Train people directly affected by the legislation. The WHO recommends that service users, their families, and health workers including mental health workers, lawyers, magistrates, review board members police and prison members must be trained in order to be able to give effect to the intention of the mental health legislation. Other critical stakeholders in the implementation of mental health legislation identified by the WHO include government agencies, service providers, advocacy groups, academic institutions and professional organisations.

Step 3: Provide adequate resources for implementation. Resources such as human, financial resources and infrastructure are critical in the implementation of the mental health legislation. The WHO recommends that negotiation for the resources must commence simultaneously with the drafting and adoption processes of the legislation.

Step 4: Prepare and produce regulations, codes of practice and other guideline documents. Regulations, codes of practice and guidelines on the legislation must be developed in order to facilitate understanding, interpretation of the legislative provisions, thereby improving implementation and compliance by stakeholders.

Step 5: Monitor legislation. The WHO further emphasises that the implementation process of the legislation must be monitored in order to identify possible bottlenecks on time and institute mitigating strategies.

The combined policy implementation approach has also been criticised for a number of reasons (Quah, 2016; Saetren, 2014). It has been argued that rather than combining the top-down and bottom-up approaches, it should be determined when a particular approach can be applied. They argue that the top-down approach is more appropriate in the early planning stages and bottom-up perspectives are more appropriate in later evaluation phases. Choosing a top-down approach may lead to resistance and disregard by the service providers, while a bottom-up approach may lead to cooperation in pursuit of individual goals that run contrary to the policy objectives (Quah, 2016). The biggest mistake will be to try and separate the top-down view from a bottom-up approach (Cloete. et al., 2006). The debate between these two approaches is not yet concluded, but there is emerging consensus that it should not be about choosing a top-down or bottom-up approach as though the two are mutually exclusive alternatives. Both approaches provides useful insights into the policy implementation process, demonstrating significant strengths and weaknesses of each in different situations (Goggin et al., 1990; Sabatier, 1999).

This section described various policy implementation theories, frameworks and guideline that emerged from the debates on the top-down, bottom-up and combined implementation approaches. For ease of reference, a summary of the assumptions from these three implementation approaches is presented in Table 2.5.

Table 2.5: Overview of the top-down, bottom-up and combined policy implementation approaches

Implementation approaches	Brief description of the assumptions from the implementation approaches	Relevant implementation theories	Critique of the implementation approaches and related theories
Top-down policy implementation Approach	<ul style="list-style-type: none"> • This approach represents a single authority view of policy implementation based on the principle of cause and effect • Implementation is determined by clear policy objectives, perfect line of authority and perfect obedience by the implementers • Implementation operates in a command-comply mode in a principal-servant relationship 	<ul style="list-style-type: none"> • Sabatier and Mazmanian theory (Sabatier & Mazmanian, 1980) 	<ul style="list-style-type: none"> • The approach and theories disregards the context of the implementation process, the attitudes and motives of the implementers • Assumes that the front line workers are educated on the policy itself and skilled on the implementation process
Bottom-up policy implementation approach	<ul style="list-style-type: none"> • This approach assumes that the policy in place does not guarantee implementation • Contextual factors and front-line workers are critical to the implementation process • Implementation arises from the interaction of policy content, context, actors and processes 	<ul style="list-style-type: none"> • Street-level bureaucracy theory (Lipsky, 1980) 	<ul style="list-style-type: none"> • They underplay the importance of management and accountability in the public sector and overestimate the discretionary power of implementers in the implementation process, which may subject clients to limited or no services rendered
Combined policy implementation Approach	<ul style="list-style-type: none"> • This approach recognises the complex, dynamic multi-actor implementation processes • It synthesises major features and assumptions from the top-down and bottom-up implementation approaches 	<ul style="list-style-type: none"> • Elmore's backwards and forward mapping theory (Elmore, 1979) • Communication theory (Goggin et al., 1990) • Rational choice theory (Coleman, 1990) • Health policy analysis (Walt & Gilson, 1994) • Policy ambiguity and conflict theory (Matland, 1995) • Preconditions for "perfect" implementation (Hogwood & Gunn, 1997) • Human service infrastructure for effective implementation theory (Fixsen et al., 2005) • Contextual Interaction theory (Bressers, 2007) • WHO guideline on implementation of mental health legislation (WHO, 2003b) • Quality implementation frameworks theory (Meyers et al., 2012) • Policy implementation enablers theory (Burke et al., 2012) 	<ul style="list-style-type: none"> • Rather than combining the top-down and bottom-up approaches, it should be determined when a particular approach can be applied in a particular situation • Adopting a top-down approach may lead to resistance and disregard of the implementation process and policy objectives, while the bottom-up approach may lead to cooperation in pursuit of individual motives, parallel to the policy objectives.

2.6. Policy implementation studies

There is a significant body of literature on policy implementation studies that dates back to the 1930s (Briggs, 1948; Charlesworth, 1933; Laatsch, 1942; Little, 1948; Loughery, 1952; Manwell, 1947; Turton, 1955). The topics are wide-ranging, and include education, health, the environment, social and economic studies (Hill & Hupe, 2014; Saetren, 2014). This section provides a brief overview of studies in the health sector, with particular focus on mental health policy implementation.

Globally, policy implementation studies in the health sector have included an examination of the construction of bio-banks in Indiana (Meslin, 2010), implementation of the Affordable Care Act in the United States of America (May, 2014); integrated health care delivery in the United States of America (Roh., 2012); patient safety and the implementation of clinical interventions in Ottawa (Manojlovich, Squires, Davies, & Grahams, 2015). These scholars have used the top-down implementation approach, more specifically the Sabatier and Mazmanian's framework and communication theory. These studies found that clear procedures and briefing memos facilitated policy implementation (Meslin, 2010), while the administrative hurdles, website debacles, lack of support for the implementers (May, 2014), lack of a common understanding of policy objectives (Roh., 2012) and poor communication among health care providers (Manojlovich et al., 2015) were the main obstacles to implementation.

Notwithstanding the potential contribution of policy implementation studies to improved service delivery (De Leon & De Leon, 2002; De Leon & Varda, 2009; O'Toole, 1997; Winter., 1999, 2003), these studies are limited in LMICs (Gilson & Raphaely, 2008). However, there is increasing application of policy implementation theories to examine the gaps between policies and implementation. In South Africa, a study on the implementation of the Occupation Specific Dispensation Policy (Ditlopo et al., 2013) used the Hogwood and Gunn's policy implementation framework. Walt and Gilson's health policy analysis framework have been used in studies on the implementation of the rural allowance in hospitals (Ditlopo. et al., 2011), nursing education reforms (Blaauw, Ditlopo, & Rispel, 2014; Rispel, 2015a) and on nurses' participation in policy making (Blaauw, Penn-Kekana, & Rispel, 2014). These studies found that careful planning, coordination, proactive leadership, resources and skills facilitated

the implementation process (Ditlopo et al., 2013; Ditlopo. et al., 2011). However policy implementation was hindered by lack of understanding of policy goals, poor communication, resource constraints and suboptimal monitoring and evaluation mechanisms (Blaauw, Ditlopo, et al., 2014; Blaauw, Penn-Kekana, et al., 2014).

Worldwide there is a dearth of policy implementation studies in mental health but there is increasing scholarly focus on this area. Studies have used Sabatier and Mazmanian's analytical framework, Shiffman and Smith's analytical approach, Knowledge, Policy and Power Framework, Lipsky's theory of "street-level bureaucracy" and Elmore's backwards and forward mapping theory (Erasmus, 2014; Green, Xuan, Kwong, Anderson, & Leaf, 2016; Mackenzie, 2014; Monagan, 2015; Roh., 2012; Walker & Sanders, 2011). The Global Mental Health Innovation Network (MHIN) conducted a study in 2014 on engagement strategies to increase the focus on mental health as a policy issue (Mackenzie, 2014) using Sabatier and Mazmanian analytical perspectives (Mazmanian & Sabatier, 1983); Shiffman and Smith's analytical approach (Shiffman et al., 2015) and the Knowledge, Policy and Power Framework (Jones, Jones, Shaxson, & Walker, 2012). This MHIN study found that the characteristics of mental health, such as its heterogeneity, stigma and discrimination, under-diagnosis and lack of financial incentives compromised the prioritisation of mental health policies in the public agenda and their implementation, unlike other health issues (Mackenzie, 2014).

Other studies used Lipsky's theory of "street-level bureaucracy" in the review of mental health services, and found that health care providers tended to use their power and discretion due to the limited resources in the field (Cooper, Sornalingam, & O'Donnell, 2015; Erasmus, 2014; Monagan, 2015; Roh., 2012). Some researchers applied Elmore's backwards and forward mapping policy theory to explore the implementation of mental health interventions for children (Green et al., 2016; Medenhall & Frauenholtz, 2014; Walker & Sanders, 2011). These studies found that the implementation of these interventions was impacted by contextual factors. Also, Ashipala et al. (2016) conducted a study in Namibia on the implementation of the mental health policy using the bottom-up policy implementation theory, and found that the implementer's motivation and capacity were important factors for effective policy implementation. Other theories that have been applied in mental health policy studies include the Evidence-Based Practice (EBP) theory (Aarons, Wells, Zagursky, Fettes, &

Palinkas, 2009); competency theory (Chu & et al, 2012); the Consolidated Framework for Advancing Implementation Research (CFIR) (Wallerstein & Duran, 2010) and the organisational readiness for change theory (Weiner, 2009). These studies recommended that the implementers must have appropriate competencies for implementation of policies and that the system must also be ready for the implementation process (Chu & et al, 2012; Damschroder & et al, 2009; Wallerstein & Duran, 2010).

In South Africa, the researcher could not find a comprehensive study on mental health policies and legislation that used policy implementation theories. Studies used the WHO-AIMS Instrument, which is based on the WHO guidelines of policy development and implementation. These include the situational analysis on the development and implementation of mental health policies, which identified weaknesses in the development and implementation of mental health policies (Flisher et al., 2007; Lund, Kleintjies, et al., 2008). Other approaches used in mental health studies in South Africa include a desktop review conducted on the Act and human rights (Simpson & Chipps, 2012); use of a questionnaire developed from International Indicators and Norms for mental health services in the study of the impact of the Act in regional and district hospitals in Kwa Zulu-Natal (Ramlall et al., 2010); a retrospective record review of Form 22 of the Act on compliance of police with the Act (Jonsson, Moosa, & Jeenah, 2009); examination of the district mental health care plans using the Medical Research Council Framework for the development and evaluation of complex interventions (Hanlon et al., 2016); a situational analysis tool developed by the Research Programme Consortium for Improving Mental Health Care (PRIME) to study challenges and opportunities for implementing integrated mental health care (Hanlon et al., 2014). Other studies reviewed some legislative provisions in the Act (Mabena., 2010; Moosa & Jeenah, 2010; Petersen et al., 2016; Ramlall, 2012; Ramlall et al., 2010; Rural Health Advocacy Report, 2015; Sibanyoni & Maritz, 2016; Swanepoel, 2011; van Rensburg, 2012). The findings from these studies showed that the common barriers to mental health services included leadership weaknesses, insufficient financing, limited health information systems, fragmented health services, poor coordination and management, limited access to care and medication, human resource limitations such as staff shortage, limited skills and negative attitudes (Freeman, 2016; Lund, Kleintjies, et al., 2010; Mental Health and Poverty Project, 2008a; Petersen et al., 2016; WHO, 2015a).

In South Africa, the researcher could not find a comprehensive, national study on compliance of psychiatric hospitals with the procedures for involuntary psychiatric admission prescribed in the Act and on the functioning of MHRBs as governance structures in mental health. In addition, I could not find a South African study on mental health policy implementation that used the theoretical frameworks of Hogwood and Gunn on pre-conditions for “perfect” policy implementation and Lipsky’s on “street-level bureaucracy”, which informed the study. These are the gaps that the study will fill. The following section presents the theoretical framework of this study.

2.7 The theoretical framework of this study

The theory of policy implementation is the theoretical framework of this study, specifically Hogwood and Gunn’s framework on pre-conditions for “perfect” policy implementation (Hogwood & Gunn, 1997) and elements of Lipsky’s “street-level bureaucracy” theory (Lipsky, 1980, 2010). The theories allow me to answer the study objectives and to apply in a mental health policy context. These theories inform the study conceptual framework presented in the next Chapter 3 of this study. Although the pre-conditions for “perfect” implementation set out by Hogwood and Gunn and assumptions from Lipsky’s theory on “street-level bureaucracy” are not intended to be exhaustive and prescriptive (Hogwood & Gunn, 1997; Lipsky, 2010), these help in the understanding of the complexities involved in the implementation processes of the Act, stakeholder involvement, the functioning of MHRBs and compliance with the procedures for involuntary psychiatric admissions. In the case of implementation of the Act, the external constraints referred to by Hogwood and Gunn in Precondition 1 are likely to be the low priority given to mental health and limited resources, stigma and discrimination (WHO, 2005c). The street-level bureaucrats in terms of Lipsky’s theory in this study are psychiatrists, nurses, medical officers and other general health care workers (WHO, 2005c).

Table 2.6 shows the alignment of the study’s theoretical framework with the study objectives.

Table 2.6: Alignment of the study objectives and the theoretical framework

Study objectives	Hogwood and Gunn's pre-conditions	Lipsky's "street-level bureaucracy" theory assumptions
Explore the extent and nature of involvement of mental health policy actors or stakeholders in the implementation of the Act in designated psychiatric hospitals	<p><i>Pre-condition 1:</i> External constraints</p> <p><i>Pre-condition 4:</i> Policy based on valid theory and acceptable to stakeholders</p> <p><i>Pre-condition 6:</i> Minimal dependency relationship</p> <p><i>Pre-condition 7:</i> There is agreement on the policy objectives</p> <p><i>Pre-condition 9:</i> Communication and coordination</p>	<p>Actions and discretion and judgments of street-level bureaucrats in the implementation of the Act</p> <p>Structuring of the context of implementation by street-level bureaucrats</p>
Describe the processes and planning followed in the implementation of the Act in designated psychiatric hospitals	<p><i>Pre-condition 1:</i> External constraints</p> <p><i>Pre-condition 2:</i> Adequate time and resources</p> <p><i>Pre-condition 3:</i> Required combination of resources</p> <p><i>Pre-condition 8:</i> Sequencing of events</p>	The impact of resources on the decisions and discretion of street-level bureaucrats in the implementation of the Act
Examine whether Mental Health Review Boards in designated psychiatric hospitals execute their prescribed roles	<i>Pre-condition 5:</i> Clear cause and effect	Conflicts and dilemma's faced by street-level bureaucrats during the implementation of the Act. These includes inadequate resources
Examine compliance of psychiatric hospitals with prescribed procedures in the Act on involuntary admissions	<i>Pre-condition 10:</i> Total compliance	<p>Freedom from organisational authority of street-level bureaucrats</p> <p>Services for "captive clients" without choice</p>

The following chapter present the study research methodology.

CHAPTER 3 : RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research design and methods, the philosophical worldview of the study, ethics and approval processes, the study population and sampling, data collection and analysis, mechanisms to ensure rigour and trustworthiness in the study and finally, the potential bias in the study and how it was addressed.

3.2 Philosophical worldviews

3.2.1 *Generic overview of philosophical worldviews*

There is no consensus on the definition of the concept "worldview", (de Vos, Strydom, Fouche, & Delport, 2011; Lincoln & Guba, 2000; Neuman, 2011, p. 111; Polit & Beck, 2012, p. 95; Wood & Smith, 2016), with some scholars referring to worldviews as paradigms, epistemologies or ontologies (Babour, 2014; Baran & Jones, 2016; Hall, Griffiths, & McKenna, 2013; Lincoln & Guba, 2000; Polit & Beck, 2012, p. 95) whereas Neuman (2011, p. 111) sees them as broadly conceived research methodologies. Guba defines a paradigm as a basic set of beliefs that guide action (Guba, 1990), while Creswell defines paradigms as a general orientation about the world and the nature of research that the researcher holds (Creswell, 2014). There are four main philosophical worldviews in research, namely: post-positivism; advocacy or participatory; pragmatism; and social constructivism.

The *post-positivist worldview* challenges the notion of absolute truth of knowledge and assumes that absolute truth cannot be found and evidence in research is always imperfect and fallible (Phillips & Burbules, 2000). According to this worldview, evidence and rational considerations shape knowledge and it further assumes that reality is driven by natural causes and ensuing factors (Hall et al., 2013).

The *advocacy or participatory worldview* developed from the arguments that the post-positivist assumptions imposed structural laws that did not fit marginalised individuals in society. According to this worldview, research inquiry needs to be intertwined with the


political agenda so that issues of social justice such as empowerment, inequality, and oppression are addressed (Creswell, 2014; Petersen & Gencel, 2013).

The *pragmatist worldview* arises out of actions, situations or consequences rather than antecedent conditions (Baran & Jones, 2016; Creswell, 2014, p. 24). The pragmatist researchers use pluralistic approaches available to understand the problem instead of focusing on a single method. The assumptions in this worldview are that the world is not an absolute unity and the truth is what works at the time. Researchers in the pragmatist worldview are not committed to any one system of philosophy but draws liberally from both quantitative and qualitative assumptions (Creswell, 2014, p. 24; Morgan, 2007). The pragmatist tradition further assumes that there is freedom of choice of methods, techniques and procedures to meet the needs and purpose of research undertaken (Baran & Jones, 2016).

Lastly, the *social constructivist worldview*, which is also called the naturalistic paradigm, is an outgrowth of cultural transformation and it emphasises the value of deconstruction of old ideas and reconstruction of new ideas (Polit & Beck, 2012, p. 95; Wood & Smith, 2016). The constructivist's tradition emphasises the inherent complexity of human beings, and assumes that they have an inherent ability to create and shape their own experiences. This paradigm assumes that reality is not a fixed entity but rather a multiple construction of meaning as human beings engage with and interpret the world from their historical and social perspectives (Polit & Beck, 2012, p. 95). The truth according to this worldview is a composite of realities, and the assumptions are that the meaning is always social and that meaning arises out of interactions within the society (Crotty, 1998, p. 95; Polit & Beck, 2012). This paradigm assumes that the voices and interpretations of participants are crucial in understanding the study phenomenon through subjective interactions (Wood & Smith, 2016).

The basic assumptions in each philosophical worldview are summarised in Table 3.1.

Table 3.1: Basic assumptions of philosophical worldviews

Philosophical Worldviews	Basic assumptions	Source
Post-positivist worldview	<ul style="list-style-type: none"> There is no absolute truth of knowledge and evidence in research is always imperfect and fallible Knowledge is shaped by evidence and rational considerations Reality is driven by natural causes and ensuing factors 	Creswell (2014) Phillips and Burbules (2000) Creswell and Poth (2017) Creswell (2015) Hall et al. (2013)
Advocacy/participatory worldview	<ul style="list-style-type: none"> Structural laws do not fit marginalised individuals in society Research inquiry must be intertwined with politics and the political agenda to address social justice 	Polit and Beck (2012, p. 95). Petersen and Gencel (2013) Creswell and Plano Clark (2010)
Pragmatist worldview 	<ul style="list-style-type: none"> Meaning arises out of actions, situations, consequences rather than antecedent conditions The world is not an absolute unity and the truth is what works at the time There is freedom of choice of methods, techniques and procedures that best meet the needs and purpose of the research study Use pluralistic approaches to understand the problem. Draws liberally from both quantitative and qualitative assumptions in research 	Creswell (2015) Creswell (2014) Creswell and Poth (2017) Babour (2014) Baran and Jones (2016)
Social constructivism worldview	<ul style="list-style-type: none"> Reality is not a fixed entity but rather a multiple construction of meaning by human beings in their engagement and interpretation of the world Emphasises the value of deconstruction of old ideas and reconstruction of ideas and structures in new ways The voices and interpretations of participants are crucial in understanding the study phenomenon 	Creswell (2014, p. 24) Morgan (2007) Babour (2014) Wood and Smith (2016)

3.2.2 The philosophical worldview for this study

This study is positioned within the pragmatist worldview. This is because the research draws from multiple sources across different levels of the health system and uses different approaches to gain knowledge and understanding on the implementation of the Act in psychiatric hospitals. The choice of this worldview was also informed by the complexity of mental health legislation, which necessitates the use of both qualitative and descriptive research methods and the crossing of the boundaries of conventional research paradigms.

3.3 Research Design

This is primarily a qualitative research study complemented with a review of patient records that focused on compliance with the procedures for involuntary psychiatric admissions. The two research designs are discussed below.

3.3.1 Qualitative research

According to Burns and Grove. (2016, p. 19), qualitative research is a systematic subjective approach used to describe life experiences and situations to give them meaning. It focuses on people's experiences and the way people interpret and make sense of the world in which they live. Field and Morse (1996, p.8) further stated that qualitative researchers adopt a person-centred and holistic perspective to understand the lived experiences of individuals.

The rationale for using qualitative research in this study was to enhance and increase knowledge about the perceptions and values of stakeholders on the implementation of the Act in psychiatric hospitals. de Vos et al. (2011) have pointed out that qualitative research is concerned with understanding rather than explanation of the study phenomenon and is a subjective exploration of reality from the perspective of the participants. A qualitative research approach was therefore appropriate to gather information from the perceptions of stakeholders on the implementation of mental health legislation, thus contributing new knowledge on policy implementation in the field.

3.3.2 Record Review

Descriptive research is designed to provide a picture of a situation as it naturally happens (Burns & Grove., 2016, p. 201). It may be used to justify current practices and make judgments. In this study, a review of records was used to determine compliance with the procedures on involuntary psychiatric admissions as prescribed in the Act.

3.3.3 The rationale for complementing qualitative research with record review

Complementing qualitative research with a record review was based on Creswell's argument that the problems addressed by social and health science researchers are complex and the use of either qualitative or quantitative research is not adequate to address this complexity (Creswell, 2014). Policy implementation occurs within a system characterised by a complex interaction of factors and stakeholders, and therefore warrants a broader, comprehensive research approach. Policy implementation is a multi-actor, multi-disciplinary complex process that requires vigorous, but also flexible research methods (Dzurec & Abraham, 1993).

Tashakkori and Teddie concur that the use of complementary research approaches provides a better and creative understanding of the research problem from both angles (Tashakkori & Teddie, 2003). This view is supported by other scholars who argue that a complementary research approach is useful in clarifying and illustrating results from one method with the use of another and in expanding the richness of research findings and study detail (Creswell, 2014; Greene, Valerie, Caracelli, & Graham, 1989; Polit & Beck, 2012).

This study aimed to generate new knowledge on and understanding of the implementation of the Mental Health Care Act in psychiatric hospitals, which would have been limited by the use of one research method. A combination of qualitative and descriptive research is in line with the selected philosophical worldview, namely the pragmatist worldview that assumes that researchers should use a combination of methods, procedures and techniques that works best to answer the research question (Dzurec & Abraham, 1993).

3.4 Conceptual Framework

De Vos, Strydom, Fouche and Delport define a conceptual framework as a model that determines which questions are to be answered by the research and how empirical procedures are to be used as tools in finding answers to these questions (de Vos et al., 2011), whereas Badenhorst (2007) has noted that a conceptual framework is a point in the study where the researcher unpacks the key concepts used in the research and identifies relationships between the concepts. The conceptual framework also provides a basic outline for analysing data and drawing conclusions in the study. The conceptual framework used in this study was drawn from the WHO guidelines on implementation of mental health legislation (WHO, 2003b) as well as Burke; Morris and McGarrigle's theory on enablers of policy implementation (Burke et al., 2012). The rationale for using these two frameworks is summarised below.

The WHO guidelines provide specific steps to be followed in the implementation of mental health legislation and therefore are a useful framework for analysing mental health policy implementation. However the framework has been used mostly in the health sector for mental health policy development and implementation. There was a need for innovation in mental health policy implementation studies. Burke, Morris and McGarrigle's theory on enablers of policy implementation yield specific factors that facilitate effective policy implementation (Burke et al., 2012). My PhD study's conceptual framework integrated policy implementation enablers with the WHO framework on implementation of mental health legislation, which were discussed in detail in Chapter 2 of this study. The four components of the study conceptual framework are as follows:

1. Stakeholders' involvement in the implementation of the Act
2. Situational factors that influence the implementation of the Act
3. Organisational support and systems
4. Planning, procedures and processes for implementation of the Act

The study conceptual framework is illustrated in Figure 3.1 and discussed below.

CONCEPTUAL FRAMEWORK

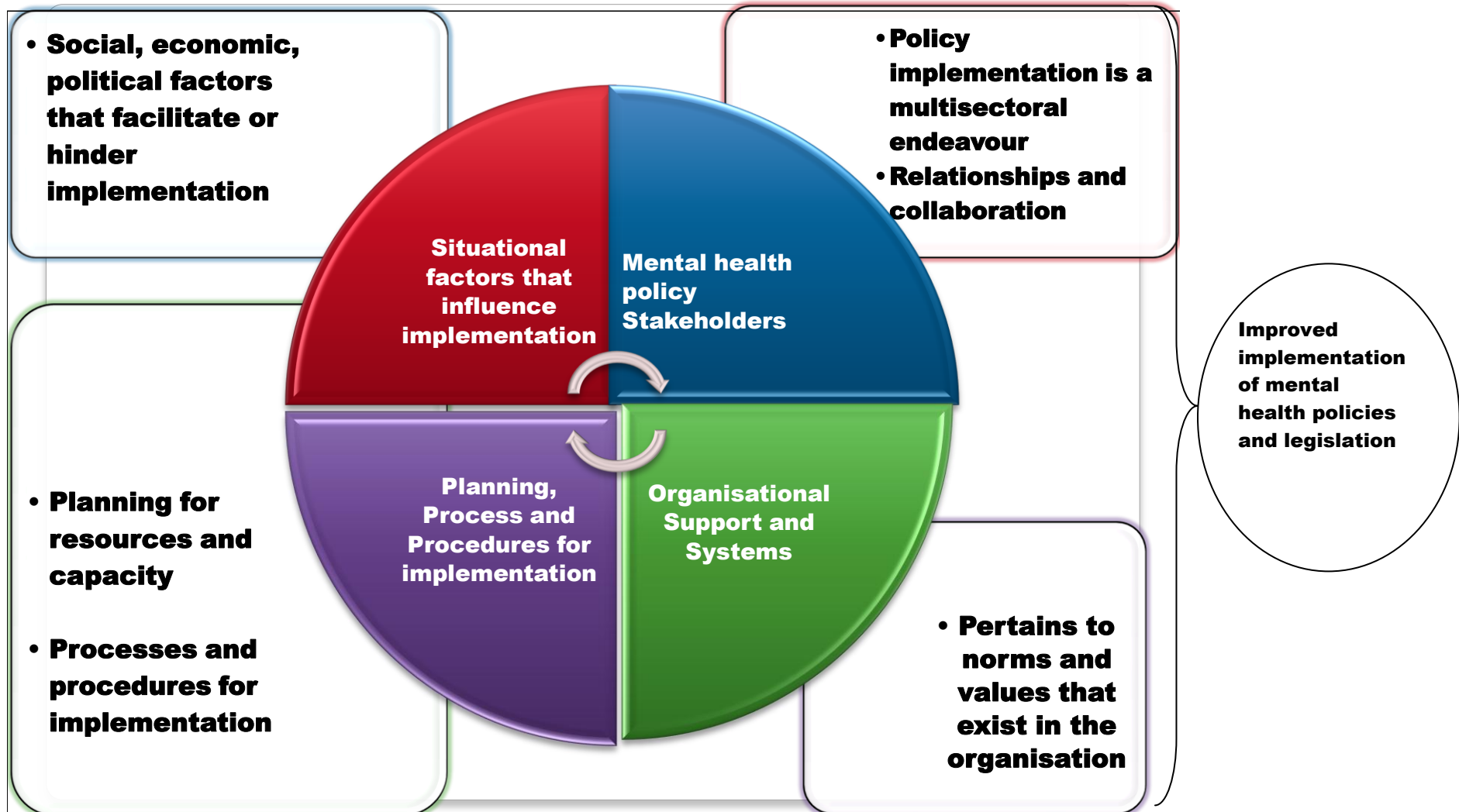


Figure 3.1: The study conceptual framework

Adapted from Burke., Morris, and McGarrigle. (2012); WHO (2003b)

3.4.1 The components of the study conceptual framework

Involvement of mental health policy stakeholders in the implementation of the Act:

The objective in this study was to determine the extent to which stakeholders in the mental health sector were involved in the implementation of the Act. Feedback on progress made and challenges encountered, monitoring systems and their experiences on the implementation of the Act were specific factors investigated in the study.

Situational factors influencing the implementation of the Act: This study aimed at identifying the factors that influence the implementation of the Act. These included specific contextual factors such as the social, economic and political factors impacting on the implementation of the Act.

Organisational support and systems: The study examined whether Mental Health Review Boards carried out their roles and functions as prescribed in the Act.

Planning, procedures and processes for implementation of the Act: The study analysed planning, procedures and processes that were followed in the development and implementation of the mental health legislation. Furthermore, the study examined whether there was compliance with procedures on involuntary admissions prescribed in the Mental Health Care Act.

The components of the conceptual framework were used to inform the research questions and were also interrelated with the specific objectives and methods used as demonstrated in Table 3.2 below.

Table 3.2: Integration of the conceptual framework, specific objectives and research

Components of the study conceptual framework	Specific objectives	Study questions	Method
Stakeholders in the implementation of the Act	<ul style="list-style-type: none"> Explore the extent and nature of involvement of mental health actors or stakeholders in the implementation of the Act in designated psychiatric hospitals 	<ul style="list-style-type: none"> Were the different stakeholders in mental health consulted in the development of the Act? To what extent were stakeholders in mental health involved in the implementation of the Act in psychiatric hospitals? Were there differences among stakeholders in the interpretation of the different provisions of the Act? 	<ul style="list-style-type: none"> Semi-structured interviews with the drafter of the Act, mental health coordinators in provinces and psychiatrists in selected psychiatric hospitals. (Qualitative research)
Planning, processes and procedures for implementation of the Act	<ul style="list-style-type: none"> Describe the processes and planning, followed in the implementation of the Act on designated psychiatric hospitals 	<ul style="list-style-type: none"> What were the narratives of different stakeholders on the planning and preparatory processes for implementation of the Act in psychiatric hospitals? 	<ul style="list-style-type: none"> Semi-structured interviews with the drafter of the Act, mental health coordinators in provinces and psychiatrists in selected psychiatric hospitals. (Qualitative research)
	<ul style="list-style-type: none"> Examine compliance of psychiatric hospitals with the prescribed procedures in the Act on involuntary admissions 	<ul style="list-style-type: none"> To what extent were psychiatric hospitals compliant with the procedures prescribed in the Act on involuntary admissions? 	<ul style="list-style-type: none"> Review of patient records on involuntary psychiatric admissions (Record review)
Situational factors that influence mental health policy implementation	<ul style="list-style-type: none"> Identify specific factors that influenced the implementation of the Act 	<ul style="list-style-type: none"> What were the factors that influenced the implementation of the Act? 	<ul style="list-style-type: none"> Semi-structured interviews with the drafter of the Act, mental health coordinators in provinces and psychiatrists in selected psychiatric hospitals (Qualitative research)
Organisational support and systems	<ul style="list-style-type: none"> Examine whether Mental Health Review Boards in designated psychiatric hospitals execute their roles and functions 	<ul style="list-style-type: none"> Did MHRBs execute their roles and functions prescribed in the Act? What were the factors that influenced their functioning? 	<ul style="list-style-type: none"> Semi-structured interviews with the Mental Health Review Boards in provinces (Qualitative research)

3.5 Ethics and Approval

This study was based on mutual trust and cooperation between the participants and the researcher (de Vos et al., 2011). Ethics approval for the study was obtained from the Human Research Ethics Committee (Medical) of the University of Witwatersrand, Johannesburg (Reference Number M1208565). The Ethics Clearance Certificate for the study is attached as Appendix 1. Approval was also obtained from the provincial health authorities. The steps to ensure and maintain the ethical approach to the study included the following:

- The Deputy Director-General of Primary Health Care granted approval for the study in all nine provinces (Appendix 2).
- The Deputy Director-General of Primary Health Care sent letters to all nine provinces advising them to grant permission for the study. Letters were sent to the provincial Heads of Department, where the request was considered by officials in research committees for approval (An example of the letters is attached as Appendix 3). Permission was granted to interview provincial mental health coordinators, Mental Health Review Boards and psychiatrists and also to review records of involuntary admissions in selected psychiatric hospitals.
- The Cluster Manager: Non-Communicable Diseases in the national Department of Health also provided a written support for the study. Permission was obtained from the chief executive officers of the selected psychiatric hospitals for the study to be undertaken.
- An information sheet was given to each participant with the contact details of the researcher, for any issues that may be raised and clarity required on the study (Appendix 4(a) for the drafter of the Act, Appendix 4(b) for provincial mental health coordinators, Appendix 4(c) for MHRBs and Appendix 4(d) for the psychiatrists).
- Potential participants were contacted to give consent to participate in the study and were informed that their participation was strictly voluntary and that they were free to withdraw from the study at any given time, should they wish to do so (Appendix 5(a) for the drafter of the Act, Appendix 5(b) for provincial mental health coordinators, Appendix 5(c) for MHRBs and Appendix 5(d) for the psychiatrists).

- Permission was also sought from key informants for an audio-tape recording of the interviews (Appendix 6(a) for the drafter of the Act, Appendix 6(b) for provincial mental health coordinators, Appendix 6(c) for MHRBs and Appendix 6(d) for the psychiatrists).
- The study and the consent forms were explained to each participant and the consent to participate was granted.
- Arrangements were made with each participant on the date, time and venue for the interviews.
- Arrangements were also made for retrieval of patient's files for review in each selected hospital.

The potential ethical challenges in this study are listed below, as well as steps taken to prevent them.

Breach of confidentiality: The researcher is a trained health professional who is registered with the Health Professions Council of South Africa, and subscribes to professional ethical codes. Only the researcher and the supervisor are in possession of the information. All information on questionnaires was kept confidential throughout the study. Only the consent forms had the names of participants, and they were kept in locked filing cabinets, separate from the interview schedules, which did not have the identifying information. Electronic information was referenced with specific codes and kept as locked computer files to prevent access by unauthorised persons, which is highly unlikely.

Full disclosure by the researcher: The second ethical issue in this study was possible limited freedom of expression by respondents based on the position of the researcher in the national Department of Health. In order to address this issue, the researcher explained to the participants that her position was not used to abuse power to gain access to psychiatric hospitals and participants. It was explained that the researcher was not acting in her capacity as an official from the Department of Health but as a PhD student from the University of Witwatersrand, Johannesburg. There was no anxiety

exhibited by participants in this regard, however, the researcher is an experienced clinical psychologist, who was in a position to allay the anxiety of participants, should the situation be warranted. Table 3.3 below shows a summary of ethical considerations particular to this study and how they were dealt with.

Table 3.3: Ethical considerations in this study

Ethical considerations	Mitigating factors
Confidentiality and privacy	<ul style="list-style-type: none"> Numbered codes for each selected psychiatric hospital and the participants were allocated. Hospital and participant's names were not recorded in the study report. Interviews with psychiatrists were conducted in as private and unobtrusive manner as possible so as not to interfere with the running of the ward. There was no direct interaction with patients in psychiatric hospitals
Informed consent	<ul style="list-style-type: none"> Information sheets outlining the objectives and the aims of the study were provided and thereafter, the participants gave informed consent to participate in the study. Consent to use digital voice recorders to record the interviews was obtained from all participants
Avoidance of harm	<ul style="list-style-type: none"> The researcher in this study carried an obligation to protect participants within all possible reasonable limits from any form of discomfort that may emerge from disclosing their perceptions on the implementation of the Act. The principle of beneficence was upheld at all times ensuring that no harm occurred to the study participants
Voluntary participation	<ul style="list-style-type: none"> Participation in the study was at all times voluntary and no one was forced or coerced to participate in the project. Participants were informed of their right to withdraw at any time from the research project with no effect. The researcher's position in the Department was not used to force participants to be involved in the study and also to gain access to the hospitals
Deception of participants	<ul style="list-style-type: none"> No information was withheld from participants or deliberately distorted in order to ensure participation when participants would otherwise possibly have refused to participate
Actions and competence of the researcher	<ul style="list-style-type: none"> Ethical approval was obtained from the University of Witwatersrand Human Research Ethics Committee before commencing with the research. Written approval of the study was obtained from the national and provincial departments of health and from the hospital managers in selected psychiatric hospitals. The researcher is a clinical psychologist with professional interviewing skills and putting people at ease during the interview. The researcher is aware of the potential bias and made sure that her experience in mental health and position in the department did not influence the research process and findings. The researcher ensured that the entire research project was conducted in an ethical manner

3.6 Study Setting

This was a national study, which was conducted across all levels of the health system, namely; the macro, meso and micro levels in all nine provinces. At the macro level, the study was located at the national Department of Health, meso level was at the provincial Departments of Health and the micro level was at the selected designated public psychiatric hospitals.

3.7 Sampling

3.7.1 Sampling Frame

The inclusion criterion for the study was a public hospital that had been designated as a psychiatric hospital in terms of the Mental Health Care Act during the study period (2005 and 2010). A list of designated psychiatric hospitals in all nine provinces was obtained from the national Department of Health. This list included both specialised psychiatric hospitals and designated psychiatric units attached to a general hospital. At the time of the study, 64 hospitals were designated as psychiatric hospitals, care and rehabilitation centres, with 13 in Limpopo, 13 in Gauteng, 11 in Kwa Zulu-Natal, 9 in Western Cape, 8 in Eastern Cape, 3 in Free State, 3 in Mpumalanga, 3 in North West and 1 in Northern Cape Provinces.

Of the 64 designated hospitals, 38 were designated psychiatric units attached to general hospitals and 26 were standalone specialised psychiatric hospitals.

3.7.2 Sampling approach

A variety of sampling approaches were used to answer the study questions.

Sampling approaches applied in qualitative component

A purposive sampling technique was used to select the drafter of the legislation at the national Department of Health and the provincial mental health coordinators. Purposive sampling ensured the selection of participants, who were “information rich” and able to answer the study questions. Creswell has pointed out that the idea behind qualitative research is to select participants purposefully and the sites or documents that will best

respond to the research problem (Creswell, 2014). Patton further adds that purposive sampling is used to select relevant participants but not a sample that can be empirically generalised to a population (Patton, 2002).

A psychiatrist was selected purposively at each of the selected hospitals (see below).

In the case of the Mental Health Review Boards, the approach took into account the number of Mental Health Review Boards in a province. In those provinces with more than one Mental Health Review Board, the Board of the selected psychiatric hospital was selected (see below). In those provinces with only one Board, that one was selected for the study.

Sampling approach used for the record review

Record review is the analysis of any written material that contains information about the phenomenon that is being researched (de Vos et al., 2011). Henning further adds that the true test of a competent researcher comes in the analysis of data, which is a process that requires analytical craftsmanship and the ability to capture and understand data (Henning, 2004, p. 101). A stratified sampling technique was used to select psychiatric hospitals for the study. The reasons for using a stratified sampling technique were to ensure that all provinces and psychiatric hospitals were included, and that both specialised psychiatric hospitals as well as general hospitals with dedicated psychiatric units were included.

All provinces were included in the study. The hospitals were divided into general hospitals (with a unit) or a standalone specialised psychiatric hospital. In each province, one hospital was selected randomly from each category of hospital. The exceptions were in Northern Cape and Mpumalanga Provinces. There was only one specialised psychiatric hospital in Northern Cape Province and no designated unit attached to a general hospital in Mpumalanga province. Hence, only one hospital was selected in these two provinces. The sampling approach is shown in Figure 3.2 below.

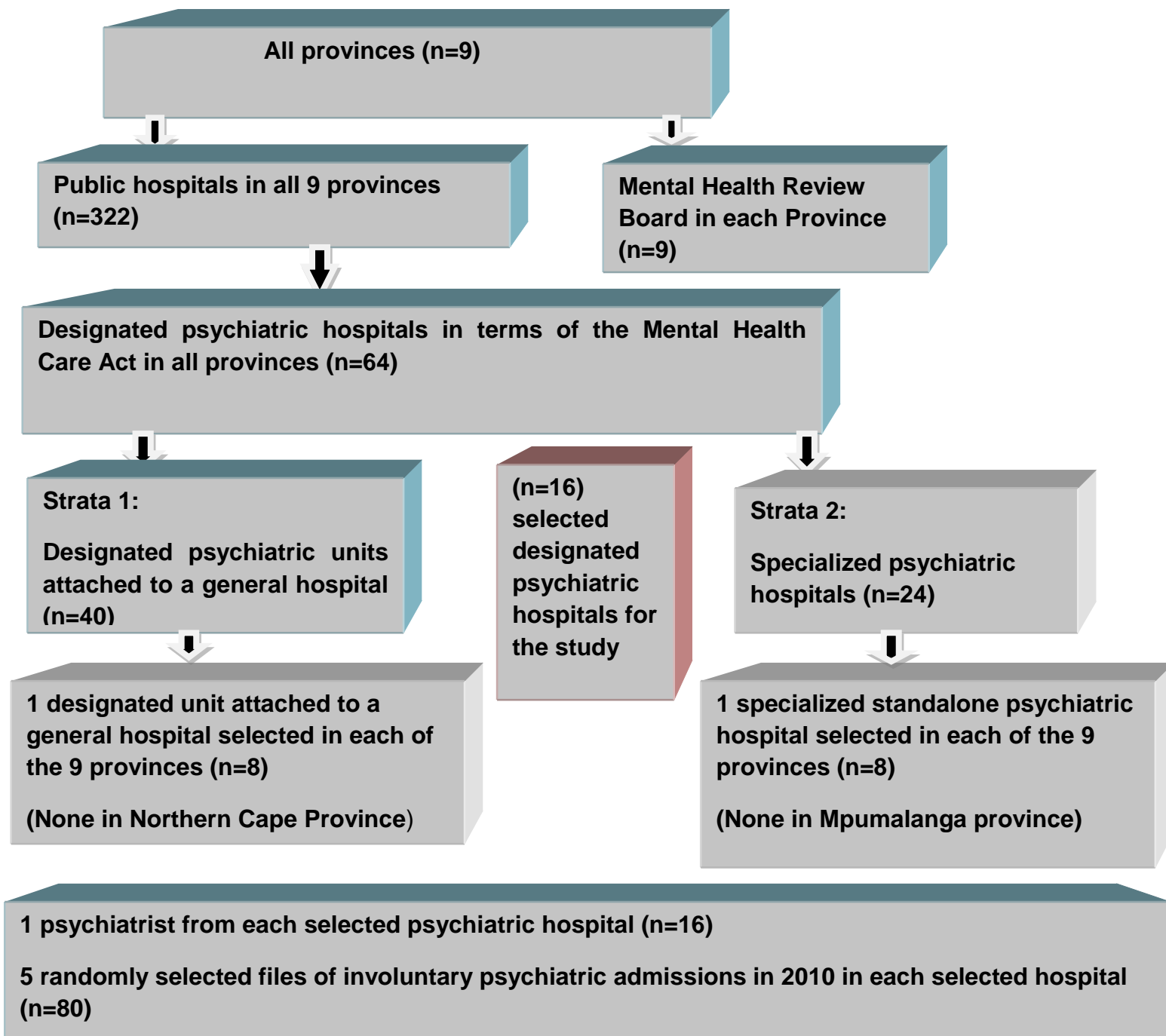


Figure 3.2: Hospital sampling approach used in the study

Hence 35 key informants and 16 designated psychiatric hospitals were selected from all provinces in this study.

The selected psychiatric hospitals in each province are shown in Table 3.4.

Table 3.4: Designated psychiatric hospitals selected for the study from each province

Province	Selected designated specialised psychiatric hospitals	Selected designated psychiatric units attached to general hospitals
Gauteng	Weskoppies psychiatric hospital	Psychiatric unit attached to Dr George Mukhari hospital
Eastern Cape	Komani psychiatric hospital	Psychiatric unit attached to Cecilia Makiwane hospital
Northern Cape	West End psychiatric hospital	
North West	Bophelong psychiatric hospital	Psychiatric unit attached to Job Shimankane Tabane hospital
Limpopo	Thabamooipo psychiatric hospital	Psychiatric unit attached to Mankweng hospital
Mpumalanga		Psychiatric unit attached to Witbank hospital
Kwa-Zulu Natal	Umzimkhulu psychiatric hospital	Psychiatric unit attached to Madadeni hospital
Western Cape	Valkenberg psychiatric hospital	Psychiatric unit attached to George hospital
Free State	Free State Psychiatric Complex	Psychiatric unit attached to Boitumelo Regional hospital
Sub-total	8	8

At each selected hospital, five patient records of involuntary admissions for the year 2010 were selected randomly, resulting in a total of 80 records from all hospitals. In each of the selected psychiatric hospitals, the hospital numbers of files of patients who were involuntarily admitted in psychiatric hospitals during 2010 were written down and put in a container. Five hospital numbers were randomly selected from the hat in each hospital in all provinces. This is how the 80 patient records were randomly selected for the study.

3.8 Study components

- Qualitative research (In-depth Interviews)
- Record Review (Review of patient records on procedures for involuntary psychiatric admissions)

Although these components are described separately, they complement one another in the study. Each component is described separately for the sake of clarity and is summarised in Table 3.5 below.

Table 3.5: Overview of the study components

Study Component	Objectives	Study population	Sample size (n)	Data collection method	Data collection and instruments
Qualitative Research					
<ul style="list-style-type: none"> Planning, Processes and Procedures followed in the implementation of the Act 	<ul style="list-style-type: none"> Describe the processes and planning followed in the implementation of the Act. 	<ul style="list-style-type: none"> Drafter of the Act. Mental health coordinators in provinces Psychiatrists 	<ul style="list-style-type: none"> A total of 35 consisting of: <ul style="list-style-type: none"> 1 drafter of the Act 9 provincial mental health coordinators 16 psychiatrists 	In-depth Interviews	Interview schedules with semi-structured questions
<ul style="list-style-type: none"> Stakeholders in the implementation of the Act 	<ul style="list-style-type: none"> Explore the extent and nature of involvement of mental health policy actors or stakeholders in the implementation of the Act in psychiatric hospitals 				
<ul style="list-style-type: none"> Organisational support and systems 	<ul style="list-style-type: none"> Examine whether Mental Health Review Boards in designated psychiatric hospitals execute their prescribed roles and functions 	<ul style="list-style-type: none"> Mental Health Review Boards 	<ul style="list-style-type: none"> 9 Mental Health Review Boards 		
<ul style="list-style-type: none"> Situational factors that influence implementation of the Act 	<ul style="list-style-type: none"> Identify factors that influenced the implementation of the Act 	<ul style="list-style-type: none"> Drafter of the Act Mental health coordinators in provinces Psychiatrists Mental Health Review Boards 			
Record Review					
<ul style="list-style-type: none"> Planning, Processes and Procedures followed in the implementation of the Act 	<ul style="list-style-type: none"> Examine compliance of psychiatric hospitals with the prescribed procedures on involuntary admissions 	<ul style="list-style-type: none"> Records of involuntary psychiatric admissions 	<ul style="list-style-type: none"> 80 patient files on involuntary psychiatric admissions in 16 selected hospitals 	<ul style="list-style-type: none"> Review of records 	<ul style="list-style-type: none"> A checklist on procedures prescribed in the Act

3.8.1 In-depth Interviews

Interviews are one of the most effective methods of collecting qualitative data (Polit & Beck, 2012). This is because interviews yield in-depth responses about people's experiences, perceptions, opinions feelings and knowledge (Creswell, 2014).

The objective of the in-depth interviews was to gather qualitative data on the implementation of the Act in psychiatric hospitals, specifically progress made, challenges and barriers to implementation encountered, and recommendations for improvement.

Interviews were conducted with the drafter of the Act at the national Department of Health, mental health coordinators and MHRBs in provinces, and psychiatrists in selected psychiatric hospitals.

Interviews of health professionals can be challenging due to time and workload constraints, lack of interest in the study topic and uncertainty about the value and applicability of the research. Therefore, there needs to be concerted efforts to contact the key informants to make special arrangements for the interview time and place (Broyles et al, 2011). In this study, an information sheet was submitted to key informants with consent forms signed before the interview to give approval for the interviews.

The specific issues regarding the interview process and objectives, recruitment and data collection in each of the in-depth interviews are discussed below.

(a) In-depth interview with the drafter of the Act

Objective

The aim of interviewing the drafter of the Act was three-fold: explore perceptions on the implementation of the Act; explore the process that was followed in the implementation of the Act; and obtain suggestions or recommendations on how to improve the implementation of the Act.

Recruitment

The researcher interviewed the drafter of the Act who was purposively selected because he possesses in-depth understanding and knowledge of the processes that were followed in the development and implementation of the Act in South Africa.

Development and piloting the interview schedules

A written interview schedule was developed in English for the drafter of the Act. Semi-structured questions ranged from general to specific issues to encourage the open and free expression of perceptions.

The questions in the interview schedule were aligned to the study conceptual framework and literature on mental health policy implementation. The interview schedule was piloted with two mental health deputy directors at the national Department of Health and nine provincial mental health coordinators, who were not involved in the study.

The inputs and comments obtained during the pilot were integrated and questions were refined into the revised tool for the study. The interview schedule for the drafter of the Act is attached as Appendix 7(a).

Data Collection

After the interview guides were developed and the consent to participate in the study was obtained from the drafter of the Act, the interview was conducted in English. The interview lasted for an hour, where the participant elaborated on processes that were followed and his perceptions on the development and implementation of the Act. Where necessary, probes and clarification of responses were used.

Although the interview was tape recorded, notes, impressions and analytic ideas were written immediately after the interviews, when the interview was still fresh in the mind of the researcher, to ensure reliability of data.

Table 3.6: Interview topics and themes for the drafter of the Act

Participant	Area	Questions and themes
Drafter of the Act and provincial mental health coordinators	General	<ul style="list-style-type: none">• Perceptions on the progress made in the field of mental health in South Africa since democracy• Challenges faced in the field of mental health
	Development and implementation of the Act	<ul style="list-style-type: none">• Opinion on the main intentions and overall goals of the Act• Factors that led to the promulgation of the Act• Individuals or organisations that played a key role in the development of the Act.• Role in the implementation of the Act• Perceptions on the overall implementation of Act during 2005-2010• The main successes of the Act.• Challenges or problems with the implementation of the Act• Unintended consequences of the Act• Desired impact of the Act

(b) In-depth Interviews with the mental health coordinators

Objectives

The objectives for interviewing mental health coordinators were to:

- Determine their perceptions on the implementation of the Act
- Explore the processes that were followed in the implementation of the Act, and
- Determine challenges encountered and obtain suggestions on how to improve the implementation of the Act.

Recruitment and sampling

The researcher interviewed nine mental health coordinators from all provinces who were purposively selected based on their experiences and involvement in the development and implementation of the Act in South Africa. The inclusion criterion was that they should have been provincial or district mental health coordinators during the study period. The mental health coordinators in each province are either appointed at provincial level or district level. Although the provincial and district mental health coordinators function in provincial and district levels respectively, they have the same responsibilities and roles, particularly in the implementation of the Act.

Development and piloting the interview schedules

A written interview schedule was designed in English for the mental health coordinators.

Semi-structured questions ranging from general to specific issues were asked so as to encourage them to share their perceptions on the implementation of the Act. The questions for mental health coordinators were drawn from the study's conceptual framework and literature on mental health policy implementation.

The interview schedule was piloted with two mental health deputy directors at the national Department of Health and nine current provincial mental health coordinators who were not involved in the study.

The inputs and comments obtained during the pilot were integrated and questions were refined into the revised tool for the study. The interview schedule for provincial mental health coordinators is attached as Appendix 7(b).

Availability of provincial mental health coordinators

Because the study aimed at provincial mental health coordinators who were employed in government during the period 2005-2010, it was not possible to get all nine coordinators available for interviews. Some provincial mental health coordinators in some provinces had retired and were thus not available for the study. In those instances, the provincial mental health coordinators were substituted with the district mental health coordinators during the study period, as they had similar responsibilities. Provinces where district mental health coordinators were interviewed were Northern Cape and Limpopo. Finally, seven provincial mental health coordinators and two district mental health coordinators were interviewed.

Data Collection

After the interview guides were developed and the consent to participate in the study obtained, semi-structured interviews were conducted with the mental health coordinators. Each participant was contacted to set the appointments for convenient place and time for the interview. All interviews were conducted in English. Probes and clarification of responses as interview techniques were used to get more detail on the study phenomenon.

The interview topics for mental health coordinators are summarised in the Table 3.7 below. Each interview lasted for about an hour, even though the duration varied depending on the responses provided by the respondents. Interviews were digitally recorded and the researcher also took notes during the interview and compiled a summary of the session.

Table 3.7: Interview topics for the mental health coordinators

Participant	Area	Questions and themes
Mental health coordinators	General	<ul style="list-style-type: none"> • Perceptions on the progress made in the field of mental health in South Africa since democracy. • Challenges faced in the field of mental health.
	Development and implementation of the Act	<ul style="list-style-type: none"> • Main intentions and overall goals of the Act. • Factors that led to the promulgation of the Act • Individuals or organisations that played a key role in the development of the Act. • Role in the implementation of the Act • Perceptions on the overall implementation of Act during 2005-2010 • The main successes of the Act. • Challenges or problems with the implementation of the Act • Unintended consequences of the Act • Desired impact of the Act

(c) In-depth Interviews with the Mental Health Review Boards (MHRBs)

Objectives

The objectives of the interviews with MHRBs were to:

- Determine their perceptions of MHRBs on the implementation of the Act in psychiatric hospitals.
- Determine how the Boards function in relation to their roles and functions prescribed in the Act.
- Identify challenges and obtain suggestions from the MHRBs on how to improve compliance to the functions prescribed in the Act.

Recruitment and sampling

The researcher interviewed one Mental Health Review Boards (MHRBs) in all nine provinces. Where there was more than one Board in a province, the chair of the MHRB

of the selected psychiatric hospital were interviewed. The inclusion criterion was that a chairperson or a member of the Mental Health Review Board must have been appointed during 2005-2010.

Development and piloting the interview schedules

A written interview schedule was designed in English for the MHRBs. Semi-structured questions ranging from general to specific issues were asked so as to encourage them to share perceptions and their own views on the functioning of the Boards.

The questions were aligned to the prescripts of the Act on the roles and functions of the Boards. The interview schedule for chairperson or member of the Mental Health Review Board is attached as Appendix 7(c).

Availability of MHRBs

The study had initially intended to interview chairpersons of the Board who were employed during the study period. Not all MHRBs who were appointed during 2005-2010 were available for interviews. Some had passed away while the term of office for others had expired and they were working elsewhere, where they could not be reached for interviews. The chairpersons of all Boards were interviewed except in Mpumalanga and Gauteng provinces, where the former chairpersons were not available and members were thus interviewed. In Eastern Cape, Northern Cape and Western Cape provinces, the chairpersons preferred to be interviewed together with other Board members, which turned into 'group' interviews. The group interviews provided a broader perspective from members on the implementation of the Act. Finally, six chairpersons of the Boards were interviewed and three group interviews were conducted.

Data Collection

After the interview guides were developed and the consent to participate in the study was obtained, semi-structured interviews were conducted. The interview topics for MHRBs are summarised in Table 3.8 below.

Arrangements on appointments of the convenient place and time for the interview were set with each MHRB.

All interviews were conducted in English. The interview techniques such as probes and clarification of responses were used to get more detail on the study phenomenon. Each interview lasted for about an hour, even though the duration varied depending on the responses provided by the participants and the number interviewed. The interviews were digitally recorded and the researcher also took notes during the interview and compiled a summary of the session.

Table 3.8: Interview topics for MHRBs

Participant	Area	Questions and themes
Chairperson or members of the Mental Health Review Boards	Background Information	<ul style="list-style-type: none">• Position on the Board• Role in the Board• Period of appointment• A written appointment agreement from the MEC• Location of the Board• Professional background of members• Number of meetings in a week• Availability of office space and equipment• Administrative support• Meeting with MEC
	Introduction	<ul style="list-style-type: none">• Availability and submission of annual strategic plans• Allocation of resources• Communication channel with the MEC• Training on the Act
	Implementation of the Act	<ul style="list-style-type: none">• Views on the implementation of the Act• Comment on the functioning of the Board• Successes of the Board• Challenges in the functioning of the Board• Conducting appeals• Investigation of complaints• Decisions on applications for involuntary care, treatment and rehabilitation• Periodic reports of mentally ill prisoners
	Recommendations	<ul style="list-style-type: none">• Insights on how to improve the functioning of the Boards

(d) In-depth Interviews with the psychiatrists in selected hospitals

Objective

The objectives for interviews with psychiatrists were to:

- Determine the perceptions of psychiatrists on the implementation of the Act in psychiatric hospitals
- Explore their role in the implementation of the Act in psychiatric hospitals
- Identify challenges and obtain suggestions on how to improve the implementation of the Act in psychiatric hospitals.

Recruitment and sampling

The researcher interviewed 16 psychiatrists from the selected psychiatric hospitals in all nine provinces, who were purposively selected based on their experiences and involvement in the development and implementation of the Act during the study period. The inclusion criterion for the psychiatrists was that they should have been employed in the public health sector during the study period of 2005-2010.

Development and piloting the interview schedules

A written interview schedule was designed in English for the psychiatrists.

Semi-structured questions ranging from general to specific issues were asked so as to share perceptions and views on the implementation of the Mental Health Act.

The questions were aligned to the conceptual framework. The interview schedule was piloted with health officials and psychiatrists who were not participating in the study. The inputs and comments obtained during the pilot were integrated and questions were refined into the revised tool for the study.

The interview schedule for the psychiatrists is attached as Appendix 7(d).

Availability of psychiatrists

Not all psychiatrists who were employed during the study period were available for the interviews. Also, not all psychiatric hospitals had psychiatrists in their employ during the

study period. In some hospitals, the psychiatrists had died, retired or relocated overseas. In hospitals where psychiatrists were not available, medical officers who had extensive experience in psychiatry during the study period and who met the study criteria were interviewed. In the selected hospitals in North West and Kwa Zulu-Natal provinces, there had not been a psychiatrist employed by the State during the study period, and psychiatric services were rendered by experienced medical officers, who were interviewed. Also in the hospital in Eastern Cape, the psychiatrist was on overseas vacation during the time of the interview and thus a medical officer who worked in psychiatry was interviewed. Thirteen psychiatrists and three medical officers were interviewed.

Data Collection

After the interview guides were developed and the consent to participate in the study obtained, semi-structured interviews were conducted with the psychiatrists and medical officers. The interview topics are summarised in Table 3.9.

Each psychiatrist or medical officer was contacted to set the appointments for the convenient place, date and time for the interview. All interviews were conducted in English. Interview techniques such as probes and clarification of responses were used to get more detail on the study phenomenon. Each interview lasted for about an hour, even though the duration varied depending on the responses provided by the participants. Interviews were digitally recorded and the researcher also took notes during the interview and compiled a summary.

Table 3.9: Interview topics for psychiatrists

Participant	Area	Questions and themes
Psychiatrists and medical officers	General	<ul style="list-style-type: none">• Perceptions on the intentions and goals of the Act• Orientation or training on the Act
	Development and implementation of the Act	<ul style="list-style-type: none">• Perceptions on the overall implementation of Act during 2005-2010.• Successes of the Act.• Challenges or problems with the implementation of the Act• The desired impact of the Act.
	Recommendations	<ul style="list-style-type: none">• The critical steps needed to speed up the implementation of the Act

Data management and analysis of qualitative data

All the recorded interviews were transcribed verbatim. The transcription of interviews and the data cleaning process took about two months. This consisted of an iterative process of checking and re-checking the transcribed interview scripts against the original recording and making corrections on the text.

Prior to analysis, the interviews were assigned specific identifiers and consolidated into one file with specific folders on interviews for each group, for ease of reference and analysis.

Qualitative data analysis was done according to the variables of the conceptual framework of the study, which is underpinned by the overarching policy implementation framework. The qualitative data were analysed using thematic content analysis and MAXQDA® 11. The characteristics of deviations and convergence of findings to the conceptual framework and the prescripts of the Act were identified and recommendations drawn for each study component. Although analysis is described here in a compartmentalised fashion, it was integrated in practice.

The specific steps followed in qualitative data analysis are listed in Table 3.10 below.

Table 3.10: Specific steps undertaken in qualitative data analysis

- Interviews were transcribed from the recorder
- Interviews were consolidated into one file for each group of participants for ease of retrieval and analysis
- Interviews assigned a unique code to ensure confidentiality of information.
- Categories and themes were developed for analysis using thematic content analysis and MAXQDA® 11

3.8.2 Record Review

Objectives

The purpose of record reviews in this study was two-fold: gather descriptive information on procedures that were followed in involuntary psychiatric admissions to determine compliance with the Act; and complement qualitative information from interviews on the implementation of the Act in psychiatric hospitals.

Sampling and procedures

The hospital numbers of files of patients who were involuntarily admitted in psychiatric hospitals in 2010 were written down and put in a container. Five hospital numbers were selected randomly in each hospital selected in the study. Hence, a total of 80 records were selected for the study.

All records for involuntary psychiatric admissions were obtained from the filing rooms in the selected psychiatric hospitals for review. An information sheet for hospital and ward managers in the selected psychiatric hospitals on review of patient's records on procedures for involuntary psychiatric admission was developed, and is attached as Appendix 8. The researcher went to the filing rooms to retrieve the files for review. There was different record keeping systems, which required the assistance of an administrator to retrieve the files for involuntary psychiatric admission during 2010. Some files had already deteriorated and were tearing apart, which posed a threat of losing valuable information from the files.

Development and piloting the checklist for record reviews

A check list for record reviews was developed in line with the procedures prescribed for involuntary psychiatric admissions in the Act. The checklist on procedures for involuntary psychiatric admissions is attached as Appendix 9.

Data collection

The researcher used the checklist to review the records. Review of each file took about 30-45 minutes, depending on the legibility of the documents and easy access of information in the file. The information and procedures reviewed from records of involuntary psychiatric admissions is detailed in Table 3.8. The findings were recorded on the checklist for each file.

Table 3.11: Procedures for involuntary psychiatric admissions reviewed in patient's records

Area	Information and procedures reviewed
Background Information	<ul style="list-style-type: none">Province, hospital, age, gender, race, marital status, employment status and diagnosis
Procedures	<ul style="list-style-type: none">Application made on the prescribed form and under oath
	<ul style="list-style-type: none">Suitability of the applicants
	<ul style="list-style-type: none">Reasons provided and steps taken to locate relatives where the application was made by a health care provider
	<ul style="list-style-type: none">Grounds for involuntary admission
	<ul style="list-style-type: none">Examination of the user by two health care providers
	<ul style="list-style-type: none">Approval of application for involuntary admission by the CEO
	<ul style="list-style-type: none">72-hour assessment done
	<ul style="list-style-type: none">Applicant informed of the outcome of application
	<ul style="list-style-type: none">Application submitted to and approved by the MHRB
	<ul style="list-style-type: none">Application authorised by the High Court
	<ul style="list-style-type: none">Change of involuntary legal status when having capacity for informed consent
	<ul style="list-style-type: none">Appeals against the involuntary admission
	<ul style="list-style-type: none">Application for an administrator to protect the user's property and annual income

3.9 Data management and analysis

The information was recorded on individual checklists, and thereafter captured on an Excel spreadsheet for ease of management and analysis. Each file was assigned specific codes according to the province and hospital. The data entry on the Excel spreadsheet was thoroughly checked by the researcher to confirm the alignment

between the data entered and the checklists. An experienced statistician checked the data codes for outliers, missing values and inconsistencies. The entire data cleaning process took two weeks.

Data from the review was analysed using STATA version 12. A preliminary descriptive analysis was done on all files, which included summary measures like the means or medians for continuous variables, age, gender, race and employment and marital status. Frequency tables were used for categorical data and cross tabulations used for the variables and procedures by province and designated psychiatric hospital.

3.10 Summary procedure for analysis

In summary, qualitative and descriptive information from each study component was analysed through different tools. Table 3.12 illustrates a summary of analysis.

Table 3.12: Analysis of the study components

Study components	Analysis
Processes followed in the implementation of the Act	<ul style="list-style-type: none"> Using the policy implementation theory, data was analysed according to the components of the study conceptual framework namely; <ul style="list-style-type: none"> ✓ Situational factors; ✓ Stakeholder involvement, ✓ Organisational support and ✓ Implementation processes and planning Thematic content analysis and MAXQDA[®] 11 were used to analyse the data.
Stakeholder in the implementation of the Act	
Functioning of Mental Health Review Boards	
Procedures for involuntary psychiatric admissions	<ul style="list-style-type: none"> STATA[®] 12

3.11 Integration of quantitative and descriptive data

Integration of data from different research methods can be integrated at several stages in the research process, namely data collection, analysis, interpretation or some combination of places (Creswell, 2014). In this study, data from the qualitative research

method and descriptive statistics were integrated in data collection, analysis of key findings and interpretation of results.

Table 3.13 shows the integration of both sets of data in this study.

Table 3.13: Analysis and integration of quantitative and descriptive data

Methods	Qualitative	Descriptive data
Data collection	<ul style="list-style-type: none"> Semi structured interviews were done 	<ul style="list-style-type: none"> Record reviews were conducted
Analysis	<ul style="list-style-type: none"> Data analysed through thematic content analysis and MAXQDA[®] 11 	<ul style="list-style-type: none"> Data analysed with Stata[®] 12
Key findings	<ul style="list-style-type: none"> Emerging themes and categories identified 	<ul style="list-style-type: none"> Descriptive statistics
Integration of data	<ul style="list-style-type: none"> Emerging themes and descriptive findings were compared against the study objectives for each of the study components. Results were compiled against the study aim, objectives and the conceptual framework 	
Interpretation of data	<ul style="list-style-type: none"> The findings were discussed taking into consideration the existing literature and the conceptual framework. 	

3.12 Ensuring rigour and trustworthiness of the study

Trustworthiness and Integrity of the study

The use of the concepts “rigour” and “validity” remains contentious in the debate about quality criteria in qualitative inquiry (Polit & Beck, 2012, p. 582). An alternative concept “trustworthiness”, which is parallel to the standard of reliability and validity in quantitative research (Lincoln & Guba, 2000) is the most preferred in qualitative research. Trustworthiness is described as the truth value of a piece of research (Holloway, 2005). A research study is deemed trustworthy when it reflects the reality and experience of the participants.

In this study, trustworthiness was ensured through the rapport that was established with the participants, openness and transparency by the researcher. The researcher’s

preconceived ideas about the implementation of the Act were laid aside, focusing on the participants' experiences and ideas.

Guba proposed criteria in qualitative research in pursuit of trustworthiness, namely, credibility, dependability, conformability, transferability and authenticity (Guba, 1990). This study conformed to Guba's criteria as follows:

Credibility: Credibility is similar to validity in quantitative research and it refers to the confidence in the data (Polit & Beck, 2012) and it exists when the findings reflect the perceptions of the study participants. In this study, different approaches were applied to enhance credibility. Firstly, appropriate, well recognised research methods i.e. qualitative and a patient record review were used within the recommended ethical standards to ensure credibility of the study. This also enhanced the research findings and yielded thick descriptions on the implementation of the Act in psychiatric hospitals. Secondly, random sampling was used to draw records of involuntary psychiatric admissions for review. Thirdly, triangulation of both research methods, different participants in the study across different levels of the health system was another way to ensure credibility of the study. Fourthly, iterative questioning was used during interviews to get a better understanding of the study phenomenon. Also, piloting the data collection instruments helped to ensure credibility of the study. Another strategy was description of the researcher's background, qualifications and experience, which is detailed in the section on handling researcher bias in this study.

Dependability: Dependability is similar to reliability in quantitative research and it refers to the stability of data over time and over conditions (Polit & Beck, 2012). The use of complementary research methods and provision of in-depth description of each method ensured the dependability of this study. It is thus possible to repeat this study with the same participants in a similar context. The data and the research report were overseen by the study supervisor in order to ensure dependability of the study.

Confirmability: Confirmability refers to the neutrality and objectivity of data (Polit & Beck, 2012). To ensure confirmability of this study data, firstly, triangulation was used to

reduce the researcher bias. Secondly, the researcher admitted the possibility of researcher bias in this study based on her experience and position in the mental health field but also put measures in place to eliminate this potential bias. Therefore the research findings are the results of the research and not the researcher's assumptions and preconceptions. Data in this study can be traced back to their sources, following the route taken from constructs, themes and their interpretation. Thirdly, the researcher recognised the possible shortcomings of subjective qualitative data and complemented it with objective descriptive data, thereby increasing the confirmability of the study. Lastly, the in-depth methodological descriptions allowed integrity of the research results to be scrutinised.

The interviews were recorded and checklists used to gather information and ensure comprehensive and vivid recording of information on the study phenomenon. To ensure that the findings reflect the participant's voice and not the researcher's bias, qualitative and descriptive data were triangulated. Also a wide range of participants and different data gathering methods were used to allow for comparisons of primary and secondary data on the implementation of the Act in psychiatric hospitals.

Transferability: Transferability means that the findings of the research can be applicable to similar situations or participants (Polit & Beck, 2012). The thick descriptions of the study phenomenon from this research, allows for possible transfer of conclusions among psychiatric hospitals in provinces. Again, the provision of a detailed background of the study to establish the context of the study and a detailed description of policy implementation allowed for comparisons among psychiatric hospitals in provinces, which ensured transferability of the study.

Authenticity: The authenticity in this study was ensured through triangulation of research methods, data sources, sampling techniques, data collection methods, theoretical frameworks and methods of data analysis.

Triangulation in this study

Triangulation is the use of more than one approach to the study of a research question in order to obtain more knowledge and a greater understanding of a research topic. It enhances the validity and confidence of the study by confirming results through use of multiple approaches, sources, theories and investigators (Berrang-Ford et al., 2012). There are four types of triangulation, namely; methodological, data, theoretical and investigator triangulation (Berrang-Ford et al., 2012). This study applied methodological triangulation by using both the qualitative and descriptive research methods and collecting data through in-depth interviews and record review. Also, the study used two data analysis methods; thematic content analysis and MAXQDA[®] 11 for qualitative data and statistical analysis using STATA[®] 12 for descriptive data. Data triangulation was conducted through the use of multiple data sources (i.e. the drafter of the Act, provincial mental health coordinators; MHRBs and Psychiatrists) that were located at the national, provincial health departments and the selected psychiatric hospitals in provinces. Another technique used in this study is theoretical triangulation, where the WHO's mental health policy implementation guideline (WHO, 2003b) was adapted with the Burke, Morris and McGarrigle's framework on policy enablers (Burke et al., 2012) to develop a conceptual framework as a theoretical lens to investigate and interpret the research findings. The application of triangulation in this study is shown in Table 3.14 below.

Table 3.14: The application of triangulation in the study

Methodological triangulation	Data triangulation	Theoretical triangulation
<ul style="list-style-type: none">• Qualitative research complemented with record review• Data collected through in-depth interviews and record review	<ul style="list-style-type: none">• Data collected from multiple sources across all levels of the health system in all provinces	<ul style="list-style-type: none">• The WHO mental health policy implementation guideline (WHO, 2003b) was adapted with Morris, Burke and McGarrigle's framework on policy implementation enablers (Burke et al., 2012) to develop the study conceptual framework

3.13 Strengths and limitations of the study

Although the Mental Health Care Act stipulates specific roles for other departments, such as Police, Social Development and Justice and Constitutional Development, this study was only limited to stakeholders in the health sector, specifically in mental health.

The high staff turnover of personnel in the health sector and the time period of the study are other limitations in this study. As shown in the thesis, the target participants in some provinces were not available anymore, and alternative measures were put in place to gather the required information. Although this did not have an impact on the target sample size, there was a slight variation in terms of the level of responsibilities related to the implementation of the Act in provinces, such as between district and provincial mental health coordinators.

This study did not focus on all the prescripts of the Act, but on the selected sections of the Act. The findings and recommendations from this study are based only on the study components and not the entire Act.

In terms of record review on involuntary psychiatric admissions, the sample size was 80 patient files. The small sample means that the multivariate statistical analysis could not be done.

In relation to the Mental Health Review Boards, the researcher only interviewed one chairperson of these Boards in each of the nine provinces. While it would have been ideal to interview all Board members to get their perspectives on implementation, this was not possible. Hence, these views of chairpersons may not be shared by all board members.

The study theoretical framework was largely based on Hogwood and Gunn's framework on "perfect" policy implementation as well as elements of Lipsky's "street level bureaucracy" theory. Hogwood and Gunn's framework has been criticised for being idealistic and impossible to achieve and therefore 'perfect' implementation is an unreal concept (Hill & Hupe, 2014). It has been argued that having explicit and ideal policy

goals without having means of attaining them is futile (Hill & Hupe, 2014). However, Gunn suggested the pre-conditions for 'perfect' implementation help us to think systematically about the reasons for policy implementation success and failures and how to improve the implementation process (Gunn, 1978). In this study, this framework supported by Lipsky's theory on 'street level bureaucracy', provided useful insights in explaining the study findings.

The cross-sectional nature of the study is another limitation. The researcher collected the data during 2013; hence the results represent the perspectives and views at a point in time. Some information may have changed by the time of writing this thesis.

Nonetheless, this study has numerous strengths. Firstly, this study was conducted in all provinces in the South Africa, which yielded thick descriptions on the implementation of the Act in designated psychiatric hospitals. This provided an opportunity for generalisability and transferability of findings from this study to other psychiatric hospitals in South Africa. The researcher interviewed stakeholders at all levels of the health system, thus gaining perspectives on implementation from different sources.

Secondly, this is the first study on the implementation of the Mental Health Care Act in psychiatric hospitals in a democratic South Africa, which will provide baseline information for future studies. The application of the WHO tool on implementation of the mental health legislation offered an international benchmark on processes followed in the implementation of the Act and also trustworthiness of the research findings. This study is credible based on the research methods applied, which were applied within the recommended ethical standards. The study was conducted using primary data from participant interviews, thus reflecting the perceptions and experiences of participants on the implementation of the Act. The record review provides an objective measure to determine compliance to prescribed procedures in the Act. The triangulation processes followed in the study, add richness to the data collected and also to the strength of this study.

3.14 Potential bias and how it was addressed in the study

Bias is defined as a tendency which prevents unprejudiced consideration of a question (Pannucci & Wilkins, 2010). It refers to the inaccuracies or errors that appear consistently throughout the research. Bias can occur at any phase of research; planning, data collection, analysis and publication phases of research.

Research, whether qualitative or quantitative, is a human activity which is subject to the same kinds of mistakes and failures as other human activities. Researchers are fallible as they make mistakes and get things wrong. Therefore, researchers need to identify potential bias in the research, guard against their own biases and determine ways to address them so that the truth is not distorted, thereby affecting the validity and reliability of the study findings. Pannucci and Wilkins argue that a thorough understanding of research bias, how it affects the study results and how it can be avoided is essential in evidence-based research (Pannucci & Wilkins, 2010).

In this study, potential biases were identified in the different phases of the research, namely; design and planning, data collection and analysis, during the funding and publication including bias relating to the role of the researcher. A variety of strategies were put in place to mitigate these biases. A detailed discussion of these potential biases and how they were addressed in the study follows.

3.14.1 Potential bias during research design and planning

Design bias: This bias occurs when the study design is flawed and inappropriate to the study objectives. In order to avoid this potential bias, the objectives and aims of the study were clearly articulated and linked to standardised data collection methods for each study component. Two well established research approaches, namely qualitative and record reviews were used in this study. This was found to be an appropriate design for this study, which was also helpful in eliminating the potential design bias. Using both methods in this study helped to gain information on the depth and breadth of the implementation of the Act in psychiatric hospitals. Data from both research approaches was complementary, which yielded rich explanations of the study phenomenon.

Sampling and selection bias: This kind of bias occurs from over inclusion or omission of one type of variable, which has a tendency of skewing data and thus distorting and confounding results. Also in sampling and selection bias, others may be excluded in making an argument on the study phenomenon, thus limiting the researcher's ability to make accurate conclusions on the findings. To address this bias in this study, a variety of sampling techniques which included purposive, stratified and random sampling methods were used to select participants across the different levels of the health sector. Thirty five participants were selected for the study, consisting of the drafter of the Act at the national Department of Health, provincial mental health coordinators, Mental Health Review Boards and psychiatrists. The aim of selecting different participants for the study was to ensure that participants were not selected to prove a specific research objective, but to gain a comprehensive picture on the implementation of the Act.

The context of the study was another way that was used to eliminate sampling and selection bias. This study was located in a national context in order to ensure that psychiatric hospitals in all provinces, including rural and urban provinces were selected. The national approach to this study helped to eliminate bias from the distinct characteristics of psychiatric hospitals in rural and urban provinces, which have significant impacts on policy implementation.

3.14.2 Potential bias during data collection

Interview bias: To avoid this bias, the researcher made sure not to ask leading questions during the interviews and that she did not express an opinion on the responses given. Follow-up questions were posed, asking for more detail and clarification on issues that needed elaboration. Another strategy that was used to avoid interview bias was to standardise the interviews so as to ask similar questions to all participants in the same group, for example, similar questions for all 16 psychiatrists, all nine mental health coordinators and all nine Mental Health Review Boards. The interview schedules were piloted by independent parties to check the language used which has a potential to steer responses in a particular direction. The researcher was aware that it is difficult for the drafter of the questions to identify interview bias, so

therefore someone who does not have a stake in the research had to look at the questions to identify biased phrases.

Measurement bias: This kind of bias occurs when inappropriate instruments are used to collect data in a study. I used the data collection instruments, namely, semi-structured interviews schedules and a checklist for record reviews which were appropriate in qualitative and descriptive studies respectively, to reduce the element of measurement bias in this study. To avoid insensitive bias, these tools were found to be sensitive enough to detect small variables which could impact on the results. Also, the expectation bias was avoided through use of the instruments that could not influence the results towards the researcher's outcome to support possible predictions on the study, which did not exist.

Another strategy that was used to eliminate measurement bias in this research was the use of the conceptual framework, which was adapted from the WHO framework on mental health policy implementation (WHO, 2003b) and Burke et al. (2012)'s framework on enablers of policy implementation. Also aligning questions to the prescripts of the Act and the existing literature on mental health policy implementation reduced the potential measurement bias. The interview schedules were developed against the study conceptual framework, literature reviewed and theoretical frameworks on policy implementation. Also, the checklist for record reviews was developed from the prescripts of the Act.

Use of labels bias: The study avoided labelling people, such as using phrases like "people who are mentally ill" but people who are diagnosed with mental illness. This classification can be offensive to people as it implies that the person only exists within that classification. This study acknowledged that a person is diagnosed with a condition rather than implying that the person is the condition.

Respondent bias: This happens when respondents try to appear consistent in their responses and also to impress the researcher. To address this potential bias, various

interview techniques were applied, such as asking follow-up questions, probing and clarification to get to the bottom of the response, especially where the response was vague or contradictory. The use of objective data collection tools also helped to avoid the respondent bias.

Sensitivity bias: In this instance, respondents may try to hide information they experienced to be sensitive during the interview. In this study, there was potential for this bias as participants had to reflect their perceptions on how the mental health system was performing in the implementation of the Act and what they perceived as challenges. Some felt as if they were indirectly reporting their supervisor's performance on the implementation of the Act. Two techniques were applied here to eliminate this potential bias. Firstly, I built trust and allayed their anxiety, during which I used skills as a registered experienced clinical psychologist by profession. Secondly, indirect questions were used so as not to make respondents feel confronted during the interviews, followed up by reflecting, paraphrasing, and probing techniques to get more information on the subject.

Recall bias: Recall bias was another potential issue in this study. It was based on the fact that subjective data sources were used to analyse the implementation of the Act during 2005 to 2010. It was possible that some information on what transpired during that period could not be recalled. In order to address this potential bias, subjective data was corroborated with objective data from record reviews.

3.14.3 Potential bias during data analysis

Reporting bias: I made use of a tape recorder to accurately record the interviews. The tape recorder was tested prior to the interview to ensure that it was in good working order. The recorder was placed strategically between the researcher and the respondent to record the conversations. All recorded interviews were transcribed. I carefully read each transcript and coded the information and developed themes from the interviews.

Furthermore, to eliminate possible bias in data analysis, data triangulation was done where information from one data set was compared with that from other data sources.

Another strategy to eliminate the potential data analysis bias was to cross reference data between sources of data. There were four major data sources in this study, namely, the drafter of the Act, provincial mental health coordinators, Mental Health Review Boards and psychiatrists, which were used for the purpose of cross referencing data sources.

Generally, the researcher kept an open mind in reporting and remained objective throughout the research process. The report was overseen by the supervisor, who is an experienced researcher.

Outlier bias: The outliers on the data collected were investigated and analysed to avoid false positive or negative results. The outliers were not overemphasised as they could bias the study results. The outliers resulted from errors in data capturing and coding. In order to eliminate this bias, three statisticians from the Department of Health, StatsSA and the University of Witwatersrand verified the coding and cleaning of data.

3.14.4 Potential bias from funding and publication

Funding and publication bias: This study report was not designed to be accepted by certain publishers and funders nor the Department of Health. It will be submitted to the Department of Health as funders of this study, and published in relevant journal articles, suitable for mental health policy implementation, even if the results may show an undesirable picture on the implementation of the Act in psychiatric hospitals.

3.14.5 Researcher bias

It was important to clarify my role and position so as not influence the study findings. Also as an interviewer in this study, I first had to examine my own potential biases, taking an honest inventory of the preconceived notions on the study phenomenon, which could potentially affect my judgement in this research.

The main source of the possible bias from the interviewer in this study was being an official employed in the national Department of Health and a researcher in this study. I was employed as a Deputy Director: Mental Health at the national Department of Health, largely overseeing implementation of the Act in provinces. I had eight years' experience in this field, by the time I conducted this study. I was therefore a very informed practitioner on the study phenomenon.

It is obvious that my thoughts and experience in mental health policy implementation had a greater chance of influencing the research process, especially in the selection of participants, data collection and data analysis processes. I also ran the danger of being biased towards many of the practices in psychiatric hospitals which were not compatible with the prescripts of the Act.

However, self-assessment is not sufficient to eliminate the possible researcher bias, because many biases exist subconsciously. While being conscious about the possible influence of my thoughts on the research, I also used objective methods and procedures in this study. I had to remind myself all the time that I was not in an official capacity from the department at work but a researcher and student at the University of Witwatersrand. I also kept in mind that participants shared perceptions from their own viewpoint on the implementation of the Act, which represented their subjective interpretation of the process. Furthermore, I used interview schedules and a checklist on Record Reviews which helped me in this case to overcome potential prejudice and expectations on the research phenomenon. Random sampling was another strategy used to eliminate researcher bias in selection of participants.

My position at the Department of Health carried another potential bias particularly on obtaining the participant's consent for the study and accessing the selected psychiatric hospitals. I was aware of this potential bias throughout the research process particularly during interviews, but my role was clarified before the interviews, and the information sheets with my contact details and the study objectives were handed to each participant

so that they did not feel sabotaged or betrayed. Furthermore, to address this potential bias, an informed consent was obtained from each participant, which clarified that they could refrain from participating should they wish to do so, with no implications. The ethical clearance from the University and approval letters from the department demonstrated the transparency of the researcher and the ethical considerations of the study, which further helped to allay the potential anxiety that could have emanated from the perceived dual role of the researcher in the study.

3.15 Conclusion

This chapter described the overall research methodology adopted in the study. The research design was qualitative research complemented with a record review of involuntary admissions, in order to gain to a broader and deeper meaning on the implementation of the Act in psychiatric hospitals. There was no inter-researcher bias as the researcher collected the information herself. The researcher was the main research instrument in this study and semi-structured interviews and review of records for involuntary psychiatric admissions were used to collect data.

A summary of this chapter is presented in Table 3.15 below.

Table 3.15: Summary of the research design of this study

Research worldview	Pragmatist worldview
Theoretical framework	<ul style="list-style-type: none">• Hogwood and Gunn’s framework on preconditions for “perfect” policy implementation (Hogwood & Gunn, 1997) is the overarching theoretical framework of this study as well as elements of Lipsky’s “Street-Level Bureaucracy” theory (Lipsky, 1980, 2010)
Research methodology	<ul style="list-style-type: none">• Qualitative and descriptive research (Record review)
Research methods	<ul style="list-style-type: none">• In-depth key informant interviews and Record review
Study setting	<ul style="list-style-type: none">• A national study (National, provincial health departments and selected psychiatric hospitals in all provinces in South Africa)
Sample	<ul style="list-style-type: none">• 35 key informants (Drafter of the Act, 9 provincial mental health coordinators; 9 MHRBs; 16 psychiatrists)• 80 records of patients who were involuntarily admitted in psychiatric hospitals (5 records from each of the 16 selected psychiatric hospitals)
Data analysis	<ul style="list-style-type: none">• Thematic content analysis and analysis and MAXQDA® 11 for qualitative data. Statistical analysis using STATA® 12 for descriptive data

The chapter further demonstrated how rigour and trustworthiness were ensured including mechanisms applied to address potential bias in the study.

Chapter 4 presents the findings from the qualitative research component of this study, on the implementation of the Act.

CHAPTER 4 : QUALITATIVE RESEARCH FINDINGS

4.1 Introduction

This chapter presents the results of the qualitative component of the study. It focuses on the contextual factors (political, social and health system) that have impacted on the implementation of the Mental Health Care Act.

4.2 Characteristics of the key informants

Thirty five key informants were interviewed in this study (Fig 4.1): the drafter of the Mental Health Care Act (n=1); the provincial mental health coordinators (n=9); members of the Mental Health Review Boards (n=9); and psychiatrists (n=16) from the selected psychiatric hospitals.



Figure 4.1: The study key informants

4.3 Implementation facilitators

The key study results emerging from the key informant interviews are presented in Table 4.1. Although these overlap, each is discussed separately below.

Table 4.1: Contextual factors that facilitated implementation of the Act

Context	Facilitators
Political	<ul style="list-style-type: none">• Democratic change in South Africa• The Constitution and Bill of Rights• Alignment of the mental health legislation with other country laws
Social	<ul style="list-style-type: none">• Advocacy for human rights• Stakeholder support for the spirit and intention of the Mental Health Care Act
Health System	<ul style="list-style-type: none">• The broader transformation of the health system• Improved access to mental health services• Enhanced governance and accountability in mental health• Community-based mental health services• Integration of mental health into general health services

4.3.1 Political contextual facilitators

The democratic change in South Africa was a key factor that created an enabling political environment for the implementation of the Act. The South African Constitution incorporating the Bill of Rights and the emerging need to align mental health legislation with other progressive laws created an opportunity for the development and implementation of mental health legislation. These enabling factors are described below and illustrated with excerpts from key informant interviews.

Democratic change in South Africa

South Africa underwent a transition from apartheid to a democratic government in 1994, introducing a new Constitution with the Bill of Rights. As a result, the 1973 Mental Health Act and the delivery of mental health services had to be aligned to the human rights outlined in the Constitution. This was perceived by key informants as having

created a favourable enabling political environment for the development and implementation of the Mental Health Care Act (the Act).

“I think in terms of South Africa’s democracy and strong Constitutional rights it gives to all citizens, our [Mental Health Care] Act had to change, it was ok in 1973, but not post 1994, it was urgent that it changed, it was really urgent” (Key Informant 22, Western Cape Province).

Another key informant said:

“Democracy facilitated a lot of real changes in the legislation itself and in the delivery of mental health services” (Key Informant 32, KwaZulu-Natal Province).

Key informants made an association between the democratic change and a shift towards human rights in the provision of mental health services and the transformation of the health system. The health system transformation resulted in a change in care delivered in big, inaccessible psychiatric hospitals to district hospitals which are closer to where people stay.

As far as mental health is concerned, democracy created an opportunity for transformation of legislation and changes in the services from a human rights perspective. Before the new Act, people were treated only in big psychiatric hospitals, [which were far away from where they stayed]. Now the district hospitals, [which are closer to communities], also render mental health services. These are good results [due to] from the transformation of mental health services” (Key Informant 2, Eastern Cape Province).

Key informants reported that the Constitution and Bill of Rights strengthened the need to review the old Act and work towards new human rights orientated mental health legislation in the country. The South African context was supported by global developments such as the WHO guidelines on mental health policies:

“In the previous Act, mental health care users did not have any rights. Our Constitution and Bill of Rights protect the rights of all citizens. So we had to revise the old Act in order to have a new mental health law that protects their rights” (Key Informant 2, Eastern Cape Province).

Another key informant commented:

“I think we moved a little more to human rights, not only due to changes in democracy in the South Africa but also due to global developments. This has had some impact in shifting the notion of institutional care. [Prior to the Act], the ideology of care was that patients with mental disorders had to be removed away from the community, and be admitted in psychiatric hospitals. The mental health legislation therefore had to be aligned to the Constitution and Bill of Rights of our country, it was critical to do so” (Key informant 5, national department of health).

Other key informants attributed the development and implementation of the Act to the recognition of mental health as an integral part of health and well-being. The old Act did not recognise mental health as part of the health programmes; as a result, the services were fragmented and vertical. There was a need in South Africa to have mental health legislation that incorporated all aspects of health. The integrated perception of mental health was anchored by the WHO in the definition of health as “a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2001d). One key informant said:

“Health had always been about the physical and social aspects, excluding mental health in South Africa. Mental health was in the past classified with criminality and not seen as an integral part of health. The World Health Organization includes mental well-being in the definition of health. South Africa had no option but to develop and implement mental health legislation incorporating all aspects of health in the definition” (Key Informant 10, Mpumalanga Province).

Alignment of the mental health legislation with other progressive laws

Key informants highlighted the need to align the old Act with post-apartheid progressive legislation in South Africa, while at the same time drawing on the global experience. They pointed to the inappropriateness of the 1973 Act.

“I think it [Mental Health Care Act] was out-dated and it was found to be irrelevant to the present government and other international mental health laws. So they had to align it. I must say that I am glad that they actually decided to repeal the whole of the old Mental Health Act of 1973 (Key informant 17, Free State Province).

A repeated theme that emerged from the key informant interviews was that the democratic South Africa had no choice but to align the mental health legislation to international human rights instruments.

“I think at that time, there was no choice, we had to have legislation that speaks about everyone’s rights. There was a need to align mental health laws in South Africa with all other international human rights instruments and mental health legislation from other countries”(Key informant 35, Gauteng Province).

Prior to the repeal of the 1973 Act, the certification process for psychiatric admissions had violated the rights of patients. Key informants described cases where people were detained under the previous law in psychiatric hospitals based on other motives notably political reasons, without following any formal procedure to confirm mental illness. This was contradictory to the practice in other countries. This therefore prompted the need for the new mental health legislation to stipulate procedures and conditions for detention in a psychiatric hospital.

“For me this is a very important step. Under the 1973 Act, a magistrate who knew nothing about health, not even mental health, who had never seen the patient, you could just go to him or her and say “this person is a danger to himself”. The

person would be certified [and placed] in whatever mental institution and that would be the end of that person". This practice constituted gross violation of the rights of people. It was based on these practices that the [health] department had to develop and implement new mental health legislation" (Key informant 10, Mpumalanga Province).

4.3.2 Social context facilitators

Two social contextual factors that contributed to the development and later to the implementation of the Act were advocacy for human rights and stakeholders' support for the spirit and intention of the Act.

Advocacy for human rights

Key informants indicated that the broader advocacy for human rights, particularly of psychiatric patients, facilitated the development and implementation of the Act. According to key informants, some of the areas of contestation included the lack of a formal system to report abuse during the previous apartheid era, where the Department of Health would only learn about the infringements from the media. The drafter of the legislation pointed this out as well:

"There were sections in the old Act where you were not allowed to report human rights abuses. We [The Department of Health] saw it to be unconstitutional, but also we had to protect users from things like taking their pictures. We heard mostly from newspapers about the abuse. There was lack of services, lack of care and physical abuse. We did take all of these into consideration and decided to change the mental health legislation" (Key informant 5, national department of health).

Another key informant shared her experience as a health provider of human rights violations of psychiatric patients, which had to be addressed through legislative changes.

“I was still a student at Westfort [hospital] when I witnessed somebody who when you follow the history, you realise that the person was never mentally ill, but just destitute. He was apprehended because he was trespassing somewhere on a farm. He couldn’t answer or explain himself because he didn’t understand the language. I believe anybody can be confused in that situation and start running in fear. He was then admitted in a psychiatric hospital and ended up being like one of them [psychiatric patients]. I will never forget this incident in my life. This kind of incidents prompted revision of the mental health legislation” (Key informant 10, Mpumalanga Province).

Key informants highlighted a range of human rights violations of psychiatric patients which culminated in advocacy by professionals and NGOs. These advocacy movements prompted government-initiated investigations into these violations. The Department [of Health] established a national Commission to investigate the human rights violations of patients in psychiatric hospitals. The findings of this Commission prompted a revision of the then mental health legislation in order to put systems in place to uphold the rights of mentally ill persons. Key informants reported as follows:

“The Minister of Health set up a Commission to investigate psychiatric institutions where we interviewed people, black and white. We found poor care, I don’t even think it met the criteria for poor care, so we called it ‘human warehousing’ like you take human beings and lock them into warehouse like stock of some sort. We found a lot of abuses and the majority of staff did not understand the notion of human rights in psychiatric institutions” (Key informant 5, national department of health).

The advocacy activities occurred in all provinces, and included psychiatrists, nurses and allied health professionals that highlighted the rights of psychiatric patients.

Advocacy movements outside government also added their voices for changes in the certification procedures, decentralisation of mental health services and community-

based mental health care, while professionals from academic institutions and interest groups advocated for improved allocation of resources for mental health.

Stakeholders' support for the spirit and intention of the Act

The focus of the new Act on human rights, together with wide-spread stakeholder support facilitated the implementation of the Act, specifically: changes in assessment, diagnosis and treatment of mentally ill persons; clarification of referral pathways; and appropriate psychiatric admissions procedures. Key informants indicated that the 72-hour assessment, a procedure to exclude and treat physical disorders that may give rise to psychiatric manifestations, was well-received.

“From my understanding, the intention is really to separate what we call true psychiatric disorders from those presenting with psychiatric symptoms with underlying [medical] pathology. Also to help us to improve our diagnosis and make a decision within 72-hours of admission in order to ensure that patients are not unnecessarily admitted in psychiatric hospitals. For me, that is very good of the Act (Key Informant 3, psychiatrist, Eastern Cape Province).

Other key informants said:

“I see the 72-hour assessment as a major improvement compared to the previous Act, because it is actually saying that if I am violent, aggressive or confused, I am not just going to be sent to a psychiatric hospital. I am going to be investigated a bit further and I might not need to go a psychiatric facility. I admire the Act for that” (Key Informant 32, KwaZulu-Natal Province).

Some key informants expressed their admiration of the intention of the Act as follows:

“This Act is very good. In the past even those that were drunk were also admitted to psychiatric hospitals. This is an important intention of the Act, to admit only those that require psychiatric care” (Key Informant 2, Eastern Cape Province).

Another key informant was very pleased that the Act emphasises the referral pathways from primary health care level to psychiatric hospitals, an aspect which did not exist under the previous mental health legislation.

“The other aspect of the Act which I really like is that it breaks down that kind of steel barrier which we used to have in the past. Now psychiatric patients are seen across all levels of the health care system, with gradual steps from primary health through to district and regional hospitals then to a psychiatric hospital. So it is not that frenzied way of just locking people away” (**Key Informant 22, Western Cape Province**).

Another key informant reflected on the importance of the procedures contained in the Act to protect those individuals with mental illness who cannot make decisions on their care. He commented as follows:

“But also most importantly, there are a proportion of our patients who suffer from mental illness to an extent that they are not able to make decisions for themselves [on psychiatric treatment and admissions]. Their capacity to make decisions is compromised [due to the nature of mental illness] so they need protection and assistance in decision-making. What I like about the new Act is that it clarifies procedures to be followed in instances like this, which was not there in the old Act” (**Key Informant 7, psychiatrist, Northern Cape Province**).

4.3.3 Health system context

Key informants highlighted the broader transformation of the health system following the democratic change in 1994 as an implementation facilitator.

The broader health system transformation

In consort with health system developments post-democracy, the mental health programme had to be transformed towards improved access, expansion in community-

based services, and enhanced governance and accountability. Because there was no provision of these developments in the old Act, this facilitated the development and implementation of the new Mental Health Care Act in order to align service delivery of mental health services with other health programmes. This was reported by a key informant as follows:

“The transformation in the health sector played a key role in the promulgation and implementation of the mental health care legislation” (Key informant 5, national Department of Health).

Improved access to mental health services

Key informants reported that the previous mental health law promoted institutional psychiatric care because all psychiatric patients were perceived to be aggressive and dangerous. Hence, the main focus of the previous legislation was to safeguard the public from the “danger” posed by psychiatric patients. This means that there was poor access to mental health services which impacted on compliance to treatment and relapse of patients. This prompted the need for new mental health legislation in the country that provided for improved access to mental health services for communities.

One key informant explained this as follows:

“It was critical for South Africa to make mental health accessible to everyone next to where people lived. Unlike in the past patients were treated in faraway facilities, which resulted in poor access to treatment and a high relapse rate” (Key Informant 20, psychiatrist, Limpopo Province).

One psychiatrist stated:

“I think the spirit of the Act is to try and improve accessibility of psychiatric services so as to address the high levels of non-compliance to treatment” (Key Informant 24, psychiatrist, Western Cape Province).

Another key informant said:

“According to the old Act of 1973, if you were mentally ill you would be locked at a distant hospital, as if you had committed a serious crime so that you could not come in contact with the public. Unfortunately, that system denied the general population basic mental health services. So we needed legislation to correct that situation” (**Key Informant 10, Mpumalanga Province**).

The need for community-based mental health services

Key informants perceived the need for community-based mental services as part of the broader transformation of the health system to have created a favourable platform for the development and implementation of the Act. This was based on the need to redress the past practices where psychiatric hospitals were always full, with minimal chances of being discharged back home once admitted at a psychiatric hospital. Community-based services supported the re-integration of people discharged from psychiatric hospitals into the community.

“In the past, psychiatric hospitals were always full. The majority of patients were kept in hospitals for many years, if not for their lifetime. It was like serving a jail sentence or life imprisonment. This created a burden for the State to provide hospital services to patients who could benefit more at the community. The health system had to be transformed towards community care and the law had to say so” (**Key Informant 12, medical officer, North West Province**).

A key informant explained the lack of community-based mental health services as a cause of a revolving door syndrome where patients were discharged and re-admitted within a short space of time due to relapses. This can be seen in the following excerpt:

“Those that were lucky to be discharged were lost in the system because of lack of a follow-up system at the community level. Patients would only be brought back to hospital when relapsed. So, there was a need to revise the past mental

health legislation to include community-based mental health care” (Key Informant 32, KwaZulu-Natal Province).

Another key informant said:

“Under the past law, it was a vicious cycle from being discharged today and being readmitted the following week, just like that. This is what is called a revolving door syndrome which resulted from the custodial care approach and lack of community care. This put a big strain on the hospitals particularly on availability of beds and medication. The new legislation had to be developed to enforce community care and alleviate the challenges” (Key Informant 1, medical officer, Eastern Cape Province).

The need for enhanced governance and accountability in mental health

The previous Act did not make provision for governance and accountability in mental health. Given the gross human rights violations reported in mental health, there was a need to put systems in place to ensure the protection of patients. This contributed to the need to revise the old legislation. Key informants indicated the need for enhanced governance and accountability in mental health service delivery, especially after democracy.

“There was a need for an independent body to oversee and monitor the human rights of patients, which was not a requirement in the past law. The mental health legislation had to be written in such a way that there was a structure such as the Mental Health Review Boards to ensure governance and accountability in mental health” (Key Informant 24, psychiatrist, Western Cape Province).

Another key informant said:

“Given the previous infringements on the rights of psychiatric patients, South Africa needed a formal structure to ensure that things were done correctly. There was no system in the past for psychiatric patients to report abuse or any

dissatisfaction about the service. To me this is the reason why we had to have a new Act that prescribed Mental Health Review Boards” (Key Informant 11, North West Province).

Although there were hospital boards before the new Act, their mandate was to oversee the general hospital management and not the human rights of psychiatric patients.

“Hospital boards existed in psychiatric hospitals just like in all other general hospitals in the past. However these Boards were looking only at the management of the hospitals. There was nobody to protect the rights of mental health care users. Health workers were free to do what they wanted to do because there was no system to hold them accountable for their actions. I think this is one factor that led to the development of our Act” (Key Informant 17, Free State Province).

Another key informant said:

“In fact looking at what was actually happening with the rights of psychiatric patients, I can say that we needed a structure like the ‘Ombudsman’ for our patients written in the Act. The old mental health law really had to change” (Key Informant 32, KwaZulu-Natal Province).

Integration of mental health into general health services

Mental health services in the past were segregated and fragmented, with services centralised in specialised psychiatric hospitals, resulting in a huge treatment gap of those who were in need. Key informants highlighted the importance of integration of mental health services as an effective way of closing the treatment gap and ensuring comprehensive health care. South Africa therefore had to develop and implement mental health legislation that provided for integrated comprehensive mental health services. The need to integrate mental health into general health services was seen by

key informants as having paved the way for the new mental health legislation. This can be seen in the following excerpts:

“I think the Act was really responding to the need for improved mental health care services in the country. The need was really about integration of mental health across various levels in the health system, at the community and into the legal system” (Key Informant 24, psychiatrist, Western Cape Province).

Another key informant further commented:

“Basically the Act was developed in response to the need to have integrated mental health services so that mental health was not rendered only in specialised [psychiatric] hospitals as it used to happen in the past” (Key Informant 3, psychiatrist, Eastern Cape Province).

4.4 Barriers to implementation of the Act

There were several barriers to implementation of the Act shown in Table 4.2 and discussed below.

Table 4.2: Barriers to Implementation of the Act

Context	Barriers
Political	<ul style="list-style-type: none"> • Relative low prioritisation of mental health
Social	<ul style="list-style-type: none"> • Stigma and discrimination • Limited knowledge and education • Suboptimal stakeholder consultation
Health System	<ul style="list-style-type: none"> • Weak leadership, governance, management and institutional capacity • Suboptimal planning and preparation of the health system • Unexpected promulgation of the Act • Lack of national mental health policy and implementation plan • Inappropriate organisation of mental health services • Suboptimal preparation of district hospitals

	<ul style="list-style-type: none"> • Resource constraints (financing, human resources and infrastructure).
	<ul style="list-style-type: none"> • Poorly functioning Mental Health Review Boards
	<ul style="list-style-type: none"> • Inadequate compliance monitoring mechanisms
	<ul style="list-style-type: none"> • Unintended negative consequences of the Act

4.4.1 Political contextual barriers

Key informants were of the opinion that the relative low priority of mental health was a barrier to the implementation of the Act. They pointed out that this was reflected in the appointment or designation of junior officials in the majority of provinces responsible for the implementation of the Act. These officials did not have the necessary authority to implement the changes necessitated by the new Act. This view was expressed as follows:

“I think part of the problem also has been that mental health hasn’t been given high enough status in provinces. Our mental health coordinators, who really should be driving the implementation in provinces, occupy very low positions and thus have limited decision making powers. Yes it differs in provinces, for example, in Gauteng the mental health programme is coordinated at a Director level while in other provinces it is led by Assistant Directors” (Key Informant 5, national Department of Health).

Other key informants pointed out that the low priority status accorded to mental health was also reflected in resource allocation, exacerbated by the fact that mental illness is not life threatening. Key informants noted that mental illness contributes significantly to high morbidity and mortality due to its relationship with chronic and communicable diseases. This is illustrated in the excerpt below.

“They are prioritising disciplines where the patient is dying. Mental health is last, so if the budget is cut, they cut from mental health because they think that no one will die from mental illness” (Key Informant 18, psychiatrist, Free State Province).

One key informant referred to the co-occurrence of mental illness with other medical conditions such as HIV and AIDS, but still it is not accorded sufficient priority. She said:

“Psychiatry is not well recognised, people are not taking it seriously. We need recognition of psychiatry as an essential service. There is a high incidence of people suffering from HIV and AIDS. We get a lot of HIV diagnosis coexisting with psychiatric problems. They are missing the point” (**Key Informant 20, psychiatrist, Limpopo Province**).

On an annual basis, provinces and districts develop plans that should inform resource allocation for priority areas in the health sector. Despite the high burden of mental illness in society, key informants reported that mental health was still not prioritised in the provincial annual performance and strategic plans. This impacted on the allocation of resources to mental health in provinces, compared to other programmes (e.g. maternal and child health) that received higher priority. A key informant said:

“Mental health had not been included in the annual provincial and strategic plans. So no budget had been specifically allocated for the programme. In the planning sessions, it is like a radio talk show, you just talk to the issues and nothing happens. At the end of the day, when everybody had achieved their objectives, the remainders were given to mental health” (**Key informant 8, Northern Cape Province**).

Key informants also reported the low priority of mental health also on staff appointments and hospital infrastructure revitalisation projects, where the mental health programmes comes last, when everything else is done for other health programmes.

4.4.2 Social Context

Key informants highlighted stigma and discrimination, limited knowledge and education, and suboptimal stakeholder consultation as some of the social barriers that influenced implementation.

Stigma and discrimination

Despite the human rights-oriented mental health legislation, key informants reported that stigma and discrimination associated with mental illness hindered progress in the implementation of the Act.

“I think the stigma towards and discrimination of mental illness is still a major problem. Even the mental health programme itself is stigmatised and often discriminated. You find people talking about other programmes such as maternal health and so forth and not mental health. So I think that the stigma and discrimination of the mental health programme really was a major barrier to the implementation of the Act” (Key informant 15, psychiatrist, Limpopo Province).

One key informant reported the stigma and discrimination against mental health is being perpetuated by health care providers themselves, as some are unwilling to provide psychiatric services despite their pre-service training. The key informant commented as follows:

“The stigma and discrimination associated with mental health is quite endemic all over, even amongst our own colleagues in the health care industry. That includes our own fellow professionals, doctors and nurses. They treat psychiatric patients differently from other patients, while others are not even willing to render the service” (Key informant 7, psychiatrist, Northern Cape Province).

Key informants pointed out that the mental health care providers themselves also faced ‘courtesy’ stigma, and were labelled ‘mentally ill’ like their patients. This impacted negatively on the availability of the human resources for mental health, especially newly qualified professionals who had interest in mental health.

“There was also an attack on people working with the mentally ill patients, they were overlooked and seen to be mentally ill. This robbed the field of

professionals who would have wanted to work in mental health” (Key informant 10, Mpumalanga Province).

Limited knowledge and education on mental health

Knowledge and education on mental illnesses is an effective way of dispelling the myths around mental health and encouraging positive behaviour. However, key informants pointed to the limited knowledge and education about mental health and the prescripts of the Act particularly among patients, families, the community and the general public.

“So for me, the main challenge is the limited knowledge of users, families and the public on mental health” (Key informant 32, KwaZulu-Natal Province).

Another key informant said:

“Patients don’t have a say in their treatment. They don’t query anything on their management even if they are not happy because they don’t know that they have the right to do so” (Key informant 16, KwaZulu-Natal Province).

Another one commented:

“There are lots of challenges with families due to lack of information and education about mental health and the Act (Key informant 16, Limpopo Province).

Key informants reported community stereotypes on mental illness as another barrier to the implementation of the Act. There was belief that mental illness was a curse and that mentally ill people must be locked away in a psychiatric hospital. A key informant illustrated this as follows:

“The other challenge is that communities have limited information about mental health and the Act. Other members still believe that mental illness is a curse and that mentally ill people should be taken directly to specialised psychiatric

hospitals and not to the clinic or district hospital” (Key informant 25, medical officer, KwaZulu-Natal Province).

Suboptimal stakeholder consultation and participation

The majority of key informants were of the opinion that consultation and participation of stakeholders in the development and implementation of the mental health legislation were suboptimal. Key informants were of the opinion that the Act was developed in a rush and that there was insufficient consultation with general health professionals, psychiatrists, users and their families, the private sector and academic institutions. This is illustrated in the excerpts below:

“I joined the Department [of Health] in 1997. In my first management committee meeting, the Director-General said “do we have any more legislation that is unconstitutional? The Department had been adjusting laws at that time. I put up my hand and said “the Mental Health Act”. She said “tell me more about that” and I explained. She said “I must draft a new legislation within a month. We then set up a small committee with experts in mental health such as in forensics and few mental health care users as a drafting team” (Key informant 5, national Department of Health).

There was a perception among key informants that the implementation process was planned by the national health departmental officials with limited consultation with other stakeholders.

“Largely, implementation of the Act was led by the national mental health directorate, with limited consultation with other stakeholders” (Key informant 8, Northern Cape Province).

“I really don’t recall if the general health care providers were involved. The Act was developed without their involvement; only mental health care practitioners were involved. Ideally, all health professionals were supposed to be involved

including district hospitals and not only mental health care practitioners” (Key informant 3, psychiatrist, Eastern Cape Province).

One informant commented:

“I think that the general staff were not adequately consulted on this Act; otherwise we wouldn’t experience so much resistance if they were involved” (Key informant 8, Northern Cape Province).

“But still I am concerned that the psychiatrists were not adequately consulted when the Act was made and implemented. Because some aspects show that the person who made the Act has never really worked as a psychiatrist. There are quite a lot of implementation gaps in the Act” (Key informant 30, psychiatrist, KwaZulu-Natal Province).

Other key informants emphasised the inadequate consultation of mental health care users and their families in the development and implementation process. They commented as follows:

“As far as I know in my province, the mental health users were not really adequately consulted. Family members are very important stakeholders because they live with these patients and they can actually advise us in terms of how best we can improve the services”(Key informant 17, Free State Province).

Key informants also reported limited consultation with communities in rural areas.

“Consultation with communities in rural places was not adequately done, like going to the chiefs, the kraals, calling Imbizos [community meetings] and thus they were not informed about the Act” (Key informant 10, Mpumalanga Province).

Key informants were of the opinion that the consultation processes for the general public was inappropriate for rural community members.

“You know, I think sometimes the processes were a little bit abstract for rural community members. They don’t know if they should attend hearings or how to respond, and I am looking at how we hold public hearings. I think we must start looking at relevant ways of consulting rural communities” (Key informant 35, Gauteng Province).

Another key informant concurred:

“Rural community members were consulted in a western approach where notices were published in newspapers, but it was only for those who could read. These communities did not really go through the proper consultation process. You may find that some communities were not even aware of the publication. Ideally in rural areas, arrangements are made with the king to consult the community. So those were not really done. Only the learned elite members could understand the western methods, but the ordinary man in the street was not informed” (Key informant 16, Limpopo Province).

Key informants reported that the private sector and academic institutions were also not adequately consulted in the development and implementation of the Act.

4.4.3 Health System Context

Key informants highlighted several constraints that compromised the implementation of the Act. These issues included: suboptimal health leadership and management and institutional capacity, poor preparation and planning for implementation; poorly functional Mental Health Review Boards; inappropriately organised mental health services; and lack of compliance monitoring mechanisms. They also reported that there were many unintended consequences of the Act.

Poor preparation and planning

Key informants reported that suboptimal planning processes and preparation of the health system for implementation of the Act constrained implementation. Key informants referred to the unexpected promulgation date of the Act during the festive season and the lack of a national mental health policy and implementation plan.

Unexpected promulgation date of the Act

There were mixed feelings among key informants about the way that the Act was promulgated. The Act was promulgated unexpectedly during the festive season when the majority of health providers were least expecting it, and they learned about the promulgation of the Act through the media. Key informants felt that this had a major impact on the implementation of the Act as the implementers were not adequately prepared for new procedures introduced by the Act.

“I still remember, December the 15th. We heard from the media that the Act has been promulgated. We did not expect it and most of us were on leave. When we came back from the festive period, we found the new Act. We were taken by surprise. There were mixed feelings (Key informant 21, psychiatrist, Western Cape Province).

Another key informant said:

“So it was for all of us a shock like the year we were struck by the Tsunami, that pandemonium. So I always compare this and I say the Tsunami struck there and the Tsunami struck here when the Act was promulgated” (Key informant 24, psychiatrist, Western Cape Province).

Lack of a national mental health policy and implementation plan

Key informants reported that the lack of a national mental health policy and implementation plan resulted in inappropriately organised mental health services; suboptimal preparation of district hospitals to implement the Act and resource

(financing, human resources and infrastructure) constraints. These created significant barriers to the implementation of the Act.

“There was no national mental health policy and plan to guide the implementation process” (Key informant 17, Free State Province).

The absence of the national mental health policy and plan opened a vacuum in the implementation process where provinces developed varying policies and plans. Key informants illustrated this as follows:

“Provinces developed their own policies and plans, which varied. That’s another problem that can be attributed to the poor implementation of the Act and mental services, because it was also very difficult I think also for my colleagues [mental health coordinators] in other provinces to develop policies and plans in the absence of a national one” (Key informant 17, Free State Province).

A key informant expressed the frustration they felt in the absence of guidance from the national department.

“What we didn’t have at the time was the competence on how to implement this new Act, it was difficult but we had to put a plan together in the dark” (Key informant 22, Western Cape Province).

Inappropriate organisation of mental health services

Another challenge emanating from the lack of a national plan highlighted by key informants was the inappropriate organisation of mental health services, which made implementation difficult. Key informants explained how the Act prescribes the organisation of mental health services in a pyramidal order, with a limited number of psychiatric hospitals at the top and a wider base of community-based services. However, at the time, the structure of mental health services was that of an inverted pyramid, with predominance of psychiatric hospitals and under-developed community

based services, inherited from the apartheid past. This inappropriate organisation of services hindered the implementation of the Act.

“The lack of community-based mental health services posed a big challenge on the implementation of the Act, which organises mental health services in a triangular manner, where psychiatric hospitals must be limited with broader community services. The aim of the Act is for the rehabilitation component to be continued at the community level, unfortunately, that is where we fall between the cracks. You find that all that had been done to rehabilitate patients becomes undone after hospital discharge due to lack of community-based mental health services” (Key informant 35, Gauteng Province).

Key informants were of the opinion that the efforts to reorganise mental health services in order to develop community services in the country was limited. The following was mentioned by one key informant:

“We don’t really see the uptake of community-based mental services, you know, it’s just on papers. Up to now, we still have big psychiatric hospitals and inadequate mental health services in the community” (Key informant 17, Free State Province).

Another key informant attributed the inappropriately organised mental health services to the hospital-centred approach to care. He commented:

“Despite our legislation and policies, we have done far too little for treatment and care of our people at the community level. I think we have a hospital-centred approach with little efforts to decentralise the services to the community. We have done badly in community care for our people. I think those are the big regrets we have had 10 years after the Act, we haven’t managed to fix this gap” (Key informant 5, national Department of Health).

Other key informants were of the opinion that the limited understanding of community-based mental health services by some managers as a further constraint to implementation.

“People still do not understand what is meant by community-based mental health services. Other managers still think that we want to create hospitals in the community. I think that is where the problem is” (Key informant 17, Free State Province).

Suboptimal preparation in district hospitals for implementation

Key informants argued that district hospitals and the staff were not adequately prepared to implement the Act. Key informants were of the opinion that the mental health services were imposed on district hospitals as there was no budget allocated for the new legislative mandate in these hospitals, no adaptation of the existing infrastructure and adjustment of human resources to render the services.

“All of a sudden district hospitals were told to admit psychiatric patients but they were not properly prepared to render the service” (Key informant 21, psychiatrist, Western Cape Province).

Another key informant said:

“There were no preparations that this is now going to happen in this particular manner and a certain set of steps were to be followed in advance in preparation for implementation of the Act, even with the simplest thing such as having the required forms” (Key informant 24, psychiatrist, Western Cape Province).

Another difficulty highlighted by key informants was the lack of mentoring for the newly qualified mental health professionals in district hospitals, which added to challenges in the implementation of the Act.

“Now when the four years nurse training course came in, a few of them started graduating and they were employed in district hospitals. The biggest challenge was that they needed to be mentored and there was no one to mentor them. Some of them did not have interest in psychiatry but they had to do it as part of the course. So you’ll find a nurse saying to you ‘I don’t know mental health and I can’t go that far because I’m not sure what am I supposed to do’. This thing caused a lot of discrepancies” **(Key informant 16, Limpopo Province).**

Resource constraints

The low level of resources in mental health influenced the implementation of the Act. Key informants felt that this resulted from the lack of an implementation plan, which should have informed finance, infrastructure and human resource requirements.

Financing mental health and the implementation of the Act

A recurring theme by key informants was the lack of a dedicated ring-fenced budget for mental health for the implementation of the Act. Key informants complained that most of the funds were allocated to HIV & AIDS and TB programmes and a very minimal amount to mental health. One key informant commented:

“Finance is a problem, there’s no dedicated budget for mental health care, not even for implementation of the new mandates brought by the Act. Everything else is about HIV/ AIDS and TB and little for mental health. For mental health, the budget is dismal; you are actually allocated the remainders” **(Key informant 11, North West Province).**

“Resources in mental health are a problem. A new Act was introduced without financial reservations. So even if the intention of the Act is good, financial resources are not enough to be able to fully implement. The budget is integrated with other programmes. HIV is taking its bit, diabetes is taking its bit, heart attack is taking its bit and mental illness gets the little bit” **(Key informant 22, Western Cape Province).**

Key informants reported that due to limited funds for mental health, the necessary equipment and material such as the admission forms, photocopiers, psychological assessment tools and transport were not enough in psychiatric hospitals.

Human resource limitations

Key informants reported a number of human resources challenges, which included: resignation of the key official who led the development of the Act from the national Department of Health; shortage of mental health personnel; inadequate skills; interpretation and translation of the Act, weak provincial leadership and management support as well as challenges with the forms and making applications under oaths.

After the Act was promulgated, the key official who led the development of the Act from the national department resigned, thus creating a vacuum on the initial preparations for implementation and also compromising the continued support to provinces. One key informant expressed this viewpoint as follows:

“The worst part of it was that all of a sudden, XYZ left the department, he was not there as the lead person who drafted the Act. We felt that he was leaving when we were supposed to implement the Act which had implications for various departments such as the police. We didn’t even know why some things were prescribed and what the role of these other departments was, but you had to answer because he was not there to give guidance. If you shy away or run away, then the system would collapse. You had to run around, phone and ask so that at the end of the day, there was something you could say to the people as a mental health coordinator, so I think that his resignation seriously impacted on the initial implementation of the Act” (Key informant 10, Mpumalanga Province).

Provincial mental health coordinators reported challenges in the interpretation and translation of the provisions of the Act after the key official left the department. One key informant said:

“An official from the national department came and explained things to us before the Act was promulgated. But remember somebody explaining things and putting them in place are different processes. All of a sudden that person was no longer there and you had to study the Act by yourself and train people. This was the difficult part of it. Remember you are not training ordinary people; but professionals such as psychologists, psychiatrist and medical doctors, it was difficult and frustrating” (Key informant 10, Mpumalanga Province).

The interpretation of Mental Health Review Boards (MHRBs) and how they were to be established as prescribed in the Act was another challenge. This impacted on the implementation process as can be seen in the excerpt below:

“We had to appoint the MHRBs and there was nothing to guide us or to say you must interpret the Act this way. It was a big struggle. I am not a legal person, but I had to interpret the Act to inform the entire province and even the Head of Department on what needs to be done. We spent sleepless nights trying to understand the Act. We were thrown in the deep end. I think this is one reason why the implementation of the Act is so problematic. I think it would have been better if there were guidelines put in place so that the procedures were standardised, then we would work together with colleagues from other provinces to decide on the requirements but not on your own as it was the case” (Key informant 10, Mpumalanga Province).

Key informants indicated that the delegation of duties as another area that was not well interpreted and understood in the Act. The clinicians and hospital management held different opinions on the responsibilities of the head of health establishment as seen in the excerpt below.

“The other challenge was about the interpretation of delegation of duties. This is one of our challenges because the delegations are not made, so we are

therefore not complying with the Act” (Key informant 15, psychiatrist, Limpopo Province).

A key informant reported shortages of human resources in mental health, particularly medical officers, psychologist and psychiatric nurses as another major barrier to the implementation of the Act.

“The other thing is that I work alone, I don’t have a single medical officer as a psychiatrist, all the other consultants in the hospital like internal medicine, surgery, they have about 3 to 4 medical officers. They don’t want to give me one and I mean it’s very frustrating. We are also functioning without a psychologist and it’s a very vital part of psychiatry. It has been for a very long time that we keep pushing and pushing and we are getting nowhere, which poses a problem on the implementation of the Act” (Key informant 28, psychiatrist, Free State Province).

Regarding shortage of psychiatric nurses, one key informant commented:

“There is a serious shortage of psychiatric nurses. If the district or hospital psychiatric nurse goes on leave or to study, then it becomes a struggle as there will be no one to replace with. Patients suffer until that person comes back” (Key informant 24, psychiatrist, Western Cape Province).

Key informants felt that the management support and leadership on the implementation processes was weak and that there was no buy-in of senior managers in provinces on the implementation of the Act. This is illustrated in the following quote:

“I remember being called to a meeting after the Act was promulgated where I was told in the management meeting that ‘We won’t have any mentally ill patients in our district hospitals’. I felt extremely shaken by this and I thought of leaving the mental health programme and go somewhere, there was no point in working

there because management did not support the Act” (Key informant 22, Western Cape Province).

Another key informant also added to the provincial mental health coordinator’s limited decision-making powers to implement the Act, which required major shifts in human resources, material and budgets in the health system.

“You can imagine if you want to shift staff out of hospitals into the community and want to use the budget from hospitals to develop infrastructure in the community. What power does coordinators have at the level of an assistant director? This is another area, I think the provincial structure is weak and we have to do more to support them. We need someone with higher powers to enforce the changes introduced by the Act” (Key informant 5, national Department of Health).

The limited skill of general professionals in mental health and on the prescripts of the Act was another issue reported by key informants in district hospitals as a stumbling block to the implementation process.

“First of all, we can’t expect people to implement the Act if they don’t know what they are implementing. I think that the district hospital personnel were supposed to have been capacitated in order to make them understand what is expected and why the Act is there because they don’t understand the Act. That must have happened before we could expect them to implement the Act” (Key informant 13, medical officer, North West Province).

Other factors reported by key informants that hindered implementation of the Act were pertaining to the forms, including: increased administrative workload; shortage of the forms; incorrectly completed forms; and that some aspects were unclear and not easy to comprehend.

The Act introduced a number of forms to be completed for involuntary psychiatric admission. These include forms that must be completed by police when they bring a

mentally ill person to hospitals, those that are to be completed after the initial assessments by two mental practitioners and after 72-hour assessments. There was an overwhelming feeling that the forms were cumbersome and have added additional work on the limited human resources in mental health. This was illustrated by a psychiatrist from the Western Cape:

“The forms are cumbersome and adds a lot of work for us” **(Key informant 24, psychiatrist, Western Cape Province).**

Another key informant said:

“Now the other challenge has to do with a lot of paperwork. Everything that you do with a mental health care user has to be documented, starting from applications, in fact starting from when police transport the patient from home to the unit, they submit Form 22, so the paperwork is too much” **Key informant 6, psychiatrist, Gauteng Province).**

In addition to the increased workload from completion of the forms, some key informants reported the shortage of the application forms for involuntary psychiatric admissions especially after hours and photocopying facilities in some hospitals. This is shown below as follows:

“Some far rural hospitals will phone and say we don’t have forms and photocopying machines, where do we get the forms. Sometimes I e-mailed the forms in the middle of the night for the doctors in those periphery hospitals. To say that it is not our responsibility to make sure that you have the forms will not benefit even the users” **(Key informant 15, psychiatrist, Limpopo Province).**

Key informants reported that another barrier to the implementation of the Act was the incorrect detail and mistakes on the application forms for involuntary psychiatric admissions submitted from district hospitals to specialised psychiatric hospitals. As a

result, those forms had to be corrected by personnel in specialised psychiatric hospitals before being submitted to the High Court to get approval for the involuntary psychiatric admission of the patient. This added another workload to the already overstretched personnel, and also increased the workload for clinicians.

“In 2005 when the forms were just starting to come I remember it was a nightmare. Every form was wrong and we had to correct each and every one. That was cumbersome and it took a lot of time” (Key informant 24, psychiatrist, Western Cape Province).

The same key informant further commented:

“Currently we have this extremely obsessive judge sitting in our High Court. So if you do not write out a word completely or if you do not indicate your full names completely, you are in trouble. Sometimes it is about small things like comas and full stops, which has nothing to do with whether the patient is receiving the proper psychiatric care or not” (Key informant 24, psychiatrist, Western Cape Province).

Some key informants reported that patients referred from private hospitals and local mines did not have the necessary application forms and this was attributed to lack of knowledge and unclear forms.

Another reported challenge was that some applications for psychiatric admissions were not made under Oath as required in the Act due to the unavailability of the Commissioner of Oaths in psychiatric hospitals, which had an impact on the authenticity of the application made. This was reported as follows:

“The other problem is the Commissioner of Oaths, we don’t have them. All applications were not made under Oath, which is illegal. Families still had to go to

SARS offices which were nearer our hospital and it becomes a problem” (Key informant 17, Free State Province).

Infrastructure challenges

Key informants reported infrastructure limitations as one of the key barriers to the implementation of the Act. The limitations included lack of infrastructure standards, shortage of fit-for-purpose buildings, and poor maintenance of facilities and weak management of infrastructure projects. Regarding the lack of mental health infrastructure standards:

“I was an Assistant Director at the provincial office when the Act was promulgated in December 2005. Now we had to designate facilities for care, treatment and rehabilitation. You had to come up with the layout and fabrics as a health care worker because there were no construction standards for mental health facilities. We had to allocate facilities in each district and also according to the population size. You can imagine the size of the districts, they are very vast and sparse, it was a struggle but we had to comply” (Key informant 10, Mpumalanga Province).

Another key informant raised the challenges related to inappropriate infrastructure for mental health. The design, layout and material used in psychiatric hospitals was not appropriate for mental health care users as they pose a safety threat to staff, other patients and property. This is illustrated as follows:

“We don’t have the appropriate infrastructure for mental health services and there are no resources to adapt the existing psychiatric hospitals to be relevant for psychiatry. This pose a danger to the patients themselves and staff and impacts on compliance with the Act” (Key informant 24, psychiatrist, Western Cape Province).

“So it’s like a question if I pose it back to say; how can we expect general hospitals to provide adequate infrastructure when we don’t have it in specialised psychiatric hospitals” (Key informant 17, Free State Province).

Key informants identified corruption in the system and poor management of infrastructure projects as exacerbating infrastructure challenges in mental health. A project to construct a psychiatric hospital in one province that has been underway for more than 10 years was given as an example in this instance.

“We have a new mental health facility that is coming up and has been under construction for the past 10 years, which is too long for the construction of a hospital. A hospital should take 2 to 3 years not 10 years. This demonstrates system problems around project management and corruption and so forth. I am sure our situation would be better off if there was no corruption as the hospital would have been completed much earlier on” (Key informant 7, psychiatrist, Northern Cape Province).

The other reported challenge pertaining to mental health infrastructure is the poor maintenance of psychiatric wards in hospitals, which are not prioritised as other hospital wards. This added to the deteriorating state of buildings in psychiatric hospitals, which impacted on the implementation of the Act.

Poorly functioning Mental Health Review Boards

The need for governance and accountability in mental health created a favourable platform for the development and implementation of the Act. However, key informants felt that even though MHRBs had been established in all provinces, some were not functional. Challenges identified in the functioning of the MHRBs included leadership, autonomy and powers of the Boards; operational procedures; and execution of their oversight functions as prescribed in the Act. Other challenges identified included a lack of training, equipment and infrastructure. Table 4.3 presents a brief overview and the functioning of the Boards in terms of their establishment after promulgation of the Act,

membership, location, equipment, delegation, availability of a strategic plan, budget, and administrative support.

Table 4.3: Brief overview of the functioning of MHRBs

Province	Overview	No. of psychiatric hospitals served by the Board	Location of the Board	Equipment and material	Board Reporting structure	Strategic plans	Budgets	Administrative support	Overall Functioning
Gauteng	<ul style="list-style-type: none"> Three Boards were established which was reduced to two and later to one. Consisting of 7 members 	<ul style="list-style-type: none"> 11 	<ul style="list-style-type: none"> Convenient. Adequate offices provided at a government building in town 	<ul style="list-style-type: none"> Adequate (Dedicated fax, computers, printers, photocopiers and telephone) 	<ul style="list-style-type: none"> The provincial mental health directorate 	<ul style="list-style-type: none"> Unavailable 	<ul style="list-style-type: none"> Not dedicated 	<ul style="list-style-type: none"> Dedicated 	<ul style="list-style-type: none"> Optimal
KwaZulu-Natal	<ul style="list-style-type: none"> Four Boards consisting of 5 members in each 	<ul style="list-style-type: none"> 11 hospitals 	<ul style="list-style-type: none"> Inconvenient. Two congested offices at Townhill nursing school 	<ul style="list-style-type: none"> Inadequate (Only telephone line and computer was dedicated) 	<ul style="list-style-type: none"> Provincial mental health directorate 	<ul style="list-style-type: none"> Unavailable 	<ul style="list-style-type: none"> Not dedicated 	<ul style="list-style-type: none"> Not dedicated (Shared secretary with the district office) 	<ul style="list-style-type: none"> Average
Eastern Cape	<ul style="list-style-type: none"> Three Boards with 3 members in each 	<ul style="list-style-type: none"> 8 hospitals 	<ul style="list-style-type: none"> Inconvenient. One congested office at a government building in town 	<ul style="list-style-type: none"> Inadequate (Fax, computers, printers, photocopiers and telephones were shared) 	<ul style="list-style-type: none"> Provincial specialised services directorate 	<ul style="list-style-type: none"> Unavailable 	<ul style="list-style-type: none"> Not dedicated 	<ul style="list-style-type: none"> Not dedicated (Shared secretary with the district office) 	<ul style="list-style-type: none"> Suboptimal
Western Cape	<ul style="list-style-type: none"> One provincial with 5 members 	<ul style="list-style-type: none"> 9 hospitals 	<ul style="list-style-type: none"> Convenient. Adequate offices at Lentegour hospital 	<ul style="list-style-type: none"> Adequate 	<ul style="list-style-type: none"> Reporting directly to the MEC 	<ul style="list-style-type: none"> Available 	<ul style="list-style-type: none"> Dedicated 	<ul style="list-style-type: none"> Dedicated 	<ul style="list-style-type: none"> Optimal

Province	Overview	No. of psychiatric hospitals served by the Board	Location of the Board	Equipment and material	Board Reporting structure	Strategic plans	Budgets	Administrative support	Overall Functioning
Limpopo	<ul style="list-style-type: none"> Five boards were established with 5 members in each. Reappointments took a long time after term expired in 2014 	<ul style="list-style-type: none"> 12 	<ul style="list-style-type: none"> Inconvenient. One office at the departmental building in town 	<ul style="list-style-type: none"> Shared fax and photocopier. Computers, printers, and a telephone dedicated 	<ul style="list-style-type: none"> Transformation and transversal programme at the MEC's office 	<ul style="list-style-type: none"> Unavailable 	<ul style="list-style-type: none"> Not dedicated 	<ul style="list-style-type: none"> Not dedicated (Duties delegated to the community liaison officer) 	<ul style="list-style-type: none"> Suboptimal by the time of the study but currently no Board exists in the province
Mpumalanga	<ul style="list-style-type: none"> One Board established. The term of office for the Board expired in 2012 except for the chairperson. New members appointed in 2014 	<ul style="list-style-type: none"> 3 	<ul style="list-style-type: none"> Inconvenient. Located at the Auditor-Generals offices at the time of the study but later moved to a psychiatric hospital 	<ul style="list-style-type: none"> Inadequate (Fax, computers, printers, photocopiers and telephones were not available. Currently using shared equipment 	<ul style="list-style-type: none"> Provincial mental health directorate 	<ul style="list-style-type: none"> Unavailable 	<ul style="list-style-type: none"> Not dedicated 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Non-functional at the time of the study. Averagely functional
North West	<ul style="list-style-type: none"> Two Boards were established which was merged later into one consisting of 5 members 	<ul style="list-style-type: none"> 4 	<ul style="list-style-type: none"> Inconvenient. Located at the private offices of the legal representative at the time of the study Currently at a hospital 	<ul style="list-style-type: none"> Inadequate. Used material at the legal official's private offices. Currently using hospital resources 	<ul style="list-style-type: none"> Mental health office 	<ul style="list-style-type: none"> Unavailable 	<ul style="list-style-type: none"> Not dedicated 	<ul style="list-style-type: none"> Official seconded from the mental health office 	<ul style="list-style-type: none"> Average
Free State	<ul style="list-style-type: none"> Three boards established and reduced to 2 with 5 members in each 	<ul style="list-style-type: none"> 3 	<ul style="list-style-type: none"> Inconvenient. No offices provided. Used the hospital boardroom 	<ul style="list-style-type: none"> Inadequate (Used shared equipment at the hospital) 	<ul style="list-style-type: none"> Through the hospital CEO, provincial mental health office to the MEC 	<ul style="list-style-type: none"> Unavailable 	<ul style="list-style-type: none"> Not dedicated 	<ul style="list-style-type: none"> Not dedicated (duties delegated to the hospital secretary) 	<ul style="list-style-type: none"> Suboptimal

Province	Overview	No. of psychiatric hospitals served by the Board	Location of the Board	Equipment and material	Board Reporting structure	Strategic plans	Budgets	Administrative support	Overall Functioning
Northern Cape	<ul style="list-style-type: none"> One board was established. New members were appointed after the expiry of the term of office for the previous Board 	<ul style="list-style-type: none"> 1 	<ul style="list-style-type: none"> Average. There was a separate unit for the board with a waiting area, kitchen and filing room 	<ul style="list-style-type: none"> Telephone available. Shared fax, computers, printers, photocopiers with the mental health coordinator 	<ul style="list-style-type: none"> Reports directly to the MEC, provincial head of health and the Mental Health Directorate 	<ul style="list-style-type: none"> Available 	<ul style="list-style-type: none"> Not dedicated 	<ul style="list-style-type: none"> Not dedicated (Duties delegated to the hospital communications officer) 	<ul style="list-style-type: none"> Optimal

Although the Act locates the appointment of the MHRBs at the level of the MECs, this function has been delegated in some provinces to other offices such as the mental health directorates. Key informants reported that this arrangement created a disjuncture in communication between the MHRBs and the MECs.

“Yes, we had to introduce ourselves to the MEC, whereas he is the one who is supposed to appoint us” **(Key informant 29, mental health review board, Eastern Cape Province).**

Another key informant commented:

“Since 2005, we met with the MEC twice. It was in 2006, when the initial 2 Boards in the province were not well functioning so we met with the MEC to explain the challenges. From then we made attempts but did not succeed, he was not available” **(Key informant 14, mental health review board, North West Province)**

The Act makes provision for the Boards to be quasi-judicial, independent and autonomous bodies to ensure that the department provides appropriate mental health services. However, informants felt that the autonomy and independence of the some Boards was challenged because they were managed and depended on the mental health unit in the department in other provinces, adopting a referee and player position. Commenting on the autonomy of the MHRBs, one Review Board member said:

“The situation with the autonomy of the Board is a bit hazy. In the fact without the provincial mental health coordinator who is directly a link between us and the MEC, the Boards will be left all by themselves. The MEC is always busy and so we had to get somebody in the office who can handle our challenges there and then or forward them further but now we have to depend on the mental health unit, so we are not autonomous” **(Key informant 27, mental health review board, Free State Province).**

The perception on the power of the Boards to enforce compliance varied among key informants. Some key informants felt that the Boards had adequate powers to exercise their duties while others thought the opposite. The diverse views on the power of the MHRBs were linked to both perceptions and knowledge of the legislation, as well as the confidence of the board members to exercise their duties as outlined in the Act.

“I think we have powers. In one example, we realised that the police were not doing their work properly as they were dumping patients in hospitals. They were reluctant and some refusing to fill in the forms. The police officer was summoned to come and answer to the Board. He was called to order by the chair and a report was submitted to their superintendent and he complied from that time” **(Key informant 14, mental health review board, North West Province).**

Other key informants felt that the MHRBs did not have adequate powers because the Act does not provide punitive measures for non-compliance.

“I feel that the power of the Board is limited. It is because we cannot enforce discipline in case of non-compliance” **(Key informant 31, mental health review board, Mpumalanga Province).**

Another review board member said:

“I remember at the summit in 2009 it was recommended that punitive measures must be included in the Act because the Board can only summon somebody. There are no punitive measures that they can recommend to anybody. It is written nowhere in the Act” **(Key informant 29, mental health review board, Eastern Cape Province).**

There were also challenges in carrying out the operational procedures by the Boards. One key informant attributed this to the lack of strategic plans by other MHRBs to inform their operational needs and budgets.

“Definitely we are planning in the dark; we do not have a strategic direction to inform our plans and resource requirements” (Key informant 29, mental health review board, Eastern Cape Province).

Another contributing factor to suboptimal functioning of the Boards was the lack of a dedicated budget.

“We don’t have a budget, we were told that there is no budget for us, we get little bits from the province” (Key informant 14, mental health review board, North West Province).

The majority of the Boards had no offices and the necessary equipment for effective execution of their duties.

“We meet once a week in this private office. There is no proper office, no computer, which is in the secretariat’s office at the Department, no fax, photocopier. We use resources provided by the legal practitioner in his private offices out of good will” (Key informant 14, mental health review board, North West Province).

“There was one computer in the manager’s office, which we were supposed to use in that office but it was very uncomfortable to work there. We were using the auditors’ fax and also their photocopier and telephone” (Key informant 31, mental health review board, Mpumalanga Province).

Another contributing factor was the inadequate training of the Boards on their roles and responsibilities.

“Yes we received training although we feel that it was not enough, we need continuity. We attended the national summit and the provincial mental health coordinator gave us something on the Act and the role of the Board at the initial

appointment in 2005, but it was not sufficient” (Key informant 14, mental health review board, North West Province).

The majority of the Boards were limited in the execution of the oversight functions, particularly on handling appeals, processing periodical reports for mentally ill prisoners and obtaining High Court authorisation for psychiatric admissions.

“Documents come; we know that the forms must go to the High Court. We say to the secretary, don’t forget to send these documents because it is their route. We however are not receiving responses from the Courts to show that they have received application forms” (Key informant 14, mental health review board, North West Province).

Another key informant said:

“High Court authorisations are submitted sometimes within the timeframe and sometimes not within the timeframes, but we cannot ask the judges or say to the judge “leave everything and attend to my application” because somewhat that would be deemed in contempt of the court” Key informant 29, mental health review board, Eastern Cape Province).

Key informants also commented on the distance between the location of the Boards and the High Courts, which posed a challenge in the submission of application documents and receipt of authorisations for psychiatric admissions.

“There are challenges because we have to take these to Bloemfontein High Court and we are in Kroonstad. It may happen that High Court is sending them back, but we are not getting them, so we haven’t received authorisations so far” (Key informant 27, mental health review board, Free State Province).

Key informants reported inadequate administrative support for MHRBs as an impediment in their functioning. Very few Boards had dedicated administrative officials while others shared the administrative support with other programmes in other provinces.

Lack of compliance monitoring mechanisms

The compliance monitoring mechanism in the Act was lacking, which opened a gap on the implementation process. One key informant attributed this to the lack of enforcement of compliance in the Act itself.

“We threaten them with the review board and then nothing happens because the boards in some provinces are not effective. This is precisely because the Act didn’t bring in some kind of enforcement of compliance” (Key informant 24, psychiatrist, Western Cape Province).

Unintended consequences from the implementation of the Act

The unintended consequences threatened successful implementation of the Act. There had been adverse incidents in general wards where psychiatric patients were mixed with other medically ill patients, which shifted the focus of stakeholders and the community to the danger of mental health care users from the actual intention of the Act.

“There are adverse events that have resulted from the implementation of the Act. For instance, the Act says people must be admitted in a district hospital and we are very specific in saying they must be admitted in medical wards with other patients. Let’s take the mentally ill person who is hallucinating, who sees a drip or a gastric tube and think that it is a snake and decide to pull it out. They may even see the oxygen cylinder next to the patient and think that it is a mermaid standing. So we really do have those unintended consequences. It was not the intention of the Act, but it’s coming up every day, we do have those unforeseen

odd incidents occurring in medical wards” (Key informant 32, KwaZulu-Natal Province).

Another key informant argued that the Act unintentionally subjects an acutely mentally-ill person to be first managed at a district hospital, where there are limited skills and inappropriate infrastructure to contain psychiatric patients who may be aggressive due to the nature of mental illness. This was exposing the staff in district hospitals to a security risk.

“If you think about it, what the Mental Health Care Act does is that it makes the first contact of your sickest patient into the system at the point of his destructivity at a district hospital. Obviously we take people in specialised hospitals that are stabilised and manageable. So it’s like we’re turning our district hospitals into holding cells. The Act is subjecting the staff in district hospitals to high risk of aggressive patients, so we see incidents where our colleagues are assaulted and killed by patients” (Key informant 21, psychiatrist, Western Cape Province).

Some wards in district hospitals are located upstairs and patients jumped through windows” (Key informant 1, psychiatrist, Eastern Cape Province).

Regarding the role of Mental Health Review Boards as tribunals, one key informant highlighted that the approach by MHRBs in reviewing application documents was a paper review system and patients are not seen by the Boards to inform their decisions. This was not the intention of the Act. Also the fact that the Boards were undertaking hospital visits for inspection purposes was not envisaged in the Act as this is the role of the inspectorates.

The MHRBs have not become tribunals as I have hoped they become. I would have hoped that they saw everybody, if not every 5th person, 10th person or 20th person or at least see somebody once every week so that it becomes a real tribunal. I have not seen the consequences of paper reviews and of not taking

each case as a review as it is currently practised, so I doubt that the magistrates under the past laws did a better job compared to what is happening now. I also had not anticipated that the Boards will start taking the role of inspectorates”
(Key informant 5, national Department of Health).

Another key informant indicated that one of the unintended consequences of the Act was the poor quality of mental health care rendered due to the integrated service delivery system. Before integrated services, psychiatric patients were seen by specialised psychiatric nurses at the clinic who monitored their mental health status regularly and even followed them up at home to ensure compliance with their medication. With the integrated approach to service delivery, psychiatric patients are mixed with everyone at the clinic and there is no consistency in the staff that reviews their status and medication. This compromised the quality of mental health care rendered.

“The Act means good but when you look at the quality of care, it was compromised. This is one critical unintended consequence of the Act where the patient lost the specialised eye and was seen by everybody due to integrated programmes. The Act intended integrated services but not compromise the quality of care, but unfortunately there is no one to monitor treatment and compliance of psychiatric patients as professionals are just pushing the queues”
(Key informant 8, Northern Cape Province).

Another issue raised by key informants was in relation to the focus on correctness of application documents submitted as compared to the care rendered. Paperwork and documentation shifted the focus from care to correctness of forms, which was really not the intention of the Act.

“I think that the forms sometimes interfere with the spirit of the Act which was around the person getting proper care and not necessarily about completing the

forms 100%, you know commas and dots that type of thing” (Key informant 24, psychiatrist, Western Cape Province).

This chapter presented the findings from the study key informants on the implementation of the Act. These findings are discussed in the next chapter.

CHAPTER 5 : DISCUSSION OF QUALITATIVE RESEARCH FINDINGS

5.1 Introduction

This is one of the first empirical studies conducted on the implementation of South Africa's Mental Health Care Act in psychiatric hospitals since its promulgation in 2004.

The study found that the factors facilitating policy implementation included: the democratic change in South Africa, which created a unique window of opportunity; widespread stakeholder support for the intention and spirit of the Act; advocacy for human rights; and the broader transformation of the health system. However, the relative low prioritisation of mental health; stigma and discrimination; limited knowledge and education on mental health; weak leadership, and governance; and insufficient management capacity hindered the implementation of the Act. The findings from this study yield important insights on the capacity of the health system to implement the Act, progress made and the limitations encountered.

This chapter discusses the findings from the qualitative component of the study in line with the study objectives, drawing on the theoretical and conceptual frameworks of the study, and the existing literature on mental health policy implementation.

5.2 Contextual factors that influenced policy implementation

5.2.1 Democratic transition in South Africa

The study found that democracy combined with advocacy for human rights, the broader transformation of the health system, new governance structures, and the rights based Constitution created a unique window of opportunity for health policy and legislative reforms. Drawing on Hogwood and Gunn's theoretical framework, this finding suggests that pre-condition 1 was met. Other studies in South Africa have also found that the political changes brought into sharp focus the inappropriateness of the 1973 Mental Health Act, leading to subsequent legislative reforms (Emsley, 2001; Foster & Swartz, 1997; McCrea, 2010; Swanepoel, 2011; Vogelmann, Perkel, & Strebel, 1992).

Political change has also been found as a facilitating factor in other countries. In Liberia, democratic transition was a window of opportunity for the development and implementation of new mental health legislation, accompanied by a 10-year National Health and Social Welfare Policy and Plan (2011-2021) (Government of Liberia, 2014). Similarly, in Latin American and Caribbean countries, the political changes in the 1980s marked the end of repressive political regimes that violated human rights, thus leading to new mental health legislation based on human rights (Caldas de Almeida, 2013; Caldas de Almeida & Cohen, 2008; Caldas de Almeida & Horvitz-Lennon, 2010; Razzouk, Gregorio, Antunes Dos Santos, & De Jesus, 2012).

In contrast, in many high income countries (England, Italy, Russia, Japan), middle income countries (Tunisia, Pakistan, Republic of Korea and Sri Lanka) and low income countries (Kenya, Uganda, Ghana, Nigeria and Zambia), mental health legislative reforms have been prompted by out-dated laws, as well as ethical and clinical considerations (Freeman et al., 2005; Gureje & Alem, 2000; House of Commons Health Committee, 2013; Jenkins, Baingana, Ahmad, McDaid, & Atun, 2011; Mwanza et al., 2008; Mwape & Mweemba, 2010; Saraceno et al., 2007; Westbrook, 2011). In Afghanistan, Cambodia, Sierra Leone, the Democratic Republic of Congo and Mozambique, mental health policies and legislation were developed and implemented in response to the devastating social and mental health impact of natural disasters (e.g. tsunamis) and wars and violence (Jenkins, Mussa, et al., 2011; Kigozi., Ssebunnya, Kizza, Cooper, & Ndyabangi, 2010; Saraceno et al., 2007; Sweetland et al., 2014). However, this was not the case in Gaza, where despite the massive psychological impact from conflict and wars, there is no mental health legislation in place, because of lack of approval by both the Gaza legislative council and the Ministry of Health (Saymah, Tait, & Michail, 2015).

5.2.2 Advocacy for human rights

This study found that human rights advocacy, another example of Hogwood and Gunn's pre-condition 1 for perfect implementation, was also a facilitator for the development and implementation of the Act in South Africa. This was also found in Latin American

and Caribbean countries (Caldas de Almeida, 2013; Caldas de Almeida & Cohen, 2008), North America and the United Kingdom and in Uganda and Nigeria, where advocacy facilitated the development and implementation of mental health legislation.

5.2.3 Wide-spread stakeholder support

Policy implementation scholars have pointed to the importance of stakeholder support for the implementation of policies and legislation. Pre-condition 4 in Hogwood and Gunn's framework recommends that policies must be based on a valid theory of cause and effect and that the policy objectives must be agreed upon by stakeholders (Hogwood & Gunn, 1997). Lipsky also highlighted that agreement on the policy objectives by key stakeholders, including the implementers, is imperative for successful policy implementation (Lipsky, 1980, 2010). The majority of key informants indicated that widespread support for the values and goals enunciated in the Act facilitated the implementation of the Act. This was also found in another South African study (Ramlall, 2012) and in India (Peters et al., 2002), where stakeholder support facilitated the implementation of the 2002 integrated health and population policy, which included mental health.

5.2.4 Broader transformation of the health system

The majority of key informants in this study indicated that the need for improved access to mental health services in South Africa was one of the driving forces in the development and implementation of the Act. This is because the existing literature and studies in several countries have demonstrated that inaccessible mental health services impact on self-care and treatment adherence, which, in turn, contribute to increased morbidity and mortality, high health care costs, as well as decreased productivity (Caldas de Almeida, 2005; Gorn, Solano, Icaza, Basauri, & Reyes, 2013; Kohn, Saxena, Levav, & Seraceno, 2004; Patel et al., 2013); in South Asia (Saxena et al., 2007; WHO, 2014a); Europe and Central Asia (Madianos, Zacharakis, Tsitsa, & Stefanis, 1999).

Studies in South Africa have also underscored the problems of access to needed mental health services (Lund. et al., 2008; Marais & Petersen, 2015; Saxena et al., 2007). This finding suggests that Hogwood and Gunn's pre-condition 5 of a clear cause and effect relationship for effective policy implementation was met.

5.2.5 The need to integrate mental health into the general service environment

The need to integrate mental health services into general health services was another factor that facilitated the development and implementation of mental health legislation. Existing evidence suggests that integration is important because it improves access to mental health services, closes the treatment gap and improves the quality of life for individuals (Kigozi, 2007; Lund, Breen, et al., 2008; Patel et al., 2013; Petersen et al., 2013; WHO, 2011b).

In Belgium (Nicaise et al., 2014), Greece and Argentina (WHO, 2011b) and Cuba (Caldas de Almeida, 2013) the need to integrate mental health into the general health service environment also facilitated the development and implementation of mental health legislation. A different situation was found in Central America, the United Kingdom, Chile, Australia, Europe where integration of mental health into general health was found, which facilitated implementation of mental health policies and legislation (Caldas de Almeida & Horvitz-Lennon, 2010).

5.2.6 The need for community-based mental health services

The need for community-based mental health services also facilitated the development and implementation of the Act in South Africa. This is because community care has been proven to be clinically effective, accessible, comprehensive and continuous while it also upholds the patient's rights through reintegration into society (Berenzon, Saavedra, Medina-Mora, Aparicio, & Berenzon, 2013).

Key informants indicated that under the previous Act, hospitalisation at a psychiatric hospital was almost like serving a 'life sentence', as there were no facilities in the community to provide continued mental health services after hospital discharge. This

constituted a major violation of human rights for people with mental illness and also proved to be a costly model for the State.

Other studies have also found that the need for community-based mental health services facilitated the development and implementation of mental health legislation in Latin America and the Caribbean, North America and many countries in the Sub-Saharan African region (Berenzon et al., 2013; Lund. et al., 2008). In Latin America and the Caribbean, the reform of mental health services was introduced by the Declaration of Caracas, which promoted a shift from hospital to community care, thus facilitating the development of compatible mental health legislation (Caldas de Almeida & Horvitz-Lennon, 2010; Levav, Restrepo, & Guerra de Macedo, 1994).

5.2.7 The need for enhanced governance and accountability

WHO defines governance as “ensuring that strategic policy frameworks exists and are combined with effective oversight, coalition-building, provision of appropriate regulations, attention to system design and accountability” (WHO, 2010b).

The need for improved governance and accountability in mental health was found to be another facilitating factor. The previous Act did not make provision for governance structures in mental health services and health providers were not held accountable for their acts and omissions. This contributed to numerous reports of human rights violations and poor quality of mental health care. A welcome prescription in the new Act was the Mental Health Review Boards (MHRBs) to ensure governance and accountability in mental health (Republic of South Africa, 2002).

Governance and accountability are also important features of the mental health legislation of Russia, Tunisia and Trinidad and Tobago. The 1992 Tunisian law regulating mental health makes provision for a review board that includes psychiatrists and representatives of local authorities, and that is chaired by a judge. The Tunisian review board conducts regular inspections of all mental health facilities and oversees involuntary admissions to ensure protection of human rights (WHO, 2003b).

5.3 Barriers to the implementation of the Act

5.3.1 Relatively low prioritisation of mental health

The study found that mental health was accorded a relatively low priority and this impacted on the implementation of the Act. Key informants complained about: the junior level of staff (assistant and deputy director level) appointed or designated to coordinate the implementation of the Act in the majority of provinces; limited prioritisation of mental health in the provincial annual performance and strategic plans; delays in the appointment processes for mental health professionals; and delays in the revitalisation of psychiatric hospitals.

The delegation of the implementation of the Act to mental health coordinators in provinces, the majority of whom did not have adequate power to influence strategic planning processes, prioritisation of staff appointments and revitalisation of psychiatric hospitals, was contrary to Hogwood and Gunn's recommendation of one implementing agency which does not depend on other agencies or has minimal dependency relationships in pre-condition 6 on "perfect" implementation (Hogwood & Gunn, 1997). Another challenge to the implementation of the Act emanated from the reliance of the mental health coordinators on other agencies, such as strategic planners, human resource and infrastructure officials to prioritise mental health in the provincial annual performance plans, resulting in multiple dependency relationships, that are not conducive to implementation (Hogwood & Gunn, 1997). Lipsky emphasised the critical role of street-level bureaucrats in policy implementation (Lipsky, 2010). In this study, the mental health coordinators had relatively low decision-making power because of their junior level in the health care system, thus compromising their ability to facilitate successful implementation of the Act in respective provinces. At the same time, other officials such as hospital CEOs, and psychiatrists interpreted the legal provisions of the Act in their own way, further constraining implementation.

Other studies in Zambia (Awenva et al., 2010); Uganda (Kigozi. et al., 2010; Mwape & Mweemba, 2010), and Ghana (Awenva et al., 2010; Draper et al., 2009; Lund. et al., 2008; Mental Health and Poverty Project, 2008b; Prince, Patel, Saxena, & et al, 2007)

have also found that there was low prioritisation of mental health, thus impacting on the implementation of mental health policies and legislation. Studies in Afghanistan, Australia, the United Kingdom, and North America also found that the implementation of mental health programmes received less priority compared to those for communicable and other non-communicable diseases, despite the apparent integration of these various programmes in strategic plans (Pollack, McFarland, George, & Angell, 1994; Saraceno et al., 2007).

Scholars have pointed out that factors that contribute to the low prioritisation of mental health include: different mental health disorders which compete for priority among themselves, thus confusing policy makers; poor, fragmented and unclear advocacy by different stakeholders (Saraceno et al., 2007); weak unconvincing mental health indicators (Freeman et al., 2005; Sartorius et al., 1993); lack of alignment between mental health and the public health agenda (Saxena et al., 2007; WHO, 2011b) and a low public interest in the wellbeing of mentally ill persons, which has been exacerbated by stigma and discrimination (Gureje & Alem, 2000).

In contrast, in Mozambique, it was found that there was a strong political will from the Ministry of Health and mental health was accorded a high priority which resulted in allocation of adequate funds for the services. However, there was inadequate research capacity and a shortage of staff, which limited the country's ability to render effective mental health services (Sweetland et al., 2014).

5.3.2 Stigma and discrimination

The study found that mental health stigma and discrimination posed a major stumbling block to the implementation of the Act, and contributed to the low status of mental health programmes.

The stigma operated at several levels. At one level 'courtesy stigma', was reportedly experienced by the mental health care providers interviewed who indicated that they were labelled 'mentally-ill like their patients'. At a different level, key informants

indicated that some generalist health care providers were reluctant to manage psychiatric patients, claiming that they do not have the required skills to deal with individuals with mental illness, despite the incorporation of common mental health conditions in their general health professional training. Other South African researchers (Bateman, 2012; Burns, 2008; Lund. et al., 2008; Mabena., 2010; Szabo, 2006; van Rensburg, 2011) also found that widespread stigma and discrimination of mental health, culminated in a fearful and negative public image of mentally ill people, thus impacting on the implementation of the Act. Another South African study found that psychiatric patients were perceived as violent, unpredictable and a threat to society and often portrayed as unkempt, poor, homeless and unemployable, weak, lazy and thus unable to do anything (Lund. et al., 2008).

Mental health stigma and discrimination combined with several other pre-conditions mentioned by Hogwood and Gunn, notably 2 (time and resources); 3 (resource combination); 6 (too many dependency relationships); 8 (problems of sequencing); 9 (communication and coordination) and 10 (complete compliance which implies the need for monitoring of the implementation process and the ability of those in authority to secure compliance with the legislative and policy mandates during the implementation process) constrained the implementation of the Act (Gunn, 1978; Hogwood & Gunn, 1997). According to Lipsky, the behaviour of health officials or street-level bureaucrats is shaped by their personal motives, attitudes and environment. Furthermore, Lipsky has suggested that psychiatric or mentally ill patients, fall within the category of “captive” clients who do not have the capacity to question or criticise providers (Lipsky, 2010). Hence, the health care providers may choose to behave with courtesy or with rudeness to their clients, with little recourse in the case of the latter because of the nature of mental illness (Lipsky, 2010).

The impact of mental illness and stigma and discrimination on policy implementation was also found in other studies in the United Kingdom (Sayce, 1998); Glasgow (Phio, 1994); Australia and New Zealand (Coverdale, Nairn, & Claasen, 2002); Pakistan (Karim, Saeed, Rana, Mubbashar, & Jenkins, 2004) and sub-Saharan African countries

(Kigozi. et al., 2010; Ndyanabangi, Basangwa, Lutakome, & Mubiru, 2004). Similarly, the widespread stigma and discrimination of psychiatric patients perpetuated by negative cultural beliefs about mental illness were also reported in Uganda (Kigozi. et al., 2010; Ndyanabangi et al., 2004).

In England and Scotland, studies reported that stigma and discrimination were reinforced by underlying myths that mental illness and violence were inseparable (Phio, 1994; Sayce, 1998). In Pakistan, stigma was perpetuated by supernatural beliefs (Karim et al., 2004), which deterred the implementation of the mental health policies and legislation.

5.3.3 Limited knowledge and understanding

Key informants reported that the implementation of the Act was also influenced by limited knowledge and understanding of mental health and of the Act by psychiatric patients themselves, their family members, general health care providers and some hospital managers. In the case of psychiatric patients and their families, they often did not know the rights enshrined in the Act. Key informants reported that the majority of medical officers did not have a good understanding of the Act, and they lacked the skills to manage mental disorders. Similarly, some hospital managers were not familiar with the provisions of the Act and they had insufficient knowledge of the Act. This lack of awareness constrained the implementation of the Act. This finding could point to insufficient and suboptimal educational and awareness programmes on mental health and the Act, prior to its implementation.

The lack of understanding of the Act was shown also from the interpretation of the delegation of duties espoused in the Act. The nine provinces interpreted the delegation of duties by the hospital managers and provision of 72-hour assessment services differently. The Act stipulated that the authorisation by hospital managers for assisted and involuntary mental health care was a clinical and not a management decision, and therefore could not be made by hospital managers, particularly those that are not mental health professionals. In some provinces, this responsibility was delegated to

clinical managers who were mental health professionals while hospital managers in other hospitals continued executing this task.

The study also found implementation challenges with the 72-hour assessment procedures, which varied among provinces. In some provinces the 72-hour assessments were conducted in seclusion rooms that were constructed in casualty departments in general hospitals. In other hospitals, these assessments were conducted in the medical wards where psychiatric patients were mixed with medical patients, which posed a safety threat by acutely ill psychiatric patients.

Hospital managers had different knowledge and interpretation the prescriptions of the Act, for example the importance of making applications for involuntary admission under Oath.

Hogwood and Gunn's pre-condition 7 recommends that there must be agreement and complete understanding of the objectives, procedures and tasks to be undertaken by stakeholders for "perfect" policy implementation (Hogwood & Gunn, 1997). Although stakeholders agreed on the common objective of the Act, the procedures and tasks in the implementation process were not well understood, which suggest that this pre-condition was partially met in this study. Lipsky's theory suggests that inexperience in a particular field by street-level bureaucrats and their limited understanding of the policy intention may result in the lack of capacity to deal with the complex implementation process (e.g. the 72-hour assessment procedure) (Lipsky, 2010).

The WHO has pointed out that information, education and communication between patients, their families and general health care providers can help to address misconceptions about mental health, dispel myths and encourage positive behaviour towards mentally ill persons (WHO, 2008, 2010b), which is fundamental to effective mental health policy implementation.

Studies in other African countries also found limited skills among general health care providers to manage mental health conditions, and inadequate knowledge by psychiatric patients and their relatives on mental health, policies and legislation (Burns, 2014; Lund et al., 2011; Lund, Stein, & Flisher, 2007; Moosa & Jeenah, 2010; Petersen, Bhangwanjee, & Parekh, 2000; Petersen et al., 2016; Ramlall et al., 2010), which impacted negatively on the implementation of the Act. The limited knowledge and education by general health providers were exacerbated by understaffing, reluctance to undergo mental health training, stigma and discrimination (Marais & Petersen, 2015).

In Australia, Argentina, Chile and United Kingdom, it was found that the implementation of mental health policies and legislation was constrained by limited knowledge and understanding of mental health by patients, their families and general health care providers (Razzouk et al., 2012). A different situation was found in Cuba, Belize, Chile, Jamaica, Mexico and Brazil, where investments were made in the training of generalists and strong public awareness programmes on mental health, which improved implementation of the policies and mental health legislation (Caldas de Almeida, 2013; Razzouk et al., 2012).

5.3.4 Suboptimal stakeholder consultation

The study found that there were challenges in meeting the requirement for “perfect” communication among stakeholders and adequate coordination of the implementation process as stipulated in pre-condition 9 of Hogwood and Gunn (1997)’s framework (Hogwood & Gunn, 1997). Key informants reported that there was insufficient consultation with mental health stakeholders, the process of drafting the Act was rushed, and the drafting team was also not representative of the main stakeholders in mental health. They pointed out that a small committee consisting of mental health experts and other stakeholders constituted the drafting team. This drafting team excluded consumer and special interest groups, non-governmental organisations, general health care providers and relevant government departments such as Police, Justice and Constitutional Development and Social Development. Consultation with the private sector and academic institutions was also limited. Experts have pointed out that

these are critical role players for effective mental health policy implementation (Mthethwa, 2012).

The development and implementation of the Act was perceived by the key informants as a 'top down' process, largely led by officials from the national Department of Health. Many policy implementation scholars have criticised the top down approach because of limited consideration of inputs by implementers on the ground, which may create resistance to the implementation of the policy, and thus impact significantly on the outcome of that policy (Mazmanian & Sabatier, 1983; Van Meter & Von Horn, 1975). The lack of buy-in and resistance by general health care providers, particularly medical officers working in rural psychiatric hospitals, could be explained by insufficient communication and consultation processes.

Key informants pointed out that public consultation did not accommodate rural communities, many of whom are illiterate. The Bill was published for comments in local newspapers only and there were no meetings with local communities organised through community leaders, especially in rural areas where the local chiefs (traditional leaders) play an important role. Other South African studies have also pointed to inadequate stakeholder consultation in the development and implementation of the Act, which constrained implementation (Draper et al., 2009; Lund. et al., 2008; Marais & Petersen, 2015). Of concern is that the 2013 National Mental Health Policy Framework and Strategic Plan 2013-2020 (Department of Health, 2013b) has also been criticised for insufficient consultation and communication (Marais & Petersen, 2015) which suggests that the lessons from the development of the Act have not been incorporated into more recent policy development processes.

Consultation is a crucial step in policy development and implementation in order to elicit inputs (Draper et al., 2009; Lund. et al., 2008; Mthethwa, 2012) and ideas from stakeholders, to build alliances and to ensure buy-in by the implementers (Burke et al., 2012; Grindle & Thomas, 1991; Klein & Knight, 2005; WHO, 2003b).

Hogwood and Gunn's pre-condition 9 suggests that imperfect communication and coordination among key stakeholders are critical barriers to the implementation process (Gunn, 1978; Hogwood & Gunn, 1997), which was found in this study. Lipsky also indicated that inadequate involvement of street-level bureaucrats in policy development processes may result in conflicting perspectives that differ from others, which, in turn, will deter the implementation of the policy (Lipsky, 2010). The resistance from general health care practitioners to embrace the Act is an illustration of this theory.

Studies in Brazil, Chile and Cuba found that optimal consultation with key stakeholders, including policy-makers, implementers, general health care providers and mental health practitioners facilitated mental health policy development and implementation (Caldas de Almeida & Cohen, 2008). Similarly, the experience in Australia, Argentina, Brazil Spain, Italy and the United Kingdom, and in Zambia and Uganda showed the importance of wide-spread consultation (Saraceno et al., 2007).

5.3.5 Weak leadership, governance and management capacity

The 2000 World Health Report has underscored the importance of stewardship and governance as the most important building block of the health system (WHO, 2000). Numerous scholars have pointed to the importance of effective leadership, governance and management in order to reduce the gap between policy and implementation (Mthethwa, 2012; Rispel & Moorman, 2010).

The study found that there was a disjuncture in the sequencing of coordination and support activities from the national Department of Health to provincial health departments in the implementation of the Act (pre-condition 9). A combination of weak leadership, suboptimal governance and inadequate management capacity at national, provincial and facility levels account for this disjuncture, and were exacerbated by the resignation of key officials at national level, and the junior level of many individuals tasked with the responsibility of managing the implementation process. Unsupportive hospital managers, many of whom did not understand the provisions of the Act, yet

were in powerful positions with regard to access to resources (pre-condition 3), added another barrier to implementation.

Studies in Latin American and the Caribbean have also found that limited leadership, governance and management capacity were major barriers to policy implementation (Caldas de Almeida, 2013). In contrast, studies in Brazil, Chile, India, Saudi Arabia and the United Kingdom found that effective leadership, governance and management capacity in mental health, facilitated implementation of mental health policies and legislation. In these countries, local and higher authority managers such as the mayors and district managers embraced mental health and were pivotal in the implementation of mental health policies and legislation (WHO, 2008).

5.3.6 Suboptimal planning and preparation for implementation

Another constraining factor found in this study was the suboptimal planning and preparation for implementation of the Act. Key informants complained about the unexpected promulgation of the Act. The promulgation of the Act was announced in the media on the 15th December 2004, which was during the festive period when many health professionals were on vacation. This resulted in limited preparation time for implementation of the Act. Many health professionals were not orientated on procedures introduced by the Act, such as the 72-hour assessments.

The absence of a national mental health policy and plan for a period of nine years after the Act was promulgated also created a vacuum. In the absence of the guiding framework, some provinces instituted their own mental health policies and plans, while others remained without mental health policies and plans. Hence, there were variations in interpretation of the Act's provisions, and the actual implementation. The variations in the implementation of the Act were also illustrated in other South African studies (Draper et al., 2009; Ramlall et al., 2010). The theories of Hogwood and Gunn (1997) and Lipsky (2010) highlight the barriers created by the lack of a clear sequence of activities to clarify the policy objectives and responsibilities to the implementing agencies. The absence of a national mental health policy nine years after promulgation

of the Act also compromised the communication and coordination processes recommended by Hogwood and Gunn in pre-condition 9 of their framework (Gunn, 1978; Hogwood & Gunn, 1997).

The WHO has recommended that explicit mental health policies and an implementation plan are essential and powerful tools to improve implementation of the mental health legislation, which will enable improvement in mental health services and the well-being of the population (WHO, 2008). Caldas de Almeida and Cohen (2008) have also emphasised the importance of a national mental health policy and implementation plan to clarify key priorities, strategies with timeframes, indicators, targets and major activities, which determine the required resources.

Despite the documented importance of mental health policies and plans in the implementation of mental health legislation, not all countries have them in place. The WHO reported that by 2014, the implementation of mental health legislation in 32% of WHO Member States was impacted by the lack of mental health policies or plans (WHO, 2014a). The latter was also found in Argentina (Caldas de Almeida & Cohen, 2008), Pakistan (Karim et al., 2004) and most countries in the African region (Hanlon, Wondimagegn, & Alem, 2010).

A different situation was found in Cuba, Chile, Brazil and Jamaica which had mental health policies and detailed plans. This facilitated the implementation of mental health legislation in these countries because specific strategic interventions such as training, programmes, resource needs and preparation of facilities were clearly outlined (Caldas de Almeida & Cohen, 2008).

5.3.7 Inappropriate organisation of mental health services

The inappropriate organisation of mental health services was a further constraint to the successful implementation of the Act. This was because at the time of the promulgation of the Act mental health services were (and they remain) largely hospital based, with limited and under-developed community-based mental health services (Lund. et al.,

2008). This was exacerbated by many of the other constraints highlighted above. Other studies in South Africa have found that the legacy of apartheid on mental health services and a hospital-centric approach to care largely remained the same, with big psychiatric hospitals and limited community-based mental health services (Lund, Breen, et al., 2008; Ramlall, 2012), and this influenced and hindered implementation of the Act (Couper et al., 2006; Lund. et al., 2008; Marais & Petersen, 2015).

A further hindrance was that district hospitals were not adequately prepared for the new Act. Key informants attributed this barrier to the absence of the national mental health policy and implementation plan after promulgation, rushed development processes of the Act which compromised consultation and plans in district hospitals, and the limited resources required for implementation. Key informants pointed out that mental health services prescribed by the Act in district hospitals were imposed because most of the hospitals did not have the mental health skills and capacity for implementation. The Act introduced a radical change in South Africa, where district hospitals, including primary health and community services, were turned into major platforms for mental health services (Ramlall et al., 2010). District hospitals were designated to conduct 72-hour assessments and some were designated to serve as psychiatric hospitals (Republic of South Africa, 2002) to ensure early screening for medical conditions that present with psychiatric symptoms. However, these hospitals were experiencing challenges due to suboptimal preparation for implementation of the Act (Burns, 2008).

Pre-condition 2 of Hogwood and Gunn suggests that adequate time and resources be made available for implementation of policies (Hogwood & Gunn, 1997). The study found that there was inadequate time to reorganise mental health services and prepare district hospitals, particularly with the resources and skills required for implementation of the Act. There was also inadequate training and professional development of general health care providers in district hospitals before the enactment of the Act. According to Lipsky's theory, inadequate information by health care providers on the policy objectives and procedures to be followed significantly impacts on policy implementation (Lipsky, 2010).

The problem of inadequate preparation of district hospitals for the new Act has also been reported in other South African studies (Lund. et al., 2008; Ramlall et al., 2010). In KwaZulu-Natal Province in South Africa, 27 district hospitals were designated for mental health services but there was no dedicated budget, or an increase in staff or facilities for implementation. Furthermore, 69.4% of the designated psychiatric hospitals were not supported to conduct 72-hour assessments while 44% were not trained on the provisions of the Act (Ramlall et al., 2010). The perception by generalists that the Act imposed mental health services in district hospitals was also found in another study in South Africa (Lund. et al., 2008). This was exacerbated by limited support of generalists by mental health specialists, lack of seclusion rooms to accommodate clinical demand, and challenges in managing disruptive patients in a general hospital setting. Furthermore, budget, human and infrastructure constraints in district hospitals impacted on the implementation of the Act and threatened the very rights that the Act sought to uphold (Moosa & Jeenah, 2008; Petersen et al., 2000).

Studies in Sri Lanka found that district hospitals were prepared and supported to render mental health services, which had a positive impact on the implementation of mental health policies and legislation (Jenkins, Baingana, et al., 2011). New mental health infrastructure in district hospitals was constructed and training and support for general health professionals by mental health specialists was also enhanced in district hospitals rendering mental health services (Jenkins, Baingana, et al., 2011).

The new Mental Health Care Act stipulated that mental health services must be integrated across all levels of the health system, including the community level, so that people could be treated closer to their families and thus be easily reintegrated into society (Republic of South Africa, 2002). This was in line with WHO guidelines that propose that the optimal mix of services is pyramidal with a few specialised psychiatric hospitals and more community-based mental health services (Sibanyoni & Maritz, 2016; WHO, 2007d). This is because the majority of mental health conditions can be self-managed or rendered in informal community mental health services such as community groups, religious organisations and schools. Also, a formalised network of mental health

services with additional expertise and support may be rendered at the community level (day care centres, residential supervised services, group homes and hospital diversion programmes) followed by primary health care and in general hospitals (WHO, 2003c). Furthermore, psychiatric inpatient services are costly and less frequently needed, compared to community care (Sibanyoni & Maritz, 2016).

Studies in Azerbaijan, Croatia, Hungary, Slovakia, Slovenia; Turkey (WHO, 2014a); Belgium (Nicaise et al., 2014) and Sudan (Ali & Agyapong, 2016) have reported similar challenges in the organisation of mental health services. In these countries, mental health care services were also rendered in specialised psychiatric hospitals with limited community-based mental health services, thus compromising access and hindering implementation of mental health policies and legislation. The implementation gaps are exacerbated by the difficulties of establishing community-based mental health services, notably resource constraints, stigma and discrimination and fragmented health services (Patel et al., 2013). In the South African context, the budgeting process for new services, lack of dedicated funding for mental health, difficulty of shifting funds from hospitals towards community services and limited political and managerial support (Couper et al., 2006; Marais & Petersen, 2015) also serve as impediments to the establishment of community-based services, and hence the effective implementation of the Act. An example is the recent tragic loss of 100 chronic psychiatric patients who were placed in unlicensed private non-governmental organisations (NGOs) in Gauteng Province (Makgoba, 2017) due to the lack of state-run community-based mental health facilities.

The problem of inappropriate mental health service organisation is not insurmountable, as was demonstrated in Cuba, Chile, Argentina, Belize and Brazil. In these countries, psychiatric hospitals were downsized while some were closed as more mental health services were rendered in district hospitals, primary health care and at community level (Caldas de Almeida, 2013; WHO/WONCA, 2008). These developments enabled the successful implementation of mental health legislation in these countries.

5.3.8 Insufficient financial resources

WHO has noted that adequate resources are critical to the reform of mental health care services and implementation of mental health policies and legislation (WHO/WONCA, 2008). Hogwood and Gunn's pre-conditions 2 and 3 underscore the need for adequate resources and for a combination of financial and human resources for successful policy implementation in (Hogwood & Gunn, 1997). Lipsky's theory also highlights the need for adequate resources to avoid the gap between policy and implementation (Lipsky, 2010).

The study found that the budget constraints, human resources limitations and inappropriate infrastructure for mental health hindered the implementation of the Act and the development of mental health services. According to key informants, this was partly because the promulgation of the Act was rushed, there was no national mental health plan, and there was no process to determine resource requirements for implementation. These resource constraints were exacerbated by mental health stigma and discrimination; and lack of knowledge on the importance of the new mental health legislation.

The experience in South Africa is not unique. Other studies have pointed to the impact of insufficient financial resources on implementation, because it is not possible to appoint sufficient numbers of mental health personnel or to revitalise infrastructure (Caldas de Almeida & Horvitz-Lennon, 2010). This, in turn, influences the quality of care delivered.

Some scholars have also suggested that, despite the fact that mental illness existed long before the scourges of leprosy, syphilis and herpes, and its socio-economic burden threatens to surpass the ravages of TB, HIV and AIDS, it has not enjoyed commensurate political and economic backing for adequate resource allocation (Burns, 2014; Lund et al., 2013). Furthermore, the resource inequities have been reported in many LMICs, which have more than 80% of the world's population but they have less than 20% of mental health resources (Hanlon et al., 2010; Saxena et al., 2007).

Resources for mental health in the African region remain disproportionately low compared to the burden of mental disorders, which are compounded by conflicts and natural disasters. However, some scholars have suggested that even when countries have resources available, the necessary financing, infrastructure and other resources are not allocated to mental health services, in part due to lack of awareness, as well as stigma, discrimination and insufficient prioritisation (Patel et al., 2013).

In consort with the findings of this research, insufficient funding for mental health has been reported worldwide despite the recognition of mental health as a serious public health and development issue (Caldas de Almeida, 2013; Demyttenaere et al., 2004; Jacobs et al., 2007; McIntyre & Gilson, 2005). A review found that there was no dedicated mental health budget in 32% of the 191 countries and a minimal budget allocation for mental health in other countries (Saxena et al., 2007).

In South Africa, the 2008 Mental Health and Poverty Project (MHaPP) report found that in theory, mental health was a national policy priority, but this priority had not translated into the commensurate budgets (Bateman, 2012; Mental Health and Poverty Project, 2008b; Ramlall et al., 2010). Other studies found that the mental health budget in KwaZulu-Natal province in South Africa was 0.03% of the health budget, and this low proportion has been fixed over the past 10 years since the Act was introduced (Ramlall et al., 2010). This is because of the traditional allocation of funds which is based on historical spending in mental health rather than the actual need (WHO/WONCA, 2008) and perceptions of insufficient gains from investment in mental health by donors and policy makers (Saraceno et al., 2007). Mental health is perceived as a charity programme with no return on investment, yet the cost-effectiveness varies for different mental disorders (McIntyre & Gilson, 2005).

Earlier research in the African region also reported severely underfunded mental health systems (Kigozi. et al., 2010; Ndyababangi et al., 2004), which relied heavily on donor funding (McIntyre & Gilson, 2005; Saxena et al., 2007). Prince pointed out the disproportionately low mental health budget in the African region and that mental health

vies for a place amongst other compelling public health priorities despite having demonstrated its importance in the attainment of Millennium Development Goals (Prince, Patel, Saxena, & et al, 2007). For instance, the budget allocation for mental health in Uganda was 1% of the health budget, which is not adequate for effective implementation of mental health policies and legislation (Kigozi. et al., 2010; Ndyabangi et al., 2004).

In Latin American and Caribbean countries, 1 to 5% of the health budget was allocated to mental health with 1% in Nepal and China (Niu, Luo, Liu, Silenzio, & Xiao, 2016; WHO, 2007a; Xu, Wang, Wimo, & Qiu, 2016), 2.35% in Brazil, 2.14% in Chile (Caldas de Almeida, 2013) and 2% in Mexico (Berenzon et al., 2013).

The WHO suggested that in LMICs, 0.5% of the median percentage of health expenditure should be dedicated to mental health and 5.1% in high income countries. However, this target has not been met in many of these countries (WHO, 2008). For example, 2% median health expenditure was reported in Bulgaria, 3.0% in Albania, 4.7% in the Federation of Bosnia and Herzegovina. A difference was found in Hungary where the median health expenditure dedicated to mental health was 5.1%, which is proposed by WHO for high income countries. Other high income countries had varying mental health expenditure. In England and Wales, the mental health expenditure was 13.8%; Germany 10.3% and Denmark 7.5% (WHO, 2008). Although England, Wales, Germany, Denmark and Australia reported high mental health expenditure, a large portion of the allocated funds were spend only in psychiatric hospitals, which demonstrates a hospital-centric approach to mental health services, that affected the implementation of mental health policies and legislation in these countries. The latter was found in Latin American and Caribbean countries where about 14 countries allocated 80% of the mental health budget to psychiatric hospitals (Caldas de Almeida, 2013).

5.3.9 Human resource limitations

Human resource challenges, especially role confusion, inadequate support from hospital managers, staff shortages and the gaps in the skills and competencies of staff, posed another major constraint to the policy implementation process.

The Act stipulates multidisciplinary teams of psychiatrists, medical officers, psychologists, occupational therapists, social workers and psychiatric nurses. However, the shortage of mental health human resources meant that the teams were incomplete in the majority of institutions leading to problems with non-compliance and poor implementation of the Act. Ward clerks were also found in this study to be inadequate in psychiatric hospitals, which contributed to delays in the coordination of psychiatric admission application documents to and from the MHRBs and the Courts within the legally set time frames, thus impacting on the implementation of the Act. This study finding suggests that Hogwood and Gunn's pre-condition 3 on an adequate combination of human resources for implementation was not met (Hogwood & Gunn, 1997).

Pre-condition 7 of the framework emphasises the impact of poor understanding of policy objectives and stakeholder tasks on the implementation process (Hogwood & Gunn, 1997). In this study, the existing mental health care providers were overwhelmed because of the new application forms for psychiatric admissions that were complicated and on which they had not been trained sufficiently. This led to an increased administrative workload, exacerbated by shortages of the forms. In practice, the forms were either incomplete or incorrectly completed. In specialised psychiatric hospitals, staff reported that they had to correct most psychiatric admission forms which were submitted from general hospitals, which further added to their workload. Psychiatric patients referred from private hospitals and the local mines were brought to the hospitals without the necessary forms, causing both delays in the admission process and adding to the workload of existing staff. This finding can also be explained by Lipsky's contention that human resource shortages and increased administrative work predispose and create stressful work conditions for providers at the front-line, which

influences implementation and the success in achieving the policy objectives (Lipsky, 2010).

In a study in KwaZulu-Natal Province, Ramlall et al., (2010) also found that mental health personnel were not satisfied with the substantial administrative load from the forms and the strictly defined time-frames for completion and submission of the application forms, which was found confusing and frustrating.

In Uganda (Kigozi. et al., 2010; Ndyabangi et al., 2004); Mozambique (Tanikwanchi, Ozden, & Vermund, 2013); Kenya (Lund. et al., 2008); Tanzania (de Jong, 1996); Ghana (BasicNeeds, 2009) and Guinea-Bissau (de Jong, 1996; Lund, Breen, et al., 2008), studies have found limited mental health human resources, exacerbated by the 'brain drain' of mental health professionals. In South Africa, the shortage of human resources influenced service provision and implementation of the Act (Burns, 2011; Ramlall et al., 2010). KwaZulu-Natal Province had 75% shortage of psychiatrists and medical and nursing staff was insufficient in 70% of psychiatric hospitals (Ramlall et al., 2010). Other factors that influence the shortage of human resources include the lack of incentives for skilled and experienced professionals; high staff turnover; limited training and production of mental health professionals; insufficient mental health funding; stigma and discrimination (Lee, Freeman, & Vivian, 1999; Petersen et al., 2008; Tanikwanchi et al., 2013; Van Deventer, Couper, Wright, Tumbo, & Kyeyune, 2008).

The shortfall of mental health human resources had been found in Greece, Australia (Hickie, McGorry, Davenport, & Luscombe, 2005), Pakistan (Karim et al., 2004); Sudan (Ali & Agyapong, 2016); New Zealand and the Caribbean countries such as Barbados, Saint Lucia, Trinidad and Tobago (Caldas de Almeida, 2013), which affected the implementation of mental health policies and legislation.

5.3.10 Infrastructure challenges

Hogwood and Gunn suggested that the required combination of resources is imperative for "perfect" policy implementation (Hogwood & Gunn, 1997). Lipsky's theory highlights

the problems of constrained work environments on the decision of health professionals whether to implement the policy (in this case the Act) or deviate from the policy objectives (Lipsky, 2010).

Despite the importance of appropriate infrastructure, key informants reported many limitations, which included the lack of mental health infrastructure standards; dilapidated and uninhabitable buildings; poor hospital maintenance and suboptimal project management in the construction of new psychiatric hospitals, and all these influenced the implementation of the Act.

Key informants pointed out that the majority of psychiatric hospitals were inherited from old leprosy hospitals and/or old prison facilities and were inappropriate as they were old, dilapidated and unsuitable for the needs of mentally-ill patients. Key informants complained about the lack of mental health infrastructure standards. This gap resulted in inappropriate design and layout of newly constructed psychiatric hospitals as the current mental health infrastructure standards were gazetted by the Minister of Health for implementation only in 2013. The design of mental health wards in general hospitals that were rendering mental health were also not fit for purpose.

Other South African studies (Ramlall, 2012) also reported infrastructure challenges, characterised by overcrowding, old and dilapidated buildings and lack of suitable facilities in general hospitals. In KwaZulu-Natal Province for instance, mental health infrastructure was inadequate in more than 60% of designated psychiatric hospitals with only 25% of acute mental health care beds available. Furthermore, only 27.8% of general hospitals in the province had dedicated psychiatric units and psychiatric services in about 41.7% of the hospitals were rendered in medical and surgical wards (Ramlall, 2012). The problems regarding mental health infrastructure resulted in the management of potentially dangerous patients in suboptimal clinical environments, which further compromised the ability to honour the standards and values enshrined in the Act and the successful implementation of the Act (Burns, 2011). The challenges have been attributed to limited mental health budgets; lack of coordinated planning

between sectors such as the Department of Public Works, Treasury and Health (Marais & Petersen, 2015); poor preparations in district hospitals to implement the Act (Burns, 2011; Ramlall, 2012; van Rensburg, 2011).

The limitations in mental health infrastructure have been also found in England and Wales, which together with insufficient staffing levels subjected personnel and patients to an unsafe instead of a therapeutic environment, thus constraining implementation of mental health policies and legislation (Swann, 2011).

5.3.11 Suboptimal functioning of Mental Health Review Boards

The majority of Mental Health Review Boards (MHRBs) in provinces were not functioning optimally despite being established as quasi-judicial authorities to uphold the rights of people with mental disorders (Mental Health Review Board Orientation Guideline and Training Manual, 2007). The main challenges found in this study were weak leadership and suboptimal execution of operational procedures and oversight functions. The study key informants were of the opinion that the suboptimal functioning of MHRBs affected their ability to protect the human rights of psychiatric patients.

The poor functioning of the MHRBs could be explained by unclear reporting and communication channels, the variation in the number of designated psychiatric hospitals among provinces, the limited power in the Act to punish or discipline officials for non-compliance, limited support by MECs and the lack of a focal structure at the national office to oversee and coordinate the functioning of the Boards. The poor functioning of the MHRBs illustrates the inability to meet pre-condition 10 of Hogwood and Gunn's framework that emphasises the need for monitoring of the implementation process and the ability of those in authority to secure compliance with the legislative and policy mandates during the implementation process (Hogwood & Gunn, 1997). Lipsky's theory highlighted the problems when there is a shift in the locus of control downwards and transfer of responsibility to lower-level officials (Lipsky, 2010). In this study, the majority of MECs transferred their responsibility for the MHRBs to provincial mental health directorates, thus creating barriers to the implementation of the Act.

Key informants pointed out the lack of strategic plans for the majority of MHRBs, which resulted in poor planning, capacity building and resourcing, as another exacerbating factor to the implementation of the Act, illustrating that pre-condition 7 of Hogwood and Gunn's (agreement of, and among stakeholders on the policy objectives and intention) was not met, and hence hampered the successful implementation of the Act (Hogwood & Gunn, 1997). The majority of the MHRBs did not have appropriate offices, lacked computers, photocopiers, fax machines, telephones and other essential equipment and material and were not adequately trained and orientated on their roles and responsibilities.

The execution of the oversight functions of MHRBs such as handling appeals, processing periodical reports for mentally ill prisoners and obtaining High Court authorisations for psychiatric admissions fell through the cracks. The majority of involuntary psychiatric admissions were illegal as the submission of the documents to the High Court was not complied with. The compounding factors were the distances between the hospitals, the Boards and the High Court; the lack of dedicated ward clerks in other hospitals to coordinate the flow of documents and the lack of High Courts in some provinces.

These findings illustrate that several other pre-conditions were also not met, notably 2 (time and resources); 3 (combination of resources); 9 (communication and coordination), and 10 (complete compliance) (Hogwood & Gunn, 1997).

The suboptimal functioning of the MHRBs was also found in other South African studies (Burns, 2011; Ramlall, 2012; van Rensburg, 2011) due to a combination of resource constraints (budgets, infrastructure, material and equipment), poor coordination and administrative support and lastly poor document tracking systems, including records management (Ramlall et al., 2010).

A study conducted in KwaZulu-Natal Province found that the functioning of the MHRBs ranged from being non-functional to dysfunctional, with fractious relations between

board members and health professionals (Ramlall, 2012). The relations were described as “dismissive and obstructive of clinicians” and clinicians reported that the MHRBs were not addressing practical issues, not helpful, difficult to communicate with and lacked the power to contribute meaningfully to the transformation of the neglected mental health services, particularly on issues related to limited mental health infrastructure, human resources and budgets (Ramlall, 2012). The latter was also reported in Gauteng Province (Moosa & Jeenah, 2010). Ramlall also found that 44% of the hospitals in KwaZulu-Natal Province did not submit the application documents to the MHRBs for approval and for further processing to the High Court and that 80% of the hospitals were not visited by the Boards in a six month period (Ramlall, 2012; Ramlall et al., 2010).

Ramsay and colleagues also found that the functioning of the MHRBs were suboptimal in Ireland, which impacted on mental health policy implementation Ramsay, et al., (2012). This was mainly due to resource limitations and fractious relationships with clinicians, which impacted significantly on their working relationship and the ultimate quality of service rendered (Ramsay, et al., 2012).

5.3.12 Poor monitoring of compliance

Precondition 10 of Hogwood and Gunn recommended focusing on the ability of those in authority to demand and obtain “perfect compliance” with the policy objectives, through *inter alia*, monitoring of implementation (Hogwood & Gunn, 1997). In this study, key informants reported that systems to monitor compliance with the Act were poor, especially by the national department. Consequently, in this study, it was evident that there was no system or tool in the Department of Health to monitor the implementation of the Act.

Scholars in the field of policy implementation (Awenva et al., 2010; Bakari & Frumence, 2013) have argued that any implementation process must be closely monitored for compliance in order to facilitate early intervention on the identified bottlenecks in the system. Mthethwa also emphasised the importance of gathering information regularly,

dissemination and feedback to assess progress toward achieving results in the implementation process (Mthethwa, 2012). This is because policy implementation is multidimensional and unpredictable and therefore monitoring and evaluation systems and indicators should be built in to measure performance, achievements and the quality of system barriers (Bhuyan et al., 2010). WHO has also suggested that there must be frequent monitoring and evaluation of the implementation plans so as to re-plan the time frames and determine resources required to address the identified loopholes (Freeman et al., 2005). This will alert decision makers and programme managers to implementation snags, intended and unintended consequences of the policy and legislation.

In South Africa, studies show post-democracy advisory committees were set up to monitor the mental health services and implementation of the policies and legislation, but they collapsed in most provinces. Because of the need for monitoring implementation of the Act, researchers recommended the revival of those advisory and multi-sectoral coordinating bodies in order to develop monitoring tools for the Act (Burns, 2011; Lund. et al., 2008; Ramlall, 2012; Ramlall et al., 2010).

Research studies on monitoring and evaluation in policy implementation in Australia found that after 12 years of mental health reform in that country, major service gaps and poor experiences of care remained unchanged mainly due to lack of reporting and monitoring systems (Hickie et al., 2005; Westbrook, 2011). This was not the case in Latin America and the Caribbean countries, where mechanisms were introduced to monitor the implementation of policies and legislation and compliance with human rights in mental health settings (Caldas de Almeida, 2013). This monitoring system improved the implementation process through early identification of system barriers and early intervention on the constraints.

5.3.13 Unintended negative consequences of the Act

This study found that the implementation was also hindered by unintended negative consequences of the Act that emanated from the decentralisation of mental health and the requirement to conducting of 72-hour assessments in district hospitals.

One of the goals of the Act was to improve access of mental health services and to exclude underlying medical conditions that manifested with psychiatric symptoms for early intervention during the 72-hour assessment. However serious negative consequences occurred during the process. These were mainly due to infrastructure challenges in district hospitals, where 72-hour assessments were conducted in general medical wards and psychiatric patients were mixed with other patients. Key informants perceived the Act to be unrealistic in this instance as it was seen to be subjecting less experienced personnel in district hospitals in suboptimal environments to the potentially dangerous acutely ill psychiatric patients. Patients were then referred to specialists in psychiatric hospitals after being assessed by generalists in district hospitals. As a result, generalists became the first point of contact for seriously ill psychiatric patients, instead of specialist psychiatrists who are better skilled at managing aggressive and difficult patients. Key informants further pointed out the challenges in the transfer of the patient to the specialised hospitals, which were often delayed due to transport shortages and the lack of appropriate infrastructure in district hospitals to contain these patients in the meantime. Key informants reported some instances, where patients and staff were attacked and even killed unintentionally by acutely ill psychiatric patients, and this hindered the implementation of the Act.

Another unintended consequence of the Act reported in this study was on the integration of mental health services into general health services. Although key informants interviewed were supportive of integration, they were of the opinion that integration resulted in suboptimal quality of mental health care services as psychiatric patients did not have access to specialist care by a dedicated mental health professional at primary health care level and the discontinuation of follow-up services at home, which affected compliance to treatment in a negative manner. Other studies have

found that the unintended consequences emanating from implementation of policies and legislation are not unique to South Africa. In Victoria, Australia, following the implementation of the community-based mental health policy, two incidents of murder of community members by psychiatric patients occurred, which shifted the focus from the importance of community-based mental health services to the danger of such services, and constrained the implementation of mental health policy (Caldas de Almeida & Horvitz-Lennon, 2010).

The following chapter presents the findings from the record review.

CHAPTER 6 : FINDINGS FROM THE RECORD REVIEW

6.1 Introduction

This chapter presents the findings from the hospital record review of 80 patients who were classified as involuntary admissions to public sector psychiatric hospitals. The data are presented and analysed under the following headings: socio-demographic characteristics of patients; diagnoses; length of stay; and procedures followed during involuntary psychiatric admissions.

6.2 Socio-demographic characteristics of patients

The socio-demographic characteristics of patients are shown in Table 6.1. The majority of involuntary admissions were male (62.5%), black African (80%) and unemployed (85%). The mean age of patients was 33 years (SD=11.5). The mean age of female patients was 38 years (SD= 11.9), ranging from 17 years to 66 years. For males, the mean age was 30 years (SD=10.3) with a minimum of 16 years and maximum of 55 years.

Table 6.1: Socio-demographic characteristics of patients

Indicator	Characteristics	Number	%
Gender	Female	30	37.5%
	Male	50	62.5%
Occupation	Employed	6	7.5%
	Unemployed	68	85.0%
	Pensioner	1	1.3%
	Student	5	6.3%
Age	<25 years	21	26.3%
	25-34 years	23	28.8%
	35-44 years	23	28.8%
	45-54 years	9	11.3%
	55+ years	3	3.8%
	Unknown	1	1.3%
Marital Status	Never married/Single	75	93.8%
	Married/living together	3	3.8%
	Widowed	2	2.5%
“Race”	Black African	63	78.8%
	White	6	7.5%
	Coloured	11	13.8%

6.3 Medical diagnoses

Table 6.2 shows the primary and secondary patients' diagnoses. There were variations in the primary diagnosis of patients, including schizophrenia (41.3%), substance-induced psychosis (20.0%) and bipolar mood disorders (18.8%). Major depressive disorders, organic mood disorders and HIV-related psychosis constituted only 1.3%.

The majority of patients (76.7%) did not have a secondary diagnosis recorded. Substance abuse was the highest secondary diagnosis at 10.0%, followed by HIV (6.3%), bipolar mood disorders (2.5%) and 1.3% epilepsy. The HIV status was recorded only in five (6.3%) out of 80 patient Record Reviewed. Only one out of the five patients was reportedly on anti-retroviral treatment.

Table 6.2: Recorded diagnoses of patients

Indicator	Diagnosis	Number	%
Primary Diagnosis	Schizophrenia	33	41.3
	Substance-induced psychosis	16	20.0%
	Bipolar mood disorder	15	18.8%
	Acute Psychosis	9	11.3%
	Post Partum Psychosis	2	2.5%
	Schizo-affective disorder	2	2.5%
	Organic Mood Disorder	1	1.3%
	HIV-related psychosis	1	1.3%
	Major depressive disorder	1	1.3%
Secondary Diagnosis	Nil recorded	61	76.3%
	Substance abuse	8	10.0%
	HIV & AIDS	5	6.3%
	Schizophrenia	3	3.8%
	Bipolar mood disorder	2	2.5%
	Epilepsy	1	1.3%
HIV Status Recorded	Yes	5	6.3%
	No	75	93.8%

The mean age of patients with schizophrenia was 35 years (SD=11.5), substance-induced psychosis 37 years (SD=13.4) and bipolar mood disorders 25 years (SD=7.9).

6.4 Length of stay in psychiatric hospitals

Table 6.3 shows the length of stay in psychiatric hospitals. Overall, the length of stay in psychiatric hospitals varied markedly, ranging from 1 day to 199 days. The mean length of stay in psychiatric hospitals was 54.24 days (SD= 47.57). For females the mean length of stay was 46.9 days (SD=31.6), and males 58.6 days (SD= 54.8).

Table 6.3: Length of stay in psychiatric hospitals

Length of stay	Number of patient records	%
1-9 days	12	15.0%
10-29 days	17	21.3%
30-59 days	26	32.5%
60-89 days	9	11.3%
90-139 days	9	11.3%
140-169 days	4	5.0%
170-199 days	3	3.8%

The mean length of stay in rural psychiatric hospitals was 45.6 (SD=44.12), with a wide range of 3 to 177 days. In urban psychiatric hospitals the mean length of stay was 80.15 (SD= 49.18), with a range of 13 to 188 days.

6.5 Procedures followed during involuntary psychiatric admissions

Table 6.4 shows the compliance with the application procedures for involuntary admissions in psychiatric hospitals.

Table 6.4: Compliance with application procedures for involuntary admissions

Indicator	Yes (n, %)	No (n, %)	Comments
Applications made using Form 4 (application form prescribed by the Act)	75 (93.8%)	2 (2.5%)	Court order =3 (3.7%) Form 4 not necessary as the involuntary admission is ordered by the Court
Applications made under Oath	51 (63.8%)	24 (30.0%)	Court order =3 (3.7%) Missing data=2 (2.5%)
Patient seen by applicant within 7 days prior to application	51 (63.8%)	6 (7.5%)	Court order =3 (3.7%) Missing data=2 (2.5%) Health care provider applications=18 (23.0%)
Reasons for involuntary admission recorded	75 (93.8%)	-	Court order =3 (3.7%) Missing data=2 (2.5%)

The record review found that the majority of applications (93.8%) were made on Form 4, an application form prescribed in the Act for involuntary psychiatric admission. The majority of specialised psychiatric hospitals (95%) and 87.5% of psychiatric units attached to general hospitals utilised Form 4 to apply for involuntary psychiatric admissions. There was no statistically significant difference between the use of Form 4 and the type of hospital i.e. specialised psychiatric hospitals and psychiatric units attached to general hospitals ($p=0.432$). There was also no statistically significant difference between the use of Form 4 and the geographical location of the psychiatric hospitals ($p= 0.358$). In terms of the Act, when the involuntary psychiatric admission was mandated by the Court, the application process does not apply. The patient gets admitted directly from the detention centre to a psychiatric hospital. In this study, 3.7% involuntary psychiatric admissions were ordered by the Court.

Table 6.5: The use of Form 4 in psychiatric hospitals in provinces

Indicator	Yes	No	Total
Province			
Eastern Cape	6 (60%)	4 (40%)	10 (100%)
Free State	10 (100%)	-	10 (100%)
Gauteng	8 (80%)	2 (20%)	10 (100%)
KwaZulu-Natal	10 (100%)	-	10 (100%)
Limpopo	9 (90%)	1 (10.0%)	10 (100%)
Mpumalanga	5 (100%)	-	5 (100%)
Northern Cape	5 (100%)	-	5 (100%)
North West	10 (100%)	-	10 (100%)

Western Cape	10 (100%)	-	10 (100%)
Total	73 (91, 25%)	7 (8, 75%)	80 (100%)

Table 6.5 show that Gauteng, Eastern Cape and Limpopo provinces were less compliant with the use of Form 4, and this difference was statistically significant ($p=0.021$). The applicants for involuntary admissions were: parents (36.3%); next of kin (26.3%); and health care providers (23.0%). The remainder were brought by guardians (2.5%), police (1.3%), security (1.3), the neighbour (1.3%) or the spouse (1.3%).

In those instances where the health care provider was the applicant, the reasons were stated in 17 of 18 cases (94.4%), but the steps to locate the relatives were recorded only in six out of 18 files (33.3%).

More than half of applications (63.8%) were made under oath: 65% in specialised psychiatric hospitals and 62% in psychiatric units attached to general hospitals. There was no statistically significant difference between the applications that were made under oath and the type of hospital ($p= 0.076$). In rural hospitals, 55% of applications were made under oath, compared to 8.75 % in urban hospitals. This difference was statistically significant ($p= 0.000$).

6.6 Health professional's assessment reports

Table 6.6 shows the categories of health professionals who conducted the general physical assessments.

Table 6.6: Categories of health professionals who conducted the assessments

Category	N (%)	Comment
Medical Officer	29 (36.3%)	Missing data 6 (7.5%)
Professional Nurse	18 (22.5%)	
Registrar (Dr in training)	10 (12.5%)	
Medical Intern	7 (8.8%)	
Community Service Medical Officer	4(5.0%)	
Psychiatrist	3(3.8%)	
Clinical Psychologist	2(2.5%)	
Community Service Nurse	1(1.3%)	

In the majority of cases, 73/80 (91.2%), there were two assessment reports by each health professional, as prescribed in the Act. Eleven (13.8%) of the reports were identical, seven in rural psychiatric hospitals and four in urban hospitals, with the same terminology and errors.

Only 53/80 (66.3%) of records showed that the patients underwent the mandatory 72-hour assessments, with 28/53 (52.8%) of these assessments conducted in specialised psychiatric hospitals and 25/53 (47.2%) in psychiatric units attached to general hospitals. Most of the 72-hour assessments were conducted in rural psychiatric hospitals (55%) while only 17% were done in urban hospitals. There was no statistically significant difference between 72-hour assessments conducted and the type of psychiatric hospitals ($p=0.230$) or the location of the psychiatric hospital ($p=0.141$).

6.7 Legal authorisation of the involuntary psychiatric admissions

Written notices by the heads of the health establishments to the applicants on the outcome of the applications for involuntary psychiatric admissions were recorded in 67/80 (83.8%) of the files. Of these written notices, 33 (49.3%) were in specialised psychiatric hospitals and 34 (50.7%) in general hospital psychiatric units. This difference was not statistically significant ($p=1.000$). In terms of geographical location, 52 (77.6%) were found in rural psychiatric hospitals and 15 (22.4%) in urban hospitals. This difference was not statistically significant ($p=0.299$).

Table 6.7 shows the authorisation of involuntary admissions in psychiatric hospitals by the Mental Health Review Boards (MHRBs) and the High Courts.

Table 6.7: Authorisation of involuntary psychiatric admissions

Indicator	Yes (n, %)	No (n, %)	Other
Form 8: Submission of applications to the MHRBs	33 (41.3%)	44 (55.0%)	Court Order= 3 (3.8%)
Form14: Approval of the involuntary admissions by the MHRB	21 (63.6%)	9(27.3%)	Court Order= 3 (3.8%)
Form16: Authorisation of involuntary admissions by the High Court	14 (17.5%)	63 (78.8%)	Court Order= 3 (3.8%)

As can be seen from Table 6.7, compliance with the submission of applications to the MHRBs was less than 50%. The majority of the 33 applications submitted (25/33=75.8%) were from specialised psychiatric hospitals and the remainder (8/33=24.2%) from psychiatric units attached to general hospitals. This difference was statistically significant ($p=0.000$). In terms of geographic location, 27/33 (81.8%) of rural psychiatric hospitals compared to 6/33 (18.2%) of urban hospitals submitted the applications to the MHRBs for approval, but the difference was not statistically significant ($p=0.583$).

The majority of the applications submitted to the MHRB (26/33=78.8%) were within seven days as stipulated in the Act. Of these, 22/26 (84.6%) were from specialised psychiatric hospitals and four (15.4%) from psychiatric units attached to general hospitals. This difference was statistically significant ($p=0.000$). In terms of the geographical location, 23/26 (88.5%) of rural hospitals compared to three (11.5%) urban psychiatric hospitals submitted the documents to the MHRB within the stipulated time frame however, this difference was not statistically significant ($p=0.060$).

In terms of approval of the applications for involuntary psychiatric admissions, 21/33 (63.6%) were approved by the MHRBs: 17/21 (81%) in specialised psychiatric hospitals and four (19%) in psychiatric units attached to general hospitals. This difference was statistically significant ($p=0.000$). Regarding the geographical location of psychiatric hospitals, 20/21 (95.2%) of applications that were approved by the MHRBs were in rural hospitals and one (4.8%) in an urban hospital. Relating to MHRB approvals in

provinces, all applications in Northern Cape Province were approved by the MHRB as required in the Act but none in KwaZulu-Natal, Limpopo or Mpumalanga Provinces were approved by the MHRBs. In other provinces, the number of applications for involuntary admissions that were approved by the MHRBs differed: North West (60%), Free State (50%), Western Cape (20%), Gauteng (20%) and Eastern Cape (10%). The difference among provinces was statistically significant ($p=0.000$).

Only 12/21 (57.1%) of the MHRBs approvals were issued within the stipulated time frame and all were to specialised psychiatric hospitals and none to psychiatric units attached to general hospitals. In terms of geographical location, 11/12 (91.7%) of these 12 approvals were issued to rural psychiatric hospitals and only one to urban hospitals. Regarding differences in provinces, all MHRB approvals in KwaZulu-Natal, Limpopo, Mpumalanga and North West provinces were issued after the stipulated time frame. Only 40% of MHRBs approvals were within the stipulated time frame in Free State and Northern Cape provinces, 20% in Western Cape and 10% in Eastern Cape and Gauteng provinces. This difference was statistically significant ($p= 0.000$).

The review found that the majority of involuntary psychiatric admissions (63/80 =78.8%) were not authorised by the High Court. The 14/80 or 17.5% authorised admissions were all in specialised psychiatric hospitals, and this difference was statistically significant ($p=0.000$). In terms of geographical location, 13/14 (92.9%) of admissions in rural psychiatric hospitals were authorised by the High Court and only one admission in an urban psychiatric hospital. Regarding differences in provinces, the number of involuntary admissions authorised by the High Court varied. In the Northern Cape Province, all involuntary admissions Reviewed in this study had the High Court authorisations, but none in KwaZulu-Natal, Gauteng and North West provinces. In Free State province, 50% of involuntary admissions were authorised, 40% in Eastern Cape, 30% in Western Cape and 10% in Limpopo provinces.

6.8 Care of property of patients

Of the 80 involuntary psychiatric admissions, financial interest was indicated in all applications. However, there were no applications made to the Master of the High Court requesting the appointment of an administrator to care for the property and finances of patients admitted.

6.9 Change of involuntary status on discharge

The review found that the majority of the discharge forms (76/80 or 95%) did not indicate a change in the involuntary status of patients: 40/76 (52.6%) were in specialised psychiatric hospitals and 36/76 (47.4%) in psychiatric units attached to general hospitals. Regarding the geographical location of psychiatric hospitals, 56/76 (73.7%) were in rural psychiatric hospitals and 20/76 (26.3%) in urban psychiatric hospitals.

6.10 Appeals against involuntary psychiatric admissions

The majority of files (78/80 = 97.5%) did not indicate whether appeals were lodged against involuntary psychiatric admissions. Only two (2.5%) appeals were lodged and these were in specialised psychiatric hospitals located in rural areas.

6.11 Conclusion

This chapter presented the findings from the review of records of 80 patients who were classified as involuntary admissions in psychiatric hospitals. The next section presents the discussion of findings from the records reviewed.

CHAPTER 7 : DISCUSSION OF FINDINGS FROM RECORD REVIEW

7.1 Introduction

A sub-component of this study examined the compliance of psychiatric hospitals with the procedures for involuntary psychiatric admissions as prescribed in the Mental Health Care Act. Worldwide, involuntary admissions are controversial, as there is the potential for violation of the human rights of the individuals. At the same time, involuntary admissions may be required in order to reduce potential harm to individuals with severe mental illness (Feiring & Ugstad, 2014).

The study found that the Mental Health Care Act has improved the overall approach to treatment and care of psychiatric patients admitted involuntarily because of its human rights orientation. However, compliance with the prescribed procedures for involuntary admissions in the selected psychiatric hospitals was poor, particularly in the following areas: legal authorisation of involuntary admissions; oversight and review function of the Mental Health Review Boards (MHRBs); the assessments of psychiatric patients and the quality of the reports submitted.

In this chapter, these findings are discussed in light of the study's theoretical underpinnings (Hogwood & Gunn, 1997; Lipsky, 2010) and conceptual framework, the study objectives, and the existing literature.

7.2 Diagnoses of patients admitted involuntarily

The record review found that the majority of patients were diagnosed with schizophrenia (33/80), substance induced psychosis (16/80), bipolar mood disorders (15/80), and acute psychosis (9/80). Notwithstanding differences in methodology, other research studies in China (Zhou et al., 2014); Australia (Australian Institute of Health and Welfare, 2013); Israel (Khawaled et al., 2009; Rosca et al., 2007); Germany (Riecher-Rossler & Rossler, 1993); Belgium, France and Netherlands (Salize, DreBing, & Peitz, 2002) and Canada (Bernado & Forchuk, 2001) have found that the primary diagnosis of patients admitted involuntarily was schizophrenia. In Ireland, depressive disorders and

schizophrenia together accounted for the majority of involuntary psychiatric admissions (Daly & Wash, 2011).

In South Africa, a 1994 study found that schizophrenia followed by mood disorders were the leading diagnoses for the majority of involuntary psychiatric patients admitted at the Free State Psychiatric Complex (Freeman, Tennyson, & Vivian, 1994). A 2006 study at Weskoppies Hospital in Gauteng Province also reported that the primary diagnoses of involuntary psychiatric patients were schizophrenia, bipolar mood disorder and substance-related psychotic disorders (Mabena., 2010). Similarly, in West End Hospital in the Northern Cape Province, schizophrenia was found to be the leading primary diagnosis that led to involuntary psychiatric admissions (Habib., van Rooyen, & Hiemstra, 2007). The 2007 South African Stress and Health (SASH) survey found that the most common diagnoses were schizophrenia followed by bipolar mood disorder, anxiety disorders and substance abuse disorder (Herman et al., 2009).

The majority of patient files reviewed did not have a secondary diagnosis recorded and only five of the 80 files had recorded the HIV diagnosis. This is despite the existing evidence of the high co-morbidity of mental illness and HIV (Joska et al., 2014; Palitza, 2009; Petersen et al., 2013).

7.3 Length of stay in psychiatric hospitals

From the records reviewed in this study, the average length of stay (ALOS) in psychiatric hospitals was 54.24 days (range 1-199 days). There were differences by geographical area, with an ALOS of 80.15 days in urban hospitals, compared to 45.6 days in rural hospitals. The ALOS in this study was lower than that of 330 days in Japan (Ima, Hosomi, Nakao, Tsukino, Katoh, Itoh & Yoshida, 2005); 122 days in Central America, Mexico and Latin Caribbean, 92 days in South America (Australian Institute of Health and Welfare, 2013); 65.7 days in China (Zhou et al., 2014), but higher than the average length of stay of 26 days in Ireland; 11.7 days in the Northern Territory of Australia and of 18.5 days in Western Australia (Australian Institute of Health and Welfare, 2013).

7.4 Compliance with prescribed procedures

This was one of the few empirical studies that focused on compliance of psychiatric hospitals with procedures for involuntary psychiatric admissions in South Africa. The results are discussed as follows: (1) legal authorisation; (2) oversight and review function of the Mental Health Review Boards (3) assessment procedures for involuntary psychiatric admissions and (4) care of property and finances during the involuntary psychiatric admission.

7.4.1 Legal authorisation of involuntary admissions

The use of Form 4

From the Record Reviewed in this study, 93.8% of applications for involuntary psychiatric admissions were made using Form 4. Although this finding shows relatively good compliance with the use of Form 4, psychiatric units attached to general hospitals used the form in more than half of their applications (6 of the 8 selected psychiatric units attached to general hospitals). This may reflect a challenge experienced by general hospitals with implementing the Mental Health Care Act and with compliance with the stipulated application procedures for involuntary psychiatric admissions, compared to psychiatric hospitals. The non-compliance with the use of Form 4 for applications for involuntary psychiatric admissions in these general hospitals could also be explained by Hogwood and Gunn's theoretical framework, especially pre-condition 2, which states that resources and training are essential for effective policy implementation (Hogwood & Gunn, 1997). Furthermore, Lipsky's assumption that a resource-constrained environment, including lack of knowledge, shapes the way street-level bureaucrats adapt and implement government policies (Lipsky, 2010), may also explain the study finding.

Nonetheless, other studies in South Africa have also highlighted the difficulties faced by the psychiatric units attached to general hospitals in implementing the Mental Health Care Act, notably human resources constraints (Bateman, 2012; van Rensburg, 2011); infrastructure challenges (Ramlall, 2012; Ramlall, et al., 2010; Moosa & Jeenah, 2010); inadequate planning in district hospitals (Burns, 2008) and lack of skills by clinicians

(Lund et al., 2007). Another South African study that examined compliance with section 40 of the Mental Health Care Act found poor compliance among health care providers at Chris Hani Baragwanath Hospital with completion of the prescribed forms compared to members of the South African Police Services (Jonsson, Moosa, & Jeenah, 2009).

In Ireland, the review of the implementation of the Mental Health Act of 2001 found that human resource constraints accounted for the majority of the problems experienced with the completion of the prescribed forms for involuntary psychiatric admissions in general hospitals (Ramsay & O'Donoghue, 2012).

The Applicants for Involuntary Psychiatric Admissions

Encouragingly, the study found 94% compliance with the prescription on the applicants for involuntary psychiatric admissions. In the majority of cases, parents (28) followed by the next of kin (21) and health care providers (19) were the applicants. Also, 82.5% of the applicants had seen the patient seven days prior to making the application. Although the 2007 WHO-AIMS report on the South African mental health system indicated poor involvement of family members in mental health (WHO, 2007), the study finding suggests active involvement of families in the applications for involuntary psychiatric admissions and that the applications were made by persons with sufficient knowledge of the patient. This has also been found in other studies which found a marked improvement in the involvement of families with the applications for involuntary psychiatric admissions (Jankovic et al., 2011; Mabena., 2010; Moosa & Jeenah, 2008, 2010).

Other country studies have found differences in compliance with the designated applicants for involuntary psychiatric admissions. In Ireland, compliance with the designated applicants was good and family members were the applicants in 61% of admissions (Ramsay & O'Donoghue, 2012), a finding similar to this study. On the other hand, non-compliance with the designated applicants was found in China, where applications for involuntary psychiatric admissions were made by community agencies, work colleagues and friends who were not legally authorised to do so. This non-

compliance with the prescribed applicants in China was due to the influential role of community agencies, work colleagues and friends in community rehabilitation programmes; the lack of knowledge of the prescripts of the mental health legislation and the resistance to change and the implementation of the law (Shao, Xie, & Zhigu, 2012).

Applications made by health care providers

In 22.5% of the cases, health care providers made the applications for involuntary psychiatric admissions. The reasons for the applications were recorded in the majority of files (94%), but the steps to locate the relatives of patients were recorded in only one third (33%) of the patient files. This finding suggests that health care providers may have placed less attention on involving family members and relatives in the patient rehabilitation programmes. Other studies have suggested that suboptimal contact between the patient and family may result in loss of contact and separation with the patient, increased burden on psychiatric hospitals from the long or revolving door patterns of frequent admissions, homelessness and at times, imprisonment of patients for criminal offences committed because of the nature of mental illness (Kruger & Lewis, 2011; Petersen, Baillie, Bhana, & Mental Health and Poverty Project, 2012; WHO, 2007d).

The behaviour of health care providers could be explained by Lipsky's theory that street-level bureaucrats often develop routines and simplifications on policy requirements to reduce the complexities and work stress and gain control over their environment (Lipsky, 2010).

Although the mental health legislation in France, Spain and Sweden also stipulates that family members must be informed upon application for involuntary psychiatric admission by a health care provider (Salize, et al., 2002), studies that focus on legislative compliance in these countries could not be found.

Applications under Oath

The study found 64% (51/80 files) compliance with the requirement to make applications for involuntary psychiatric admissions under oath. The majority of those applications (86.3%) were made in rural specialised psychiatric hospitals. The study sample was small and firm conclusions cannot be drawn. However, this finding suggests that health care providers from urban specialised psychiatric hospitals and units attached to general hospitals encountered challenges in accessing the Commissioners of Oaths for these involuntary psychiatric applications or that those in rural psychiatric hospitals appeared to follow procedure. This could be because a Commissioner of Oaths is only available in local police stations and post offices, who also deal with matters beyond the applications for involuntary psychiatric admissions. The potential access problems to a Commissioner of Oaths does not seem to have been taken into account in the planning and preparation for implementation, and this is an important pre-condition, as suggested by Hogwood and Gunn (Hogwood & Gunn, 1997). On the other hand, Lipsky's theory of "street-level bureaucrats" may also explain the behaviour and poor compliance with procedures of those health care providers in urban specialised psychiatric hospitals and units attached to general hospitals.

The inaccessibility of Commissioners of Oaths for involuntary admissions in psychiatric hospitals is not unique to South Africa. In Virginia in the United States, the Commissioner of Oath could only be accessed from the office of the circuit clerk, the courthouse; public libraries, country sheriff and local banks, and this resulted in non-compliance as well. In order to address this challenge in psychiatric hospitals, hospital personnel were appointed as Commissioners of Oaths for involuntary psychiatric applications (Caldas de Almeida, 2013).

Written notices by the Heads of Health Establishments on the outcomes of the applications for involuntary psychiatric admissions

In 83.8% of cases, written notices were issued by the heads of the health establishments to the applicants of involuntary psychiatric admissions. Although there

was relatively good compliance, the study found that 76% of these notices were issued in rural psychiatric hospitals, which implies less compliance by the chief executive officers (CEOs) of urban psychiatric hospitals. The reasons for the non-compliance are not clear but it could include insufficient awareness of responsibilities, lack of orientation to the policy objectives and activities to be undertaken (Hogwood & Gunn, 1997), workload or that the responsibility to issue the notices was not delegated in the absence of the CEO, as prescribed by the Mental Health Care Act.

Although the mental health legislation in France, Germany, United Kingdom and Spain also requires that written notices be issued on the outcome of the applications (Salize et al., 2002), similar studies on legislative compliance in these countries could not be found.

Authorisation by the High Court

The study found that there was only 18% compliance with the High Court authorisations of involuntary psychiatric applications. Of these, the majority were in rural specialised psychiatric hospitals (93%). There were differences in compliance among provinces, with all applications in Northern Cape Province authorised by the High Court and none in KwaZulu–Natal, Gauteng, Mpumalanga and North West provinces. In the Western Cape Province, there was no evidence of the High Court authorisations in some patient records.

Although the study sample was small, the findings suggest that the majority (82%) of involuntary psychiatric admissions during the review period were illegal. The non-compliance could be due to geographical distances between the outlying hospitals and the Mental Health Review Boards in some provinces, the lack of dedicated administrative officers to collate documents necessary for authorisation, poor reporting or insufficient planning, preparation, orientation and training of implementing agencies, according to Hogwood and Gunn's pre-condition for perfect implementation (Hogwood & Gunn, 1997).

The poor compliance with High Court authorisations could be due to the poor functioning and limited capacity of MHRBs, which was also found by van Rensburg (2011). A Department of Health technical report also found incorrect completion of application forms and poor coordination between the MHRBs and the judicial system on applications for involuntary psychiatric admissions as the most contributory factors to the poor compliance with High Court authorisations (Department of Health, 2013). The study findings paint a rather bleak picture on legal authorisations of involuntary admissions in the selected psychiatric hospitals in South Africa, and also illustrate a gap between policy on paper and its implementation, highlighted in other policy implementation studies (Ditlopo. et al., 2011; Rispel & Moorman, 2010).

Although there are differences in the authorising structures in other countries (Salize et al., 2002), studies have found 70% compliance in Ireland (Ramsay, et al., 2012) and 100% compliance in Finland (Salize, et al., 2002) which was attributed to a good cooperation between mental health experts and the judicial system.

7.4.2 Oversight and review function of the Mental Health Review Boards (MHRBs) *Approval of involuntary psychiatric admissions by the Mental Health Review Boards (MHRBs)*

The study found that 41.3% (33/80) of the application documents were submitted to the MHRBs for approval and further processing to the High Court responsible for the authorisation. Although it was found that 78.8% (26/33) of these application documents were submitted to the MHRBs within the stipulated time frame, only 15.4% (4/26) were from units attached to general hospitals and 84.6% (22/26) from psychiatric hospitals. This finding illustrates the health system challenges of implementing the Mental Health Care Act in psychiatric hospitals, supporting the findings of other studies in South Africa (Burns, 2008; Ramlall et al., 2010).

In terms of the approvals, 64% (21/33) of the submitted applications were approved by the MHRBs but only 57.1% (12/21) were issued within the stipulated time frame. Again,

very few of these MHRB approvals were found in urban psychiatric units in general hospitals. The study found good compliance in the Northern Cape Province compared to no compliance in KwaZulu-Natal, Limpopo or Mpumalanga Provinces. There was partial compliance in other provinces which means that some patients were already discharged from the hospitals by the time the MHRB approvals were received. This partial compliance is against the prescription and intention of the Mental Health Care Act (Republic of South Africa, 2002), which has introduced MHRBs as independent quasi-judicial bodies to protect the rights of psychiatric patients and oversee involuntary psychiatric admissions (Department of Health, 2013). The reasons for the discrepancy found among psychiatric hospitals across provinces are not clear but may be related to the functioning of the MHRBs, systems in place to coordinate work between the MHRBs and the hospitals, differences in the availability of resources across provinces, and different interpretations and implementation by health care providers of the prescripts of the Act, in line with Lipsky's theory of street-level bureaucracy (Lipsky, 2010).

It is interesting that only one MHRB in South Africa (Northern Cape Province) was compliant with submission and receipt of application documents in this study. This could be because of the close proximity to the hospital (West End Hospital in Kimberley), which made submission of documents to and from the MHRB easy and within the prescribed time frames. On the other hand, it may reflect high level support at provincial health leadership level for the MHRB.

The findings of this research are borne out by the findings of other studies in South Africa that have also found challenges in the review and oversight function of MHRBs across provinces (Department of Health, 2013; Ramlall, 2012; van Rensburg, 2011; Moosa & Jeenah, 2008). The most common challenges reported were budgetary constraints, poor administrative support, and lack of basic resources to conduct business, poor document management systems to keep track of the application documents which limited the capacity of the MHRBs to execute the mandates. Studies by Ramlall (2012) and Ramlall, et al. (2010) in KwaZulu-Natal Province found that 44% of the hospitals did not submit the application documents to the MHRBs for approval;

the majority (80%) of the hospitals had not been visited by the Boards in a 6-month period and poor relations between clinicians and the MHRB members that were described as “obstructive and dismissive of clinicians”. Furthermore, clinicians in KwaZulu-Natal Province reported that the MHRBs were not addressing practical issues in the province, were difficult to communicate with and lacked the power to contribute meaningfully to the transformation of the neglected mental health services (Ramlall, 2012). Similarly, a review conducted by Moosa and Jeenah (2008) in Gauteng Province on the applications for involuntary admissions submitted to the MHRBs found dysfunctional MHRBs and fractious relations of members with health officials.

Hogwood and Gunn suggest that when too much is expected too soon, especially when the policy introduces new procedures which require substantive resourcing and change of behaviour and attitudes, the chances for successful implementation are minimal (Hogwood & Gunn, 1997). Pre-condition 10 further suggests that those in authority must also be in power to be able to secure compliance with the policy objectives by the implementers (Hogwood & Gunn, 1997). This is not the case with MHRBs.

In Ireland, non-compliance of the MHRBs with their legal responsibilities has also been found (Ramsay, et al., 2012), especially in Galway (Murray, et al., 2009) and Dublin (Murphy, Smith, Barry, & Feeney, 2012), where the majority of the applications for involuntary psychiatric admissions were not approved by the MHRBs. Negative views by psychiatrists about the adversarial nature of MHRBs were also reported in Ireland and the negative impact on the working relationship among the MHRB members and clinicians (Jabbar, Kelly, & Casey, 2010).

Appeals against involuntary psychiatric admissions

The majority of Record Reviewed (97.5%) did not have evidence of appeals against involuntary psychiatric admissions except two appeals from rural specialised psychiatric hospitals. This finding could be a result of few appeals that were lodged or a possible violation of patients' freedom of expression and choice, as enshrined in the South African Constitution. Hogwood and Gunn's pre-condition 9 suggests that implementation requires understanding and agreement by the implementers on the objectives to be achieved and policy procedures to be followed (Hogwood & Gunn, 1997). The finding could also be explained by this unmet pre-condition. In contrast, Bateman (2012) reported that six to ten appeals were lodged by patients at the Western Cape MHRB in one week.

The reasons for non-compliance with appeals in South Africa are not well described in literature, but could be attributed to the lack of knowledge by patients and their families about their right to lodge appeals. There are no systems in hospitals to ensure that on admission, psychiatric patients and their families are educated about their rights. This is in line with Bateman's argument that the more patients and families understood their right to appeal, the more appeals would be lodged in psychiatric hospitals (Bateman, 2012).

Compared to the findings of this study, 72% compliance with the appeals process was found in New Zealand (O'Brien, Mellsop, McDonald, & Ruthe, 1995) and 57% in Ireland with 68% in Galway (Murray, et al., 2009) and 42% in Dublin (Murphy, Smith, Barry, & Feeney, 2012). In Ireland, factors that impacted on compliance with appeals were increased workloads for psychiatrists, reduced training time for junior doctors on appeal processes and the high loads of paperwork involved (O'Donoghue & Moran, 2009).

7.4.3 Assessment procedures for involuntary psychiatric admissions

The initial assessment

From the Record Reviewed in this study, 91.2% (73/80) compliance was found with the initial assessment of involuntary psychiatric patients by two health professionals as

stipulated in the Mental Health Care Act. Although this is an encouraging finding, it is of concern that 15% (11/73) of the assessment reports were found identical, with the same terminology and errors. The majority (63.6%=7/11) of the identical reports were found in rural psychiatric hospitals, which is against the general ethical guidelines for health care professionals and the guidelines on the keeping of patient records (HPCSA, 2008). Hogwood and Gunn emphasised the need for skills capacity building and adequate human resources in pre-conditions 2 and 3 of the framework (Hogwood & Gunn, 1997). The study finding suggests that these conditions were not met for general health care providers on the implementation of the Act. Lipsky argued that resource inadequacy in policy implementation may result in street-level bureaucrats resisting the organisational expectations and behaving in an unacceptable manner in their work (Lipsky, 2010). This closely explains the behaviour of general practitioners on the initial assessment reports found in this study.

Compliance with the initial assessment of psychiatric patients by general practitioners reported in this study is better than the other countries such as China (Shao, et al., 2012); United Kingdom (Bhatti, Kenny-Herbert, & Cope, 1999); Scotland (Humphreys, Kenney-Herbert, & Cope, 2000) and Ireland (Jabbar et al., 2010) Compared to the findings of this study, other South African studies found poor compliance with the initial assessment of psychiatric patients by general practitioners, which may be one of the reasons for copied reports found in this study. Habib. et al. (2007)'s study in 2003 at West End Hospital in Northern Cape Province confirmed that general practitioners experienced challenges in the assessment and diagnosis of psychiatric patients and consequent compilation of reports. The same was found in Chris Hani Baragwanath Hospital in Gauteng Province, where general practitioners were able to do assessments only in 10% of patients who were brought in by members of the South African Police Service (Jonsson et al., 2009). Similarly, in Eastern Cape Province, Schierenbeck, Johansson, Anderson, and van Rooyen (2013) reported challenges with the initial assessment of psychiatric patients by general practitioners and compilation of the assessment reports.

The other contributory factors in copying of assessment reports by general practitioners may be associated with increased workload and high paperwork, and the long time it takes to assess a psychiatric patient (Charlson et al., 2016). Other factors pertain to limited skills in mental health by general practitioners and inadequate knowledge of the mental health law (Bhatti et al., 1999; Humphreys, Kenney-Herbert, & Cope, 2000) and inadequate training (Schierenbeck, Johansson, Anderson, & van Rooyen, 2013).

72-hour assessments

The study found 66% compliance with the 72-hour assessment of involuntary psychiatric patients with the majority conducted in urban specialised psychiatric hospitals. The 34% of the involuntary psychiatric patients who were not assessed within the prescribed period was mostly in rural specialised psychiatric hospitals and psychiatric units attached to general hospitals. This finding could mean a missed opportunity for other underlying medical conditions that often manifest in psychiatric symptoms and treatment delays for these patients as early treatment initiation is the greatest advantage of 72-hour assessment (South African Federation for Mental Health, 2005).

Moosa and Jeenah's study has highlighted the importance and value of the 72-hour assessment to enable a comprehensive assessment and analysis of the patient's condition and personal circumstances (Moosa & Jeenah, 2008). The importance of the 72-hour assessment is also illustrated by a survey on mental health systems by the World Health Organization (WHO) that found that in Central America and India, about a third of patients who were admitted in psychiatric hospitals without undergoing the assessment suffered from conditions other than psychiatric disorders (WHO, 2004). Similar instances were found in psychiatric hospitals in South Africa where about a quarter of patients (24.1%) who were assessed in West End psychiatric hospital in Northern Cape Province suffered from a general medical condition and not mental illness (Habib. et al., 2007).

The finding from this study shows that although general hospitals were listed to conduct 72-hour assessments in terms of the Mental Health Care Act, compliance with the assessments was unsatisfactory. The contributory factors may be drawn from the previous studies in Gauteng (Moosa & Jeenah, 2008); KwaZulu-Natal (Ramlall, 2012; Ramlall et al., 2010) and Eastern Cape Province (Schierenbeck et al., 2013) which reported infrastructure limitations, budget constraints, human resource inadequacies and security challenges in the listed hospitals. Other local studies also argued that the listed facilities were not adequately prepared for the service that they are expected to render (Ramlall, 2012).

These contributory factors can also be explained by Hogwood and Gunn's pre-conditions for perfect implementation, specifically the need for adequate funding and a combination of resources including training on policy objectives and procedures (pre-conditions 2 and 3); adequate preparations for implementation (pre-condition 8) and the importance of compliance monitoring (pre-condition 10) (Hogwood & Gunn, 1997). These pre-conditions were not met and this impacted on compliance with the 72-hour assessments in psychiatric hospitals. Lipsky argued that it is the role of government agencies to conduct training, especially on new policy procedures in order to facilitate effective implementation (Lipsky, 2010). As shown in the qualitative study component, this was not done adequately in general hospitals that were not well prepared for the 72-hour assessments for psychiatric patients.

In Belgium, a study found good compliance with the assessments, despite the fact that their observation period is far longer (40 days) than that in South Africa. This was mainly due to secure assessment units that were built specifically for this purpose and located either at a psychiatric hospital or a general hospital (Salize, et al. 2002).

Similar challenges were found in Ireland where there was non-compliance with the assessments as a result of inadequate resources, insufficient training on the prescripts of the Act and a high workload (Ganter, Daly, & Owens, 2005). Also in Finland,

infrastructure limitations were found to be the main challenge in the assessments of psychiatric patients (Valimaki, Taipale, & Kaltiano-Heino, 2001).

7.4.4 Care of property of patients

From all the records reviewed in this study, no evidence was found regarding applications to the Master of the High Court requesting appointment of an administrator to care for the property and finances of the patients. Although financial interest was recorded for consideration during the application process for all patients, the determination of the value of the property and finances was not undertaken. This may be because of poor recording or that the procedure to safeguard the property and finances of patients was not undertaken, thereby violating their rights. Clinicians are expected to follow this procedure and the reasons for the non-compliance are not clear.

The researcher could not find published research literature in this area to make comparisons with the findings of this study.

7.5 Conclusion

Worldwide, involuntary psychiatric admission is a controversial topic that has raised ethical debates because of the potential violation of the right to liberty and freedom (Riecher-Rossler & Rossler, 1993). In response, South Africa promulgated the Mental Health Care Act stipulating specific human rights orientated procedures for involuntary psychiatric admissions. However, the results of this study suggest the challenges with implementing these procedures in psychiatric hospitals. The study found poor compliance with the legal authorisation of involuntary psychiatric admissions, unsatisfactory oversight by the MHRBs and challenges with assessments of psychiatric patients and reports. These demonstrate gaps between policy and implementation of the prescribed procedures for involuntary psychiatric admissions.

The non-compliance with the procedures for involuntary admissions in psychiatric hospitals may be due to resource limitations, infrastructure challenges, inadequate preparations in district hospitals to implement the Mental Health Care Act, poor inter-

sectoral collaboration, particularly with the judicial system. These factors were also reported in previous local research (Bateman, 2012; Cooper et al., 2012; Szabo, 2006).

According to Hogwood and Gunn's framework on "perfect" policy implementation and Lipsky's theory of "street level bureaucracy", the requirements for adequate resources, training, communication and coordination and compliance monitoring, were not met and this impacted on compliance with the legal procedures for involuntary psychiatric admissions (Hogwood & Gunn, 1997; Lipsky, 2010).

Interventions therefore need to be put in place to address the identified challenges, thereby improving compliance in psychiatric hospitals with procedures for involuntary psychiatric hospitals. The following chapter integrates these findings from record review and those from the qualitative component of this study to arrive at both recommendations as well as areas for future research.

CHAPTER 8 : INTEGRATION OF FINDINGS, RECOMMENDATIONS AND CONCLUSION

8.1 Introduction

The overall aim of this PhD study was to examine the implementation of the Mental Health Care Act (the Act) in psychiatric hospitals in South Africa, focusing on the period 2005 to 2010. The specific objectives of the study were to: explore the stakeholders' involvement in the implementation of the Act; examine the policy planning processes followed in the implementation of the Act; determine if Mental Health Review Boards execute their prescribed roles and functions; examine the implementation of legal procedures for involuntary psychiatric admissions; and identify factors that influenced the implementation of the Act.

Using policy implementation theory as its foundation, the study was guided by a conceptual framework adapted from the WHO guidelines on the implementation of mental health legislation (WHO, 2003b) and Burke, Morris and McGarrigle's policy implementation enablers (Burke et al., 2012). The four key components of the framework were: situational factors that influenced implementation; stakeholders in the implementation process; organisational support and systems; and processes, planning and procedures for implementation.

The overall study approach was qualitative in nature, complemented with a review of records of involuntary patient admissions in 16 selected hospitals. The qualitative component consisted of 35 in-depth interviews with: the drafter of the Act (n=1); provincial mental health coordinators (n=9); a psychiatrist at each of the selected hospitals (n=16); and the chair of a mental health review board in each of the provinces (n=9). At each selected psychiatric hospital, five patient records were selected randomly (n=80), focusing on compliance with the legal procedures for involuntary admissions (see Chapter 3).

This final chapter brings together the findings from the qualitative component of the study and the record review in light of the study's theoretical underpinnings (Hogwood & Gunn, 1997; Lipsky, 2010), the conceptual framework, the study objectives, and the existing literature. The chapter highlights the scholarly contribution of this study, outlines the recommendations flowing from the study's key findings and concludes with proposals for future research in the field.

8.2 Key findings

The study key findings are shown in Table 8.1 below.

Table 8.1: Summary of the key study findings

Key study findings
<ul style="list-style-type: none"> • A combination of South Africa's political transition, wide-spread stakeholder support for the spirit and intention of the Act; advocacy for human rights; the broader transformation of the health system, the need for community-based mental health services, and calls for enhanced governance and accountability in mental health created a unique window of opportunity for the implementation of the Mental Health Care Act • The unexpected announcement of promulgation of the Act and the rushed implementation process hindered planning and preparations of the health system for implementation • There was insufficient involvement of key stakeholders, namely health care providers, the private health sector, academic institutions, mental health care user and family groups, and other core government departments in the implementation process • Suboptimal functioning of the MHRBs compromised governance and accountability in mental health, which impacted on the implementation of the Act • There was poor compliance with the prescribed legal procedures for involuntary admissions to psychiatric hospitals • The implementation of the Act was hindered by: <ul style="list-style-type: none"> ✓ Resource limitations (human resources, budgets and infrastructure) ✓ Relative low prioritisation of mental health ✓ Mental health stigma and discrimination ✓ Weak leadership and management capacity for implementation ✓ Inadequate monitoring systems for compliance with the provisions of the Act • Overall, the study found that the implementation of the Act was suboptimal, and can be classified as unsuccessful implementation in Hogwood and Gunn's framework

The study findings are presented according to the components of the study conceptual framework shown in Figure 8.1 and discussed further below.

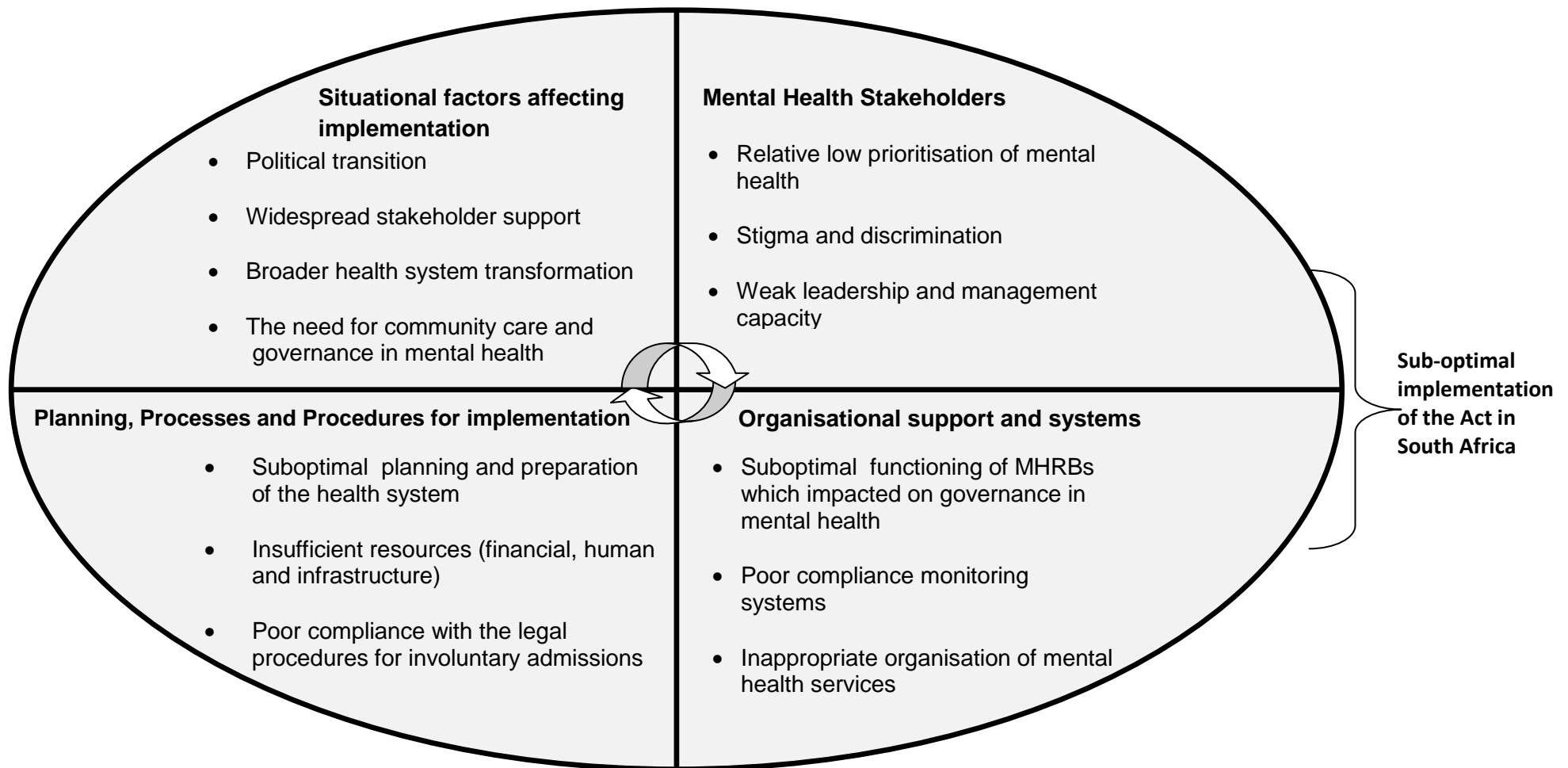


Figure 8.1: The study findings according to the conceptual framework

8.2.1 Situational factors that influenced implementation of the Act

Hogwood and Gunn suggested in pre-condition 1 that consideration must be given to external factors that have an impact on the implementation process (Hogwood & Gunn, 1997). In this study, these external factors were largely positive, and included a combination of: South Africa's political transition; wide-spread stakeholder support for the spirit and intention of the Act; advocacy for human rights; the broader transformation of the health system such as the need for community-based mental health services; and calls for enhanced governance and accountability in mental health. Some of these factors were also found to facilitate reforms in mental health policy in several other countries (Caldas de Almeida & Cohen, 2008; Caldas de Almeida & Horvitz-Lennon, 2010; Government of Liberia, 2014; Razzouk et al., 2012) as discussed in Chapter 5. Advocacy also played a facilitating role in Latin American and Caribbean countries (Caldas de Almeida, 2013), North America and the United Kingdom (Razzouk et al., 2012; Westbrook, 2011) while governance and accountability contributed to the implementation of mental health legislation in Tunisia and Russia (WHO, 2001d).

The strong advocacy for a human rights approach to the management of mental health conditions by health professionals, academic institutions and other interest groups both aided development of the Act, and support for its implementation.

8.2.2 Planning, Processes and Procedures for Implementation

The implementation of the Act was rushed as the Department was under pressure to introduce new mental health legislation after South Africa's democratic transition. The Act was announced unexpectedly during the 2004 festive period, with insufficient time to plan and prepare the health system for implementation of the Act. As a result, the implementation processes were rushed, which compromised successful implementation of the Act. The situation was exacerbated by the prolonged absence of the national mental health policy for nine years after promulgation of the Act, resulting in variations and inconsistencies among provinces on the interpretation and implementation of the Act. The National Mental Health Policy Framework and Strategic Plan was only adopted in 2013 in South Africa (Department of Health, 2013b).

The suboptimal planning and preparation created barriers to implementation. These barriers include resource limitations, suboptimal skills and capacity of general health practitioners, insufficient knowledge of mental health among individuals with mental illness and their relatives, non-compliance with the procedures for involuntary psychiatric admissions and the inappropriate organisation of mental health services.

Resources such as budgets, human resources and infrastructure were insufficient for implementation of the prescripts of the Act. There was no budget dedicated for the implementation process, the multidisciplinary teams in psychiatric hospitals that must comprise psychiatrists, psychologists, medical officers, occupational therapists, social workers and psychiatric nurses in terms of the Act were not complete. Also, the infrastructure in psychiatric hospitals was old, dilapidated and uninhabitable as the majority of these hospitals were condemned for use while others were donated after being used for leprosy patients or prison barracks in the past. Although the Act turned district hospitals into important platforms for mental health services, the infrastructure design and layout in these hospitals was not appropriate for the provision of mental health services. This posed a safety risk for the staff, patients and visitors in district hospitals rendering mental health services. Hogwood and Gunn recommended that adequate time and resources be made available with sufficient planning and preparations for the implementation process (Hogwood & Gunn, 1997). This however, does not seem to have been taken into account in the implementation process of the Act in South Africa.

The general health practitioners in district hospitals appeared to bear the brunt of inadequate planning processes for implementation. These practitioners received insufficient training in mental health and on the implementation of the procedures prescribed in the Act. This finding was confirmed in the record review component of this study, which revealed that 15% of the assessment reports compiled by general health providers appeared to have been copied among the professionals. This has both ethical implications and for the accuracy and authenticity of these reports, which should inform plans for further care, treatment and rehabilitation of psychiatric patients.

Hogwood and Gunn's pre-conditions suggest that when new procedures are introduced without adequate training and capacity by the implementers, the likelihood of successful implementation of those procedures is limited (Hogwood & Gunn, 1997). The study findings suggest that this was not the case, especially for general health care providers. Furthermore, the record review found that the large majority of patient files (97.5%) did not have evidence of appeals lodged by psychiatric patients themselves or their relatives, suggesting that they might not be fully aware of their legal rights and the appeal processes to follow against involuntary psychiatric admissions.

Regarding procedures for involuntary psychiatric admissions, compliance with these procedures was poor. This is in contrast with Hogwood and Gunn (1997)'s recommendation in pre-condition 10 for total compliance and adequate monitoring systems on the implementation process (Hogwood & Gunn, 1997). For example, 37% of applications for involuntary admissions were not made under Oath as prescribed by the Act in this study and this has been attributed to the unavailability of the Commissioner of Oaths in hospitals. Only 23.7% of patients underwent 72-hour assessments, which is against the intention of the Act and only 33.3% of the reviewed files recorded the steps taken to locate family members when the applications for involuntary psychiatric admission were made by health care providers (Republic of South Africa, 2002). This study found that the majority (63/80; 78.8%) of involuntary psychiatric admissions were not legally authorised by the High Court in terms of the Act. None of the involuntary admissions in psychiatric units attached to general hospitals were legal, with notable inconsistencies among psychiatric hospitals in provinces. **This is a contravention of the rights of involuntary psychiatric patients**, which may be partly explained by the challenges encountered in general hospitals in implementing the prescribed procedures for involuntary psychiatric admissions. Other related factors include non-compliance with the legal authorisation of the involuntary admissions by the High Courts, as these courts are non-existent in some provinces.

Mental health services are still hospital-centric with limited and under-developed community-based mental health services in the country, which further impacted on the implementation of the Act. Although efforts have been made to reduce the size of newly constructed psychiatric hospitals, attempts to shift the budgets towards the

establishment of community-based services remain futile, which is compounded by the lack of political and managerial support. A recent tragedy in South Africa which resulted in the loss of 100 psychiatric patients in private NGOs is an illustration of the lack of community-based mental health services in South Africa (Makgoba, 2017). Similar findings were reported in other South African studies (Lund, Kleintjies, et al., 2010; Marais & Petersen, 2015; Ramlall, 2012). Also in Sudan (Ali & Agyapong, 2016), Turkey (WHO, 2014a) and Belgium (Nicaise et al., 2014), community-based mental health services were limited and services were centralised in psychiatric hospitals. Some of the attributing factors in these countries included resource constraints, stigma and discrimination (Patel et al., 2016), similar to South Africa. These factors are a clear illustration of the impact of a resource constrained work environment (Lipsky, 2010) and lack of sequencing of events and coordination of the implementation process (Hogwood & Gunn, 1997). These study findings therefore suggest that orientation on the policy objectives and procedures on the Act together with improved resources (infrastructure, human resources and budgets) are crucial for improved implementation of the Act, as recommended by Hogwood and Gunn (1997) and Lipsky (2010).

8.2.3 Mental Health Actors/Stakeholders in implementation

Stakeholder consultation is a crucial step in policy development and implementation. It is through consultation that alliances are built, stakeholders give inputs to the processes and buy-in is obtained (Burke et al., 2012; Mthethwa, 2012). However, this study found that consultation processes on the Act were inadequate. The drafting team was not representative of all stakeholders in mental health and consumer, family and special interest groups, general health providers, private sector, academic institutions and other core stakeholder departments such as the Police, Justice and Constitutional Development and Social Development were not involved in the implementation process. The inadequate consultation of stakeholders found in this study implies that the inputs of key role players in the development and implementation of the Act were limited, which poses the risk of resistance to the implementation process (Bhuyan et al., 2010), or unsuccessful implementation (Hogwood & Gunn, 1997).

Rural communities, many of whom are illiterate were also not adequately consulted on the Act. There were no community consultations held through the local community

leaders, where the Act and its intentions would have been explained. As a result, rural communities are not conversant with the objectives of the Act and their expected roles in social and family reintegration with their mentally ill members. This is in contrast with Hogwood and Gunn (1997)'s pre-condition 9, which recommends effective communication and coordination among stakeholders for 'perfect' implementation. The limited consultation with key role players was also reported by other South African researchers (Draper et al., 2009; Marais & Petersen, 2015). In contrast, studies in Cuba, Chile, Brazil and Australia reported adequate consultation with key stakeholders, including general health practitioners and consumer groups, which facilitated implementation of mental health policies (Caldas de Almeida & Cohen, 2008; Saraceno et al., 2007). This study finding suggests that platforms must be created where key stakeholders and departments including general health providers are continuously engaged in the implementation of the Act.

This study also found that prioritisation of mental health and the Act has been relatively low in South Africa. Despite having a much applauded Act for its human rights approach and the newly adopted Mental Health Policy and Strategic Framework, mental health still does not translate into a priority for implementation in South Africa. The low priority of mental health is manifested in the junior level of the coordinators in province, as mentioned earlier, limited inclusion of mental health in the annual performance and strategic plans, including district health plans, and delays in the revitalisation of psychiatric hospitals discussed earlier. This had a significant impact on the implementation of the Act as cautioned by Hogwood and Gunn that those in authority must have adequate power to command compliance by the implementers (Hogwood & Gunn, 1997). This was not the case with the majority of provincial mental health coordinators. Similar findings were reported in Zambia (Kigozi. et al., 2010), Ghana (Awenva et al., 2010), North America and Afghanistan (Pollack et al., 1994; Saraceno et al., 2007). Factors attributed to the low priority accorded to mental health in these countries included poor advocacy programmes, poor information management systems, low public interest, including stigma and discrimination (Gureje & Alem, 2000; Saraceno et al., 2007; WHO, 2010a, 2011b). In contrast, mental health in Mozambique enjoyed political will and support (Sweetland et al., 2014).

Stigma and discrimination by stakeholders in the field were other major barriers to the implementation of the Act and significantly contributed to the low status accorded to mental health. Stigma was found in different levels in this study. At one level, it was courtesy stigma experienced by mental health care providers, where mental health care professionals were seen to be “also mentally ill” like their patients. This resulted in few general health providers who were willing to work in the mental health field, adding to the shortage of professionals in the field. At another level, generalists were reluctant to engage with psychiatric patients claiming that they had not specialised in the field, whereas basic mental health care was part of their training. Other local studies reported that stigma and discrimination in mental health culminated in fearful and negative public images of mentally ill people as they were perceived to be violent, unpredictable and a threat to society, which is not a true picture and a further illustration of stigma and discrimination of mentally ill persons (Bateman, 2012; Lund, Kleintjies, et al., 2008; van Rensburg, 2011). Other studies in the United Kingdom (Sayce, 1998) New Zealand (Coverdale et al., 2002) and Pakistan (Karim et al., 2004) also reported stigma and discrimination in mental health.

Regarding leadership and management capacity on the implementation of the Act, scholars have underscored the importance of effective leadership, governance and management in strengthening health systems (WHO, 2010c) and reducing the policy implementation gap (Rispel & Moorman, 2010). However, this study found that these important attributes were weak across the national, provincial and facility levels in South Africa for effective implementation of the Act, mainly due to the resignation of a key official who facilitated the development of the Act at the national office shortly after promulgation of the Act. This weakened leadership for implementation of the Act as provinces lost guidance on the translation of the intentions of the Act. At the provincial level, the majority of mental health coordinators who are responsible for steering the implementation processes were in junior positions. This disempowered their decision making power required to introduce the change envisioned in the Act and major policy shifts and resources for implementation. At the facility level, some hospital managers were unsupportive of the Act, which compromised the resource provision for mental health compared to other programmes in general hospitals, which was against Hogwood and Gunn (1997)’s pre-condition on adequate resources. This was associated with lack

of understanding of the importance of mental health, stigma and discrimination by hospital managers and limited resources, for which mental health must often compete with other health priority programmes. These can also be explained through Lipsky's assumption that the street-level bureaucrats tend to ration services based on their perceptions and attitudes towards their clients. Those that cannot question their actions and seem to be less worthy than others, as is often the case with psychiatric patients (Mackenzie, 2014), are rendered less or no services altogether (Lipsky, 2010). Other local studies reported similar findings (Draper et al., 2009; Marais & Petersen, 2015). Internationally, the same was found in Latin America and Caribbean countries (Caldas de Almeida, 2013). However in Brazil, India, and the United Kingdom, leadership, governance and management in mental health were effective, where the mental health programme was led by the higher authorities such as district managers (WHO/WONCA, 2008).

8.2.4 Organisational support and systems for implementation

The organisational support and systems for implementation were found to be weak in this study. Despite MHRBs being established in the Act as quasi-judicial authorities to uphold and oversee the rights of mentally ill people, this study found that they were functioning poorly. The weaknesses were caused by weak leadership, limited strategic planning and management and poor resourcing. The Act prescribes that the MHRBs must be appointed by MECs in respective provinces, yet this function had been downgraded to lower levels in provincial health departments and mostly in mental health programmes. This compromised the independence, power and authority of MHRBs as well as their support from the MECs offices. Also at the national Department of Health, coordination and support for MHRBs did not receive specific attention as this function was located in the mental health directorate, which was inadequate, given the findings by the Health Ombud following the tragic incident of the deaths of 100 patients in Gauteng Province (Makgoba, 2017). This arrangement of the MHRBs in the department creates a referee and player situation, where the MHRBs in most instances were forced to rubberstamp the decisions of clinicians on certain issues, which impacted on their oversight role envisaged in the Act. This study further found that the majority of the MHRBs did not have proper offices, computers, photocopiers, fax machines, telephones and other essential equipment for effective execution of their duties. Compliance with the

prescribed oversight role was also found to be poor. Of the 80 records reviewed in this study, less than 50% applications for involuntary psychiatric admissions were approved by the MHRBs and few of those approvals were submitted back to the psychiatric hospitals within the stipulated timeframe. Only a limited number of those applications were submitted to the High Courts for final authorisation of the involuntary psychiatric admission. The attributing factors include poor coordination of application documents from the psychiatric hospitals to the offices of the MHRBs and further to the High Courts. Also the unavailability of ward clerks responsible for coordinating the documentation between the registry departments in the hospital, MHRBs and the High Court is a major barrier in the process.

This study finding suggest that training of MHRBs on how to conduct their business and coordination of application documents needs to be strengthened in order to improve compliance with the procedures of the Act. Challenges in the functioning of MHRBs were also reported in local studies (Ramlall, 2012; Ramlall et al., 2010; van Rensburg, 2011) and in Ireland, where they are referred to as Mental Health Tribunals, which are accounted for by resource challenges and poor relationships with clinicians (Murray et al, 2009; Ramsay, 2012). The findings from this study call for a review of the location of the MHRBs in order to ensure their independence and power to secure compliance on the Act. Also, training of members on the provisions of the Act is imperative. These findings can be explained through Hogwood and Gunn's pre-condition 2 on adequate time and resources, pre-condition 6 on having minimal dependencies during the implementation process, pre-condition 8 on sequencing and planning for implementation and pre-condition 9 on adequate communication and coordination of the implementation process (Hogwood & Gunn, 1997), which were all not met in the organisational support and system for MHRBs.

Regarding compliance monitoring systems, this study found unintended consequences that resulted from the implementation of the Act, specifically the 72-hour assessments and the integration and decentralisation of mental health services to district hospitals. These aspects derailed the attention of implementers from the real intention of the Act, also increasing resistance, stigma and discrimination against mental health and people with mental illness. Despite the good intention of the Act on the 72-hour assessment

procedure, serious negative consequences occurred largely due to misunderstandings, poor planning and suboptimal skills of general health practitioners in mental health. Because 72-hour assessment is a medical procedure, it was conducted in the medical wards in other general hospitals, where psychiatric patients were mixed with acutely ill psychiatric patients. These posed a serious threat to medical patients in the same ward, where key informants reported that personnel and other patients were fatally attacked by acutely ill psychiatric patients. This could have been averted if there were compliance monitoring systems in place. This finding therefore calls for improved monitoring systems on the implementation of the Act, which is in line with pre-condition 10 of Hogwood and Gunn (1997)'s framework.

Key informants also felt that dangerous and acutely ill psychiatric patients were subjected to less experienced personnel in suboptimal environments and poor infrastructure in the majority of district hospitals. This was compounded by delays in the transportation of patients to specialised psychiatric hospitals for further care and treatment. As a result, generalists became the first point of contact with seriously ill patients without the proper skill and an enabling environment to manage psychiatric patients effectively. Furthermore, in primary health care, integration resulted in patients losing the special care and follow-up services at home by dedicated mental health professionals. This impacted on the quality of mental health care in primary health care and increased relapse of psychiatric patients due to non-compliance to treatment. This study argues that should compliance monitoring systems have been in place, these gaps would have been identified on time and corrective measures put in place. According to Lipsky, the freedom of street-level bureaucrats from managerial oversight impacts on the implementation process (Lipsky, 2010). In this study, the lack of compliance monitoring system opened a window of unintentional consequences of the Act to go unnoticed until negative incidents occurred, such as loss of lives and follow-up of psychiatric patients. Similar examples were reported in studies in Victoria, where, following the development of community mental health services, incidents of murder were reported in the facilities. This shifted the focus of the community from the benefits of community care to the dangerousness and unpredictability of psychiatric patients (Caldas de Almeida & Horvitz-Lennon, 2010).

Another poorly monitored provision of the Act is the care of property of psychiatric patients who are involuntarily detained in psychiatric hospitals. This study found that none of the 80 files reviewed had evidence of steps taken to care for the patient's property, even where financial interest was highlighted on the application forms. This is a highly neglected area that needs urgent attention.

Overall, the implementation of the Act was suboptimal and few of Hogwood and Gunn's pre-conditions were met, hence it was unsuccessful implementation.

8.3 Recommendations

The proposed recommendations of this study are based on the study findings, conceptual framework and the WHO's building blocks for mental health systems, shown in Table 8.2 and discussed below.

Table 8.2: The key recommendations of the study

Recommendations	Health Authorities			
	National	Provincial	MHRBs	Psychiatrists
Improve organisational support and leadership in mental health				
1. Review the National Health Act to strengthen leadership on the implementation of the Act	X			
2. Amend the Act to devolve the legal authorisation of involuntary psychiatric admissions	X	X		
3. Include mental health as a prominent agenda item of the National Consultative Health Forum	X			
4. Designate or appoint an official at the national Department of Health to oversee and support MHRBs	X			
5. Develop national guidelines on recruitment, appointment, retention and other conditions of service for MHRBs	X			
6. Ensure that the level of mental health coordinators is commensurate with the responsibility and burden of mental illness		X		
7. Expand the scope of MHRBs to include sanctioning for non-compliance with the Act	X			
8. Review the organogram at psychiatric hospitals to ensure compliance with the Act		X		
9. Improve oversight and coordination of MHRBs at the national Department	X			
10. Liaise with the Office of Health Standards Compliance to develop a national tool to monitor the implementation of the Act	X	X		
Improve planning process, resourcing and capacity building in mental health and the Act				
11. Include mental health in annual provincial and district health plans	X	X		
12. Provide a ring-fenced budget for mental health and the implementation of the provisions of the Act	X	X		
13. Establish a dedicated mental health infrastructure grant	X	X		

Recommendations	Health Authorities			
	National	Provincial	MHRBs	Psychiatrists
14. Develop a standardised training programme for general health practitioners on mental health and the Act	X	X	X	X
15. Develop a training programme for MHRBs on their roles and responsibilities	X	X		X
Enhance stakeholder involvement, consultation and public awareness in mental health and the Act				
16. Organise and hold five-yearly seminars or round table discussions to review the implementation of the Act with all stakeholders	X	X	X	X
17. Ensure compliance with national quarterly provincial coordinators meeting	X	X		
18. Hold annual public awareness campaigns on mental health	X	X	X	X

Regarding organisational support and leadership for mental health, this study recommends that the National Health Act be reviewed in order to improve leadership in mental health and the implementation of the Act. Currently, the National Health Act locates the responsibility of implementing policy and legislative mandates in provinces, while the National Minister of Health only develops and monitor policies and legislation. This has contributed to the implementation challenges of health policies and legislation, including the Act. A 2017 example is the tragedy that occurred in Gauteng Province where the legislative mandate on community-based mental health services was inappropriately implemented in the province (Makgoba, 2017), and it illustrated the relative lack of power on the implementation processes by the national Minister of Health. The amendment of the National Health Act together with prioritisation of mental health as an agenda item in the National Consultative Health Forum will enhance leadership and political support on the implementation of the Act and mental health services in general. In provinces, the level of coordination must be commensurate with the responsibilities and burden of mental illness. Provincial mental health coordinators must have the necessary power and authority to lead and coordinate the implementation of the Act.

The study further proposes the amendment of the mental health legislation, to address challenges with legal authorisation of involuntary psychiatric admissions by the High Courts, which are not available in all provinces. This has contributed to the non-compliance of psychiatric hospitals located in these provinces with the legal authorisation of these admissions. This study therefore recommends that the authorisation for involuntary admissions in psychiatric hospitals be devolved to the Magisterial Courts which are easily accessible in all provinces. This will improve compliance with legal authorisations of admissions, thereby enhancing the implementation of the Act. In addition, training and designation of a Commissioner of Oaths at each psychiatric hospital should also be considered

In terms of governance in mental health, although the Act introduced MHRBs as quasi-judicial bodies in mental health to oversee human rights and compliance with the legislated procedures, there is no legal provision that gives the MHRBs the power to sanction non-compliance and abuse of human rights. This study proposes that the Act be amended to enable MHRBs to enforce disciplinary measures for non-compliance. This study further recommends improved support and focus on MHRBs by the national and provincial Departments of Health, including the development of guidelines on the appointment, training and support for MHRBs.

Although the WHO recommended adequate resources and skills by health care providers as a system building block to facilitate the implementation of mental health legislation, this study found serious challenges in this area. This study recommends that the skills of general health care providers, hospital managers and MHRBs be enhanced in mental health and the provisions of the Act. There is an urgent need for a dedicated budget for mental health services and the implementation of Act. Mental health often competes with other health programmes, which are perceived to be more important, and loses the competition for resource allocation. This has resulted in budget limitations, human resource shortages and inadequate infrastructure for mental health, thus impacting significantly on the implementation of the Act. This study therefore recommends that a dedicated budget be made available, which will, inter alia, improve mental health infrastructure in specialised psychiatric and district hospitals, and improve community-based mental health services.

Last, to improve stakeholder consultation and public awareness, the study recommends that mental health fora, such as summits or round table discussions, be held with stakeholders to cross-pollinate best practices and lessons across provinces on mental health and the Act. Advocacy and public awareness have been highlighted as effective tools to reduce the stigma and discrimination against mental health, and to dispel negative perceptions and myths about mental illness (WHO, 2014a). Hence advocacy should be strengthened and public awareness campaigns should be embarked on to improve mental health services and the implementation of the Act. This study recommends that annual public awareness campaigns and educational programmes be organised with and for families and consumer groups, the private sector and academic institutions on mental health and the provisions of the Act.

The key lessons from this study for future drafters and implementers in order to avoid the same mistakes are: Improved leadership, governance and management of the mental health programme across all levels, optimal planning and preparation of the health system, adequate resourcing, stakeholder consultation and buy in; and a clear monitoring and evaluation framework.

This study has yielded new knowledge on the implementation of the Act in psychiatric hospitals and proposed specific interventions to improve the implementation of the Act in South Africa. The contribution of this study to the research field is discussed in detail below.

8.4 Contribution and originality of this study

This PhD study is an original piece of research. This study was largely driven by gaps in the existing empirical literature and limited application of policy implementation theories in mental health. This research makes a significant original contribution to research in the following ways, namely:

- Contribution to new knowledge
- Methodological contribution
- Contribution to policy and practice in the field of mental health

Each is discussed below.

8.4.1 Contribution to knowledge

This study yielded deep and rich narratives and views from key policy actors in mental health on factors that influenced the implementation of the Act in South Africa, during the period 2005 to 2010.

The new knowledge generated by the PhD includes knowledge on compliance of psychiatric hospitals with the legal procedures for involuntary psychiatric admissions and the [non] functioning of MHRBs in fulfilling their governance role in mental health.

This study has been extensive in that it covered all nine provinces in South Africa, 16 psychiatric hospitals and documented the enormous challenges faced by general health practitioners in district hospitals in the implementation of the Act.

8.4.2 Methodological contribution of the study

The study combined the WHO guidelines on implementation of mental health legislation (WHO, 2003b) and Burke, Morris and McGarrigle's enablers of policy implementation (Burke et al., 2012) to develop a conceptualisation on how to explore or analyse the implementation of the Act.

Using policy implementation theory as its foundation, the study used a combination of research methods, namely rich qualitative research and detailed record reviews, to examine the implementation of the Act in psychiatric units in South Africa. The theoretical framework of the study used Hogwood and Gunn's and Lipsky's "street-level bureaucracy" theories, albeit imperfect, this provided a novel way of exploring implementation of a complex policy, in psychiatric hospitals which have hitherto been under-explored as a major study setting.

8.4.3 Contribution to policy and practice in mental health

The study generated useful findings which can be used to improve mental health policy and practice, and to inform a review and amendment of legislation, policies and plans.

The timing of the PhD is critical as 2017 has witnessed pronouncements by the Ministry of Health to review both the National Health Act and the Mental Health Care Act.

Furthermore, the findings of this study will inform the discourse on provincial and national mental health programmes and services, greater prioritisation of a vulnerable group of people with mental illness.

8.5 Recommendations for future research

This study was only limited to officials in the health sector, while the Act specifies roles for other sectors such as the Department of Justice and Constitutional Development, Social Development, Police and National Prosecuting Authority. Future studies should explore the perceptions of officials in these departments on the implementation of the Act and compliance with the prescribed roles and responsibilities in these departments.

Existing evidence shows that the burden of mental illness in countries including South Africa is high. There is need for updated information on the epidemiology of mental illness and its determinants. Furthermore, mental health lags behind when it comes to prioritisation of human resources, budgets and infrastructure. Research is needed on strategies and actions to shift the mind-set of policy makers and planners on mental health in society and to ensure its prioritisation.

The study recommended 18 intervention strategies to improve implementation of the Act and consequently the mental health of South Africans. However, this may be overwhelming for decision-makers in the context of limited resources. Research is required to test the interventions and draw scientific evidence on the effectiveness of the recommended strategies.

The record review focused on 80 patients. There is also a need to evaluate on broader scale compliance with procedures for involuntary psychiatric admissions in order to confirm the findings that the majority of admissions were unlawful and strategies needed for remedial action. Another study should also evaluate the implementation of the prescripts for involuntary evaluation against a human rights framework.

The comparison between designated psychiatric hospitals and units attached to general hospitals is limited in this thesis by the small sample size. This is an area for future research.

Lastly, this study analysed implementation of the Act in the context of the study components. Other areas of the Act such as compliance with the procedures for assisted mental health care users, state patients and mentally-ill prisoners including care of the property of patients should be studied so as to identify implementation bottlenecks and generate possible solutions.

8.6 Conclusion

This is one of the first empirical studies conducted on the implementation of the Mental Health Act Care in South African psychiatric hospitals since its promulgation in 2004.

South Africa's political transition created a window of opportunity for the implementation of the Act. Wide-spread stakeholder support for the spirit and intention of the Act, advocacy for human rights, the broader transformation of the health system, and the need for enhanced governance and accountability in mental health, facilitated the implementation of the Act. However, implementation was hindered by: the relatively low prioritisation of mental health; stigma and discrimination; poor planning and preparation for implementation; resource constraints; and suboptimal stakeholder consultation. There was poor compliance with the prescribed procedures for involuntary psychiatric admissions, exacerbated by suboptimal governance by, and functioning of, the Mental Health Review Boards, thus resulting in *de facto* illegal detention of patients.

The implementation of the Mental Health Care Act is an important policy lever to address the burden of mental illness, provide quality mental health services, and indirectly contribute to the reduction of poverty in South Africa. However, the enabling potential of the Act can only be realised if the following issues are addressed: improved, and dedicated resources for mental health; training and capacity building of health professionals and hospital managers on key aspects of the Act; improved governance, leadership and accountability through well-functioning Mental Health Review Boards; and improving mental health infrastructure and community-based services.

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UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Ms Nkeng E Mulutsi

CLEARANCE CERTIFICATE**M120865****PROJECT**Implementation of the Mental Care Health Act
in Psychiatric Hospitals**INVESTIGATORS**

Ms Nkeng E Mulutsi.

DEPARTMENT

School of Public Health

DATE CONSIDERED

31/08/2012

DECISION OF THE COMMITTEE*

Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 28/09/2012
CHAIRPERSON *PE Cleaton-Jones*
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor : Prof Laetitia Rispel

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES..



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

Private Bag X828, PRETORIA, 0001, 19TH Floor, Civitas, Crn Struben & Andries Street, PRETORIA, 0001 Tel: +27 (0) 12 395 8000 Fax: +27 (0) 12 395 8422

Ms NE Mulutsi
Deputy Director: Mental Health and Substance Abuse
Department of Health
Private Bag X828
PRETORIA
0001

Dear Ms Mulutsi

IMPLEMENTATION OF THE MENTAL HEALTH CARE ACT IN PSYCHIATRIC HOSPITALS

Your request for permission to collect data towards a national PhD study on the "Implementation of the Mental Health Care Act in Psychiatric Hospitals" refers.

Kindly note that permission of the study has been granted.

Letters informing the provincial Heads of Health in this regard have been submitted accordingly.

Regards

mp
Dr T. O. Mbekeke, Acting DDC
DR Y PILLAY
DEPUTY DIRECTOR-GENERAL: PRIMARY HEALTH CARE
DATE:
24/1/2013

**Letter from the Deputy Director-General: Primary Health Care to the
Provincial Heads of Department**

Appendix 3



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

Private Bag X828, PRETORIA, 0001, 19TH Floor, Civitas, Crn Struben & Andries Street, PRETORIA, 0001 Tel: +27 (0) 12 395 8000 Fax: +27 (0) 12 395 8422

Prof KC Househam
Head of Health
Western Cape Department of Health
PO Box 2060
CAPE TOWN
8000

Dear Prof Househam

**RESEARCH ON THE IMPLEMENTATION OF THE MENTAL HEALTH CARE ACT IN
PSYCHIATRIC HOSPITALS**

Ms NE Mulutsi, an official at the National Department of Health has been granted a Departmental Bursary to pursue a PhD study at the University of Witwatersrand. The title of the study is "Implementation of the Mental Health Care Act in psychiatric hospitals".

The components of the study are:

- (a) Record review of mental health care users to determine whether processes for involuntary admissions prescribed in the Act are followed;
- (b) Interviewing a psychiatrist on his/her perceptions regarding the implementation of the Act;
- (c) Self completed questionnaires by the Mental Health Review Board on their functioning; and
- (d) Interviews with the drafters and implementers of the Act at National and Provincial Departments.

This study is valuable to the Department as it will yield research evidence on the implementation of the Mental Health Care Act in psychiatric hospitals and make recommendations regarding possible solutions to improve compliance with the prescripts of the Act.

The University has already approved the research protocol and granted an unconditional Research Ethics Approval Certificate.

May I please request that you grant Ms Mulutsi permission to collect data at George and Valkenberg Hospitals in your province.

Regards

PP
DR Y PILLAY

DEPUTY DIRECTOR-GENERAL: PRIMARY HEALTH CARE

DATE:

29/1/2013

Information sheet for the drafter of the Act at the National Department of Health

Implementation of the Mental Health Care Act in psychiatric hospitals

Introduction and background

My name is **Evah Mulutsi** from the **School of Public Development and Management at the University of Witwatersrand**. I am registered for PHD studies and conducting a study on the implementation of the Mental Health Care Act, 2002 (No 17 of 2002).

The overall aim of this study is to analyse the implementation of the Act in designated psychiatric hospitals from 2005 to 2010, thereby exploring the field of policy implementation in mental health.

The specific objectives are to assess the perceptions of stakeholders in mental health regarding the implementation of the Act in designated psychiatric hospitals; analyse the processes that were followed in the implementation of the Act; determine whether Mental Health Review Boards in designated psychiatric hospitals carry out their roles and are functions as prescribed in the Act and to analyse whether procedures prescribed in the Act on involuntary admissions are followed in designated psychiatric hospitals. The information obtained could be used to inform improvements in mental health services in line with the objectives of the Act.

You are requested to participate based on your position in the Department and knowledge of the Act.

The interview will last for an hour. If you agree to participate in the interviews, I will ask you questions about your views on the implementation of the Act in designated psychiatric hospitals. There are no right or wrong answers to the questions. I will also not pass judgement on your responses but will listen and understand your point of view on the matter.

Confidentiality

The information that you provide will be kept confidential. All interviewees will be assigned a code, which will be known by the researcher only. Your name will not be revealed in any written data or report of the study. All information gathered will be consolidated and analysed for emerging themes and experiences. These themes will be written up in the form of a report.

Consent

Permission to conduct the study has been obtained from the University of Witwatersrand Research Ethics Committee and the Department of Health. Your participation in this study will be appreciated and you are requested to sign the informed consent form, if you agree.

Benefits and risks of participation

Kindly note that participation in this study is voluntary and there will be no direct benefits to the all participants. There is no compensation for taking part in the study. Those who do not wish to be interviewed will face no negative consequences. During the interview, you have the right to withdraw your participation, decline to answer questions that you are uncomfortable with or stop the interview any time.

Recording the interview

Your permission to audiotape the interview is requested as it will be difficult to write down all your answers quickly enough to capture your responses. Some important information that you will share in response to the questions asked may also be missed if I do not record them. Kindly note that the tapes and notes will be listened to by the researcher only and confidentially kept. Your identity will not be disclosed but the codes assigned to each respondent. We are interested in your honest opinion on the implementation of the Mental Health Care Act. These tapes will be kept in a locked cupboard and will be destroyed two years after publication of the research findings, which is in line with the national requirements.

Contact Details

You may contact me for clarity on any issue pertaining to the study at (tel) 012 395 8044, (cell) 082 3020 444 or (e-mail) mulute@health.gov.za.



Appendix 4(b)

Information sheet for provincial mental health coordinators

Implementation of the Mental Health Care Act in psychiatric hospitals

Introduction and background

My name is **Evah Mulutsi** from the **School of Public Development and Management at the University of Witwatersrand**. I am registered for PHD studies and conducting a study on the implementation of the Mental Health Care Act, 2002 (No 17 of 2002).

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The specific objectives are to assess the perceptions of stakeholders in mental health regarding the implementation of the Act in designated psychiatric hospitals; analyse the processes that were followed in the implementation of the Act; determine whether Mental Health Review Boards in designated psychiatric hospitals carry out their roles and are functions as prescribed in the Act and to analyse whether procedures prescribed in the Act on involuntary admissions are followed in designated psychiatric hospitals. The information obtained could be used to inform improvements in mental health services in line with the objectives of the Act.

You are requested to participate based on your position in the Department and knowledge of the Act.

The interview will last for an hour. If you agree to participate in the interviews, I will ask you questions about your views on the implementation of the Act in designated psychiatric hospitals. There are no right or wrong answers to the questions. I will also not pass judgement on your responses but will listen and understand your point of view on the matter.

Confidentiality

The information that you provide will be kept confidential. All interviewees will be assigned a code, which will be known by the researcher only. Your name will not be revealed in any written data or report of the study. All information gathered will be consolidated and analysed for emerging themes and experiences. These themes will be written up in the form of a report.

Consent

Permission to conduct the study has been obtained from the University of Witwatersrand Research Ethics Committee and the Department of Health. Your participation in this study will be appreciated and you are requested to sign the informed consent form, if you agree.

Benefits and risks of participation

Kindly note that participation in this study is voluntary and there will be no direct benefits to the all participants. There is no compensation for taking part in the study. Those who do not wish to be interviewed will face no negative consequences. During the interview, you have the right to withdraw your participation, decline to answer questions that you are uncomfortable with or stop the interview any time.

Recording the interview

Your permission to audiotape the interview is requested as it will be difficult to write down all your answers quickly enough to capture your responses. Some important information that you will share in response to the questions asked may also be missed if I do not record them. Kindly note that the tapes and notes will be listened to by the researcher only and confidentially kept. Your identity will not be disclosed but the codes assigned to each respondent. We are interested in your honest opinion on the implementation of the Mental Health Care Act. These tapes will be kept in a locked cupboard and will be destroyed two years after publication of the research findings, which is in line with the national requirements.

Contact Details

You may contact me for clarity on any issue pertaining to the study at (tel) 012 395 8044, (cell) 082 3020 444 or (e-mail) mulute@health.gov.za.

Information sheet for the chairpersons or members of the Mental Health Review Board

Implementation of the Mental Health Care Act in psychiatric hospitals

Introduction and background

My name is **Evah Mulutsi from the School of Public Development and Management at the University of Witwatersrand**. I am registered for PHD studies and conducting a study on the implementation of the Mental Health Care Act, 2002 (No 17 of 2002).

The overall aim of this study is to analyse the implementation of the Act in designated psychiatric hospitals from 2005 to 2010, thereby exploring the field of policy implementation in mental health.

The specific objectives are to assess the perceptions of stakeholders in mental health regarding the implementation of the Act in designated psychiatric hospitals; analyse the processes that were followed in the implementation of the Act; determine whether Mental Health Review Boards in designated psychiatric hospitals carry out their roles and are functions as prescribed in the Act and to analyse whether procedures prescribed in the Act on involuntary admissions are followed in designated psychiatric hospitals. The information obtained could be used to inform improvements in mental health services in line with the objectives of the Act.

You are requested to participate as a chairperson or member of the Mental Health Review Board, based on your knowledge and experience on the implementation of the Act.

A questionnaire is attached to this information sheet, with specific questions about how your Board functions in relation to the roles prescribed in the Act. If you agree to participate, please respond to the attached questionnaire and send your responses back to me. There are no right or wrong answers to the questions. I will also not pass judgement on your responses but will note and understand your point of view on the matter.

Confidentiality

The information that you provide will be kept confidential. All participants will be assigned a code, which will be known by the researcher only. Your name will not be revealed in any written data or report of the study. All information gathered will be consolidated and analysed for emerging themes and experiences. These themes will be written up in the form of a report.

Consent

Permission to conduct the study has been obtained from the University of Witwatersrand Research Ethics Committee and the Department of Health. Your participation in this study will be appreciated and you are requested to sign the attached informed consent form, if you agree.

Benefits and risks of participation

Kindly note that participation in this study is voluntary and there will be no direct benefits to the all participants. There is no compensation for taking part in the study. Those who do not wish to participate will face no negative consequences. You have the right to withdraw your participation or decline to answer questions that you are uncomfortable with.

Completed questionnaires

Kindly note that responses and notes will be kept by the researcher only and confidentially kept. Your identity will not be disclosed but the codes assigned to each questionnaire. We are interested in your honest opinion on the implementation of the Mental Health Care Act. These questionnaires will be kept in a locked cupboard and will be destroyed two years after publication of the research findings, which is in line with the national requirements.

Contact Details

You may contact me for clarity on any issue pertaining to the study at (tel) 012 395 8044, (cell) 082 3020 444 or (e-mail) mulute@health.gov.za.

Information sheet for the psychiatrists in selected psychiatric hospitals

Implementation of the Mental Health Care Act in psychiatric hospitals

Introduction and background

My name is **Evah Mulutsi** from the **School of Public Development and Management at the University of Witwatersrand**. I am registered for PHD studies and conducting a study on the implementation of the Mental Health Care Act, 2002 (No 17 of 2002).

The overall aim of this study is to analyse the implementation of the Act in designated psychiatric hospitals from 2005 to 2010, thereby exploring the field of policy implementation in mental health.

The specific objectives are to assess the perceptions of stakeholders in mental health regarding the implementation of the Act in designated psychiatric hospitals; analyse the processes that were followed in the implementation of the Act; determine whether Mental Health Review Boards in designated psychiatric hospitals carry out their roles and are functions as prescribed in the Act and to analyse whether procedures prescribed in the Act on involuntary admissions are followed in designated psychiatric hospitals. The information obtained could be used to inform improvements in mental health services in line with the objectives of the Act.

You are requested to participate in the study as a psychiatrist working in the psychiatric hospital selected for the study, based on your knowledge in the mental health field and experience on the implementation of the Act.

There are no right or wrong answers to the question and I will also not pass judgement on your responses but will note and understand your point of view on the matter.

Confidentiality

The information that you provide will be kept confidential. All interviewees will be assigned a code, which will be known by the researcher only. Your name will not be revealed in any written data or report of the study. All information gathered will be consolidated and analysed for emerging themes and experiences. These themes will be written up in the form of a report.

Consent

Permission to conduct the study has been obtained from the University of Witwatersrand Research Ethics Committee and the Department of Health. Your participation in this study will be appreciated. If you agree to participate in the interviews, please sign the

attached informed consent and send it back to me with your contact details and the most suitable time and date for the interview.

Benefits and risks of participation

Kindly note that participation in this study is voluntary and there will be no direct benefits to the all participants. There is no compensation for taking part in the study. Those who do not wish to participate will face no negative consequences. You have the right to withdraw your participation or decline to answer questions that you are uncomfortable with during the interview.

Completed questionnaires

Kindly note that responses and notes will be kept by the researcher only and confidentially kept. Your identity will not be disclosed but codes will be assigned to the responses.. We are interested in your honest opinion and perception on the implementation of the Mental Health Care Act. These questionnaires will be kept in a locked cupboard and will be destroyed two years after publication of the research findings, which is in line with the national requirements.

Contact Details

You may contact me for clarity on any issue pertaining to the study at (tel) 012 395 8044, (cell) 082 3020 444 or (e-mail) mulute@health.gov.za.



Appendix 5(a)

Consent by the drafter of the Act at the National Department of Health

Implementation of the Mental Health Care Act in psychiatric hospitals

I have received the information sheet on the study entitled: *Implementation of the Mental Health Care Act in psychiatric hospitals*. I have read and understood the Information Sheet. All my questions have been addressed satisfactorily in the Information Sheet.

I understand that it is up to me to participate or not in the interview and that there will be no negative consequences if I decided not to participate. I also understand that I do not have to answer any questions that I am uncomfortable with and that I can stop the interview at any time.

I understand that the researchers involved in this study will take precautions to ensure that confidentiality of my name is ensured and that my details will not appear in the study report. My comments will not be reported back to anybody else.

I therefore consent voluntarily to participate in the interview for this study. I have been supplied with the researcher's contact details if I have any questions or concerns about the research.

Participant's signature----- Date-----

Interviewer's signature ----- Date -----



Consent by provincial mental health coordinators

Implementation of the Mental Health Care Act in psychiatric hospitals

I have received the information sheet on the study entitled: *Implementation of the Mental Health Care Act in psychiatric hospitals*. I have read and understood the Information Sheet. All my questions have been addressed satisfactorily in the Information Sheet.

I understand that it is up to me to participate or not in the interview and that there will be no negative consequences if I decided not to participate. I also understand that I do not have to answer any questions that I am uncomfortable with and that I can stop the interview at any time.

I understand that the researchers involved in this study will take precautions to ensure that confidentiality of my name is ensured and that my details will not appear in the study report. My comments will not be reported back to anybody else.

I therefore consent voluntary to participate in the interview for this study. I have been supplied with the researcher's contact details if I have any questions or concerns about the research.

Participant's signature----- Date-----

Interviewer's signature ----- Date -----



Appendix 5 (c)

Consent by the chairpersons or members of the Mental Health Review Board

Implementation of the Mental Health Care Act in psychiatric hospitals

I have received the information sheet on the study entitled: *Implementation of the Mental Health Care Act in psychiatric hospitals*. I have read and understood the Information Sheet. All my questions have been addressed satisfactorily in the Information Sheet.

I understand that it is up to me to participate or not in the study and that there will be no negative consequences if I decided not to participate. I also understand that I do not have to answer any questions that I am uncomfortable with and that I can stop the interview at any time.

I understand that the researchers involved in this study will take precautions to ensure that confidentiality of my name is ensured and that my details will not appear in the study reports. My comments will not be reported back to anybody else.

I therefore consent voluntary to participate in the study and complete the attached questionnaire on this study.

I have been supplied with the researcher's contact details if I have any questions or concerns about the research.

Participant's signature----- Date-----

Interviewer's signature ----- Date -----

Consent by psychiatrists at the selected psychiatric hospitals

Implementation of the Mental Health Care Act in psychiatric hospitals

I have received the information sheet on the study entitled: *Implementation of the Mental Health Care Act in psychiatric hospitals*. I have read and understood the Information Sheet. All my questions have been addressed satisfactorily in the Information Sheet.

I understand that it is up to me to participate or not in the telephonic interview and that there will be no negative consequences if I decided not to participate. I also understand that I do not have to answer any questions that I am uncomfortable with and that I can stop the interview at any time.

I understand that the researchers involved in this study will take precautions to ensure that confidentiality of my name is ensured and that my details will not appear in the study reports. My comments will not be reported back to anybody else.

I therefore consent voluntary to participate in the telephonic interview for this study.

I have been supplied with the researcher's contact details if I have any questions or concerns about the research.

Participant's signature----- Date-----

Interviewer's signature ----- Date -----



Appendix 6(a)

Informed consent for audiotape-recording by the drafter of the Act at the National Department of Health

Implementation of the Mental Health Care Act in psychiatric hospitals

I have received the information sheet on the study entitled: *Implementation of the Mental Health Care Act in psychiatric hospitals*. I have read and understood the Information Sheet. All my questions have been addressed satisfactorily in the Information Sheet.

I understand that I can decide whether or not the interview should be tape-recorded and that there will be no consequences for me if I do not want the interview to be recorded.

I understand that information from the tapes will be transcribed and transcripts will be given a code and my name will not be mentioned. I understand that if the interview is tape-recorded, the tape will be destroyed two years after publication of the findings.

I understand that I can ask the person interviewing me to stop tape recording, and to stop the interview altogether, at anytime.

I consent voluntarily for the researcher to record the interview.

Participant's signature----- Date-----

Interviewer's signature ----- Date -----



Appendix 6(b)

Informed consent for audiotape-recording by provincial mental health coordinators

Implementation of the Mental Health Care Act in psychiatric hospitals

I have received the information sheet on the study entitled: *Implementation of the Mental Health Care Act in psychiatric hospitals*. I have read and understood the Information Sheet. All my questions have been addressed satisfactorily in the Information Sheet.

I understand that I can decide whether or not the interview should be tape-recorded and that there will be no consequences for me if I do not want the interview to be recorded.

I understand that information from the tapes will be transcribed and transcripts will be given a code and my name will not be mentioned. I understand that if the interview is tape-recorded, the tape will be destroyed two years after publication of the findings.

I understand that I can ask the person interviewing me to stop tape recording, and to stop the interview altogether, at anytime.

I consent voluntarily for the researcher to record the interview.

Participant's signature----- Date-----

Interviewer's signature ----- Date -----



Appendix 6(c)

Informed consent for audiotape-recording by the chairpersons or members of Mental Health Review Board

Implementation of the Mental Health Care Act in psychiatric hospitals

I have received the information sheet on the study entitled: *Implementation of the Mental Health Care Act in psychiatric hospitals*. I have read and understood the Information Sheet. All my questions have been addressed satisfactorily in the Information Sheet.

I understand that I can decide whether or not the interview should be tape-recorded and that there will be no consequences for me if I do not want the interview to be recorded.

I understand that information from the tapes will be transcribed and transcripts will be given a code and my name will not be mentioned. I understand that if the interview is tape-recorded, the tape will be destroyed two years after publication of the findings.

I understand that I can ask the person interviewing me to stop tape recording, and to stop the interview altogether, at anytime.

I consent voluntarily for the researcher to record the interview.

Participant's signature----- Date-----

Interviewer's signature ----- Date -----



Appendix 6(d)

Informed consent for audiotape-recording by psychiatrists in selected psychiatric hospitals

Implementation of the Mental Health Care Act in psychiatric hospitals

I have received the information sheet on the study entitled: *Implementation of the Mental Health Care Act in psychiatric hospitals*. I have read and understood the Information Sheet. All my questions have been addressed satisfactorily in the Information Sheet.

I understand that I can decide whether or not the interview should be tape-recorded and that there will be no consequences for me if I do not want the interview to be recorded.

I understand that information from the tapes will be transcribed and transcripts will be given a code and my name will not be mentioned. I understand that if the interview is tape-recorded, the tape will be destroyed two years after publication of the findings.

I understand that I can ask the person interviewing me to stop tape recording, and to stop the interview altogether, at anytime.

I consent voluntarily for the researcher to record the interview.

Participant's signature----- Date-----

Interviewer's signature ----- Date -----

**Interview schedule for the drafter of the Act at the National Department of Health****Implementation of the Mental Health Care Act in psychiatric hospitals****For official use only**

Location: National Department of Health							
1. Questionnaire serial number	<table border="1"><tr><td></td><td></td><td></td></tr></table>						
2. Date of interview:	DD/MM/YY <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
3. Was the interview completed?	<div><input type="checkbox"/> No 0 <input type="checkbox"/> Yes 1</div> <table border="1"><tr><td></td></tr></table>						

STATEMENT OF CONSENT

I have been given an information sheet and I understand the objectives of the study. I further understand that my responses will be kept confidential and that it is up me whether or not to participate in this interview. It has been explained to me that even if I choose not to participate in the interview, it will in no way prejudice me.

I agree voluntarily to participate in the interview **(please tick)**.

☐ **Yes**

☐ **No**

Signature:.....

Date:.....

IF YOU AGREE TO PARTICIPATE, THE FOLLOWING QUESTIONS WILL BE ASKED AND PLEASE FEEL FREE TO ASK FOR CLARITY WHERE NECESSARY.

SECTION 1: BACKGROUND CHARACTERISTICS

For official
use only

101	What is your position in the Department?	_____
102	What is your gender?	<input type="checkbox"/> Male...1 <input type="checkbox"/> Female...2
103	What is your racial background?	<input type="checkbox"/> Black African...1 <input type="checkbox"/> Coloured...2 <input type="checkbox"/> Indian...3 <input type="checkbox"/> White...4 <input type="checkbox"/> Other...9 Specify:_____
104	How many years have you been in your current post?	_____ years (Answer 0 if less than 1 year)
105	What is your professional background?	<input type="checkbox"/> Professional Nurse...1 <input type="checkbox"/> Clinical Psychologist...2 <input type="checkbox"/> Social Worker-----3 <input type="checkbox"/> Other.....4 Specify:_____
106	How many years have you been qualified in your profession?	_____ years (Answer 0 if less than 1 year)

SECTION 2: THE IMPLEMENTATION PROCESS

Below are a number of questions about the implementation of the Act. Think about the situation and answer as broadly as you can recall.

- 201: In your view, what are the main intentions of the Act?
- 202: Can you describe how stakeholders were orientated on the new Act?
- 203: Can you identify stakeholders that were orientated on the Act?
- 204: What preparations were made for the implementation of the Act?
- 205: Were there any foreseen challenges that could impede the implementation of Act? Please elaborate.
- 206: If there were challenges identified, could you describe measures that instituted to address them?
- 207: Who was involved in the processes of implementing the Act?
- 208: Was there any coordinating structure established for the implementation of the Act? Please give detail.
- 209: Were guiding materials developed on the implementation of the Act? Give examples.
- 2010: Was a national plan drawn with timeframes and resource requirements for the implementation of the Act? Please explain.
- 2011: What system is in place to monitor the implementation of the Act?
- 2012: Are there any other comments you will like to make?

SECTION 3: PERCEPTIONS

- 301: What is your perception of the implementation of the Act in general?
- 302: How would you regard the implementation of the Act specifically in psychiatric hospitals? Please explain.
- 303: If you perceive the implementation of the Act as ineffective, what do you think are the barriers?
- 304: From your viewpoint, what successes have been achieved in the implementation of the Act?
- 305: Are there any specific factors in psychiatric hospitals that impede implementation of the Act?
- 306: From your own view, are the intentions of the Act met?
- 307: What suggestions do you have to improve the implementation of the Act?
- 308: Are there any final comments you would like to make on the implementation of the Act?

THANK YOU FOR YOUR PARTICIPATION



Interview schedule for provincial mental health coordinators

Implementation of the Mental Health Care Act in psychiatric hospitals

For official use only

Location: Provincial Department of Health	
1. Questionnaire serial number	<input type="text"/> <input type="text"/> <input type="text"/>
2. Date of interview: <u> </u> DD/MM/YY	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3. Was the interview completed?	<input type="checkbox"/> No 0 <input type="checkbox"/> Yes 1 <input type="text"/>

STATEMENT OF CONSENT

I have been given an information sheet and I understand the objectives of the study. I further understand that my responses will be kept confidential and that it is up to me whether or not to participate in this interview. It has been explained to me that even if I choose not to participate in the interview, it will in no way prejudice me.

I agree voluntarily to participate in the interview **(please tick)**. ☐ **Yes**

☐ **No**

Signature:.....

Date:.....

IF YOU AGREE TO PARTICIPATE, THE FOLLOWING QUESTIONS WILL BE ASKED AND PLEASE FEEL FREE TO ASK FOR CLARITY WHERE NECESSARY.

SECTION 1: BACKGROUND CHARACTERISTICS

For official
use only

--	--

101 What is your position in the Department? _____

--

102 What is your gender? ☐ Male...1
☐ Female...2

--

103 What is your racial background? ☐ Black African...1
☐ Coloured...2
☐ Indian...3
☐ White...4
☐ Other...9
Specify: _____

--

104 How many years have you been in your current post? _____ years
(Answer 0 if less than 1 year)

--	--

105 What is your professional background? ☐ Professional Nurse...1
☐ Clinical Psychologist...2
☐ Social Worker-----3
☐ Other.....4
Specify: _____

--

106 How many years have you been qualified in your profession? _____ years
(Answer 0 if less than 1 year)

107 How many years have you been employed in the province? _____ years
(Answer 0 if less than 1 year)

SECTION 2: THE IMPLEMENTATION PROCESS

Below are a number of questions about the implementation of the Act. Think about the situation and answer as broadly as you can recall.

- 201: In your view, what are the main intentions of the Act?
- 202: Were you officially trained on the Act? Please provide details.
- 203: Can you describe how the training on the Act is being coordinated in your province?
- 204: In terms of your position in the department, do you have adequate powers to influence implementation?
- 205: What was your involvement in the preparations for the implementation of the Act?
- 206: What preparations were made in the province for the implementation of the Act?
- 207: Was there any coordinating structure established for the implementation of the Act in the province?
- 208: What factors impedes the implementation of the Act in psychiatric hospitals in your province?
- 209: Could you describe measures that are put in place to address the challenges?
- 2010: Are there national guiding materials available on the implementation of the Act? Give examples.
- 2011: Is there a provincial mental health policy to strengthen the implementation of the Act?
- 2012: Was a provincial plan for the implementation of the Act drawn with timeframes and resource needs?
- 2013: How is the implementation of the Act monitored in your province?
- 2014: Are there any other comments you will like to make?

SECTION 3: PERCEPTIONS

- 301: What is your perception of the implementation of the Act in your province?
- 302: How would you regard the implementation of the Act specifically in psychiatric hospitals in your province? Please explain.
- 303: Are there any specific factors in psychiatric hospitals that impede implementation of the Act?
- 304: From your viewpoint, what successes have been achieved in the implementation of the Act in your province?
- 305: In your view, are the intentions of the Act met in psychiatric hospitals?
- 307: What suggestions do you have to improve the implementation of the Act in psychiatric hospitals?
- 308: Are there any final comments you would like to make on the implementation of the Act?

THANK YOU FOR YOUR PARTICIPATION



Interview schedule for Mental Health Review Boards

Implementation of the Mental Health Care Act in psychiatric hospitals

For official use only

Province ID	

1. Questionnaire serial number	

2. Date of interview:	DD/MM/YY

3. Was the interview completed	Yes ----- No -----

STATEMENT OF CONSENT

I have been given an information sheet and I understand the objectives of the study. I further understand that my responses will be kept confidential and that it is up to me whether or not to participate in this interview. It has been explained to me that even if I choose not to participate, my refusal to participate will in no way prejudice me.

I agree voluntarily to participate in the interview **(please tick)**. ☐ **Yes**

☐ **No**

Signature:.....

Date:.....

IF YOU AGREE TO PARTICIPATE, THE FOLLOWING QUESTIONS WILL BE ASKED AND PLEASE FEEL FREE TO ASK FOR CLARITY WHERE NECESSARY.

SECTION 1: BACKGROUND INFORMATION

1. What is your position on the Board? ☐ Chairperson...1
☐ Member...2
2. What is your role on the Board ☐ Legal Practitioner...1
☐ Mental Health Care Practitioner...2
☐ Community Member...3
3. When were you appointed on the Board?
-----Year
4. Did you receive a written employment agreement with all conditions of your service from the MEC? ☐ Yes...1
☐ No...0
5. Where is the board located?
☐ Hospital...1
☐ District office...2
☐ Provincial mental health office...3
☐ Governance office...4
☐ MEC's office...5
☐ Other...9
6. What is your professional background? ☐ Nurse...1
☐ Psychologist...2
☐ Social Worker...3
☐ Lawyer...4
☐ Medical Doctor...5
☐ Other...9

Specify:_____
7. How long have you been serving on the Board the Board? -----Years
☐ Less than 1 year...1
☐ 1 to 3 years ...2
☐ 3-6 years...3
☐ 6 years and more----4
8. How many times in a week do you meet as a Board _____ times

9. **Does your Board have any of the following?**
- ☐ A dedicated office: Yes---1 No--0
☐ Office shared with other Programmes: Yes---1 No--0
☐ Computer: Yes---1 No--0
☐ Fax: Yes---1 No--0
☐ Photocopier: Yes---1 No--0
☐ Telephone: Yes---1 No--0
Others:_____
10. **Does your Board have administrative support?**
- ☐ Yes...1
☐ No...0
11. **Have you met with your MEC in 2005 to 2010?**
- ☐ Yes...1
☐ No...0
12. **How many meetings have you had with the MEC during 2005-2010?**
- None----0
One----1
Twice----2
More than Twice----3

SECTION 2: INTRODUCTION

13. Does your Board draw ad submit an annual strategic plan indicating all planned activities and the resource requirements? ☐ **Yes...1** ☐ **No...0**
14. Is there an annual budget provided for the Board? ☐ **Yes...1** ☐ **No...0**
15. Is there a platform where the Board presents to the MEC and in the Province their performance reports? ☐ **Yes...1** ☐ **No...0**
16. Did you receive any training on the Mental Health Care Act and your role as a Board?
- ☐ **Yes...1** ☐ **No...0**
17. In your view, was the training sufficient? ☐ **Yes...1** ☐ **No...0**
18. What are your views on the implementation of the Mental Health Care Act in that psychiatric hospital?
19. Could you comment on the functioning of the Mental Health Review Board?
20. What are the successes of the Mental Health Review Board?
21. Can you please explain the challenges in the functioning of the Mental Health Review Board?

SECTION 3: CONDUCTING APPEALS

22. Have the Board conducted appeals during 2005- 2010? ☐ Yes...1 ☐ No...0
23. Were there witnesses summoned by the Board to appear before the Board to give evidence relevant to the appeal during this period? ☐ Yes...1 ☐ No...0
24. Were the summoned persons compensated by the provincial Department for expenses incurred to attend the appeal? ☐ Yes...1 ☐ No...0
25. Were mental health care users legally represented during the appeals?
☐ Yes...1 ☐ No...0
26. What was the nature of the appeals lodged during that period?
27. How were the notices of the scheduled appeals communicated by the Board during this period?
28. What were the outcomes of the appeals held during 2005-2010?
29. What challenges were encountered by the Board when conducting the appeals?
30. What possible solutions do you recommend to address the challenges?

SECTION 4: INVESTIGATIONS OF COMPLAINTS IN PSYCHIATRIC HOSPITALS

31. Did the Board visit any psychiatric hospital to investigate an alleged complaint in 2010?
☐ Yes...1 ☐ No...0
32. What issues relating to the complaints lodged were identified at the psychiatric hospital?
33. How did the Board resolve the issues found at the psychiatric hospital?
34. In your viewpoint, does the Board have adequate powers to enforce disciplinary measures to those found contrary to the human rights of the mental health care users?
35. What do you recommend could be done to empower the Boards on the investigations of alleged complaints?

SECTION 5: DECISIONS ON APPLICATIONS FOR INVOLUNTARY CARE, TREATMENT AND REHABILITATION

36. Were the application documents for further involuntary admissions submitted to the High Court for authorization in 2010? ☐ Yes...1 ☐ No...0
37. Did the Board receive outcomes of the applications accordingly from the High Court?
☐ Yes...1 ☐ No...0
38. What are the challenges encountered in processing applications for involuntary admissions from psychiatric hospitals?
39. How did the Board address those challenges identified on the application process?

40. What are the challenges in obtaining authorization of involuntary admissions from the High Court?
41. What do you recommend could be done to address the challenges with the High Courts?

SECTION 6: PERIODIC REPORTS ON THE MENTAL HEALTH STATUS OF MENTALLY ILL PRISONERS.

42. Were periodic reports for mentally ill prisoners submitted to the Board during 2010?
☐ Yes...1 ☐ No...0
43. What are the challenges in processing the periodic reports for mentally ill prisoners?
44. What could be done to address the challenges?

SECTION 7: FINAL COMMENTS

Are there any final comments you want to make regarding the functioning of the Board?

THANK YOU FOR YOUR PARTICIPATION

Interview schedule for psychiatrists or medical officers in selected psychiatric hospitals

Implementation of the Mental Health Care Act in psychiatric hospitals

For official use only

Provincial ID:	
1. Questionnaire serial number	<input type="text"/> <input type="text"/> <input type="text"/>
2. Date of interview: <u>DD/MM/YY</u>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3. Was the interview completed?	<input type="checkbox"/> No 0 <input type="checkbox"/> Yes 1

STATEMENT OF CONSENT

I have been given an information sheet and I understand the objectives of the study. I further understand that my responses will be kept confidential and that it is up me whether or not to participate in this interview. It has been explained to me that even if I choose not to participate in the interview, it will in no way prejudice me.

I agree voluntarily to participate in the interview **(please tick)**.

☐ **Yes**

☐ **No**

Signature:.....

Date:.....

IF YOU AGREE TO PARTICIPATE, THE FOLLOWING QUESTIONS WILL BE ASKED AND PLEASE FEEL FREE TO ASK FOR CLARITY WHERE NECESSARY.

SECTION 1: BACKGROUND CHARACTERISTICS

**For official
use only**

101 How many years have you been in your current post? _____

102 What is the gender of mental health care users in the ward? ☐ Male...1
☐ Female...2

104 How many years have you been working in this ward? _____ Years

105 What is your professional background? ☐ Registered psychiatrist----1
☐ Medical Officer with psychiatry diploma...2
☐ Medical officer with no formal qualification in psychiatry-----3
☐ Other.....4
Specify: _____

106 How many years have you been qualified in your profession? _____ years
(Answer 0 if less than 1 year)

107 How many years have you been employed in the province? _____ years
(Answer 0 if less than 1 year)

SECTION 2: THE IMPLEMENTATION PROCESS

Below are a number of questions about the implementation of the Act. Think about the situation and answer as broadly as you can recall.

- 201: Have you been officially trained on the Act? Please provide details.
- 202: When did you receive the last training and orientation on the Act?
- 203: Are you conversant with the Mental Health Care Act?
- 204: How would you describe the present status of the implementation of the Act in the hospitals?
- 205: In your view, do you think that the hospital has the capacity to implement the Act?
- 206: Are there aspects in the Act that you think cannot be practically implemented in the hospital?
- 207: Do you feel supported by the province on the implementation of the Act?
- 208: Are there sufficient material available to translate the prescripts of the Act for implementation in the hospital?
- 209: What are the challenges on the implementation of the Act in the hospital?
- 2010: Would you say that the implementation of the Act in the hospital is successful or not?
- 2011: Are psychiatrists in the province involved in the plans for implementation of the Act?
- 2012: Are there any challenges regarding the documentation or forms for mental health care users prescribed by the Act
- 2013: From your viewpoint, what successes have been achieved in the implementation of the Act in the hospital?
- 2013: Are there any final comments you would like to make on the implementation of the Act in the hospital.
- 2014: Is there a system in the hospital to monitor implementation of the Act?
- 2015: Are there any final comments you would like to make on the implementation of the Act?

THANK YOU FOR YOUR PARTICIPATION

Information sheet for hospital and ward managers in the selected designated psychiatric hospitals for review of involuntary mental health care user's files on admission procedures

Implementation of the Mental Health Care Act in psychiatric hospitals

Introduction and background

My name is **Evah Mulutsi** from the **School of Public Development and Management at the University of Witwatersrand**. I am registered for PHD studies and conducting a study on the implementation of the Mental Health Care Act, 2002 (No 17 of 2002).

The overall aim of this study is to analyse the implementation of the Act in designated psychiatric hospitals from 2005 to 2010, thereby exploring the field of policy implementation in mental health.

The specific objectives are to assess the perceptions of stakeholders in mental health regarding the implementation of the Act in designated psychiatric hospitals; analyse the processes that were followed in the implementation of the Act; determine whether Mental Health Review Boards in designated psychiatric hospitals carry out their roles and are functions as prescribed in the Act and to analyse whether procedures prescribed in the Act on involuntary admissions are followed in designated psychiatric hospitals. The information obtained could be used to inform improvements in mental health services in line with the objectives of the Act.

You are requested to allow the researcher access to review the patient's files in order to evaluate if the procedures prescribed in the Act are followed accordingly. Findings from the record reviews will not be singled out per hospital but consolidated to give a broad general overview of the situation.

Confidentiality

The information will be kept confidential. All hospitals and patient's files will be assigned a code, which will be known by the researcher only. The name of the hospital will not be revealed in any written data or report of the study. All information gathered will be consolidated, analysed and written up in the form of a report.

Benefits and risks of participation

Kindly note that participation in this study is voluntary and there will be no direct benefits to the all participants. There is no compensation for taking part in the study. Hospitals that do not wish to participate will face no negative consequences. The hospital can be withdrawn from participating in the study.

Completed questionnaires

Kindly note that findings and notes will be kept by the researcher only and confidentially kept. The ward and mental health care user's identity will not be disclosed but the codes will be assigned to each response sheet. We are interested in your honest opinion on the implementation of the Mental Health Care Act. The responses will be kept in a locked cupboard and will be destroyed two years after publication of the research findings, which is in line with the national requirements.

Contact Details

You may contact me for clarity on any issue pertaining to the study at (tel) 012 395 8044, (cell) 082 3020 444 or (e-mail) mulute@health.gov.za.

Checklist for review of procedures for involuntary psychiatric admissions

Implementation of the Mental Health Care Act in psychiatric hospitals

Province:

Hospital:

Review date:

File no:

Gender:

Occupation:

Age:

Diagnosis:

Admitted on-----Discharged on-----Total No. of admission days:

	Yes=1	No=2	Comments
1. Was the application for involuntary admission made on the prescribed form?			
2. Last seen in 7 days			
3. Form 4			
4. Form 5 x2			
5. Categories of MH practitioners who conducted the exam?			
6. Findings of the two practitioners duplicated			
7. Is there a commissioner of oaths?			
8. Who made the application on behalf of the mental health care user? Applicant			
9. Does the person meet the criteria for applicants prescribed in the Act?			
10. If the applicant is not a relative to the user, were reasons indicated why the application is made by him or her and what steps were made to locate the relatives?			
11. Is it indicated on the documents the grounds on which the applicant believes that involuntary care, treatment and rehabilitation are required?			
12. Is there evidence that the head of the health establishment caused the mental health care user to be examined by two			

mental health care users? Form 7: Notice by HOHE			
13. Was the application approved by the head of the health establishment?			
14. Does the person meet the criteria for applicants prescribed in the Act?			
15. Is it indicated on the documents the grounds on which the applicant believes that involuntary care, treatment and rehabilitation are required? Reasons for involuntary admissions?			
16. Is there evidence that the head of the health establishment caused the mental health care user to be examined by two mental health care users?			
17. Is there evidence that the mental health care user underwent 72-hours assessment? Form 6			
18. Were the application documents for involuntary admission submitted to the Mental Health Review Board for approval? Form 8			
19. Is there evidence on the response of the Board on the application for involuntary admission? Form 14			
20. Was the submission to and response from the Board within the necessary timeframes prescribed in the Act?			
21. Is there proof of approval of the involuntary admission by the High Court? Form 16			
22. Was the involuntary status of the user changed on recovery of the mental status?			
23. Had the user absconded during admission? If yes, were the members of the SAPS informed? Form 25			
24. Request for administrator? Form 39			
25. Appeal of admission? Form 15			
26. Generally, do records comply with the prescripts of the Act?			

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