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Evidence of Balanced Care in South African and International Mental Health Treatment Trends

Judith M. Mondo

672073



Supervisor: Prof. Tanya Graham

A research report submitted in partial fulfilment of the requirements for the degree of Master of Arts in Psychological Research in the Faculty of Humanities, University of the Witwatersrand, Johannesburg, 2017.

Declaration

I hereby declare that the thesis report titled, *Evidence of balanced care in South African and International mental health treatment trends,* was written by me, and is being submitted to the faculty of Humanities (University of the Witwatersrand) in partial fulfilment of the degree of Master of Arts in Psychological Research. This is my original work and all conclusions drawn in this study are based on the material collected by me.

I further declare that this work has not been submitted to this or any other University for the award of any other degree, diploma or equivalent course.

Judith Muwawa Mondo

Signed this 8th Day of August, 2017

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Thank you

Judith Mondo

Abstract

Mental ill-health constitutes a substantial burden of disease worldwide, representing more than the burden of disease caused by all cancers combined. However, the provision of mental health care remains inadequate around the world. To address the shortages in mental health care expenditures, the WHO-HEN (2003) proposed treatment priorities and policy goals in different contexts, based on their financial resources. This study investigates the state of mental health treatment provision in high-, middle-, low-income and the South African contexts, in order to assess the efforts that have been made in these contexts to counter the shortages in mental health care provision, and to promote public mental health, following the WHO-HEN (2003) suggestions. This study uses the mixed methods approach to review literature published between 2004 and 2016 within the *AJCP, AJP, CMHJ, SAJPs and SAJP*. The findings reveal that treatment trends across contexts align with, and extend beyond the WHO-HEN (2003) suggestions in most cases, and that the balanced care approach is progressively being implemented in the delivery of integrated mental health services in high-income countries and South Africa specifically. These results prove that efforts are being made across contexts to provide effective mental health care, and to ensure the promotion of mental health and prevention of mental disorders.

Keywords: balanced care, mental health care, high-income, low-income, middle-income, mental illness, South Africa, World-Health Organization- Health Evidence Report.

List of abbreviations

ACT:	Assertive Community Treatment
AJCP:	American Journal of Community Psychology
AJP:	American Journal of Psychiatry
APA:	American Psychological Association
BAD	Bipolar Disorders
CBT:	Cognitive Behaviour Therapy
CMHJ:	Community Mental Health Journal
DBT	Dialectical Behaviour Therapy
DSM:	Diagnostic and Statistical Manual of Mental Disorders
GAD	Generalised Anxiety Disorder
GNI:	Gross National Income
HIV	Human Immunodeficiency Virus
ICD:	International Classification of Diseases
IDDT	Integrated Dual Diagnosis Treatment
LGBTI	Lesbian Gay Bisexual Transgender and Intersex
MHC:	Mental Health Care
MI:	Mental Illness
PCC	Primary Care Centre
PTSD:	Post-Traumatic Stress Disorder
SAJP:	South African Journal of Psychology
SAJPs:	South African Journal of Psychiatry
SES	Socioeconomic Status
SMI:	Serious Mental Illness
SUDs	Substance Use Disorders
UK	United Kingdome
US	United States
WHO:	World Health Organization
WHO-HEN:	World Health Organization- Health Evidence Network

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CHAPTER ONE: INTRODUCTION

This study presents an empirical review of the literature on mental health care (MHC) from 2004 to 2016, through an evaluation of treatment trends in mental health-related research published within the *American Journal of Community Psychology (AJCP), American Journal of Psychiatry (AJP), Community Mental Health Journal (CMHJ), South African Journal of Psychiatry (SAJPs)* and *South African Journal of Psychology (SAJP).* This study aims to investigate how international and local contexts have addressed the burden of mental health by examining the types of MHC that were mostly used and researched in the past thirteen years. This chapter discusses the importance and relevance of research of this nature, presenting the aims of this study and the approach it takes to addressing them; and finally this chapter outlines the chapter organisation and content of the entire thesis.

1.1. Rationale

Mental health is commonly understood as the mere lack or absence of mental disorders. However, it is more than just that. According to the WHO (1992), concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one's intellectual and emotional potential. Mental ill-health is therefore the compromise of any of these concepts, as it impacts a person's potential, their capacity to work productively and contribute to their society (Petersen, Bhana, Fisher, Swartz & Richter; 2010; WHO, 2004). Mental health is thus a concern for all, as its problems affect society as a whole, and present a major challenge to global development. Mental illnesses are among the most common conditions affecting health today, in both developed and developing countries. A study by Murray and Lopez (1996) reported that Neuropsychiatric conditions contributed 10.5% of the worldwide burden of disease in 1990, increasing to 12% in 2000, and predicted to reach 15% in 2020.

Mental illness represents a substantial burden to the world. Psychiatric disorders, and depression in particular, were reported to be on average the second cause of disability in developed countries and the fourth in the entire world in 1998 (Lopez & Murray, 1996). A report

by the WHO (2013) also confirmed that mental illness is one of the current biggest threats to human and community well-being in the combined extent of prevalence, persistence and extent of impact. In a study conducted by the World Health Organization, the World Bank, and Harvard University, it was revealed that mental illness, including suicide, accounts for over 15 percent of the burden of disease in the United States' market economies, representing more than the disease burden caused by all cancers (National Institute of Mental Health, 2006). Studies investigating the incidence of mental illness in Africa suggest that the prevalence is at least comparable with that of the international community (Hugo, Boshoff, Traut, Dirwayi & Stein, 2003). It was reported for instance that neuropsychiatric conditions contribute 4% of the total burden of disease in Africa, which is predicted to increase to 18% by 2020 (WHO, 2001). Although the burden of mental illness is comparable worldwide, mental health and mental disorders are not accorded the same importance as physical health in most parts of the world.

In South Africa, the mental health policy and legislation have been subject to a number of important reforms, and despite these reforms, the domain of mental health is still faced with numerous challenges. These challenges often range from inequity of distribution of mental health services and resources between provinces, lack of public awareness of mental health, to lack of accurate data regarding the extent of mental health service provision and management (Lund et al., 2009). The National Mental Health Policy Framework and Strategic Plan 2013-2020 is the most recent MHC reform that is set to improve and transform mental health service provision in SA in line with the WHO-HEN (2003) recommendations. Despite South Africa's progressive mental health legislation, it has been reported that a staggering 75% of the individuals that are mentally affected countrywide do not receive the care that they require (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009).

Multiple barriers to the financing and development of mental health services still exist both in developed, middle and low-income countries, significantly impacting the quality of treatment provided to the affected (WHO, 2007). A study conducted by Street, Molinari and Cohen (2013) shows that at least 18 American states make no specific reference to Serious Mental Illness (SMI) in their nursing home regulations, reporting a lack of appropriate care for nursing home residents with SMI. Such conditions show that the challenges that individuals with mental illness are faced with worldwide constitute one of the great human rights scandals of this century (Drew

et al., 2011). Studying the effectiveness of treatment provision for MI is thus necessary in order to improve not only the lives of the affected individuals, but also to address some of the human rights issues that the lack of effective treatment constitutes. Such studies are also needed to inform policy makers in developing effective care policies for MI.

In a Health Evidence Network report from 2003, the WHO states that for mental health to be promoted and protected, and for mental illness to be controlled for, it is a necessity that national budgets around the world be allocated to developing adequate infrastructures and services for mental illness, and that human resources needed to provide care for the affected population be ameliorated (WHO-HEN, 2003). This study thus aims to investigate the content of locally (South African) and internationally published work on MHC, in order to assess the ways in which the treatment agenda for MI as reflected in the published literature has responded to this call from the WHO-HEN (2003), both locally and internationally.

Moreover, this 2003 WHO-HEN report suggests that it is paramount that states around the world provide not only an accessible medical support budget, but also finance the training and sustenance of the active providers of the medical care, including professional mental-health care providers, since the competency of the care providers is an important need for the recovery of individuals with mental disorders. However, the resources dedicated to MHC remain universally inadequate, with remarkable gaps in service delivery. Scarcity of available human, financial and infrastructural resources, as well as inefficiency of mental health policies have often been pointed to be the reasons for mental treatment gaps worldwide (Saxena, Thornicroft, Knapp & Whiteford, 2007). Statistics from the WHO (2015) show that most low to middle income countries (African countries in particular) have a median number of 5 beds and below per 10 000 population with mental illnesses (most of which are placed in psychiatric hospitals), compared to at least 50 beds per 10 000 population in high-income countries (WHO, 2015). In terms of trained mental health professionals, statistics show that the global median number of mental health workers is of 9 per 100 00 population, varying from below 1 per 10 000 population in low and middle income countries to over 50 in high-income countries (WHO, 2015); whereas levels of public expenditures on MHC are even worse off in low and middle-income countries, with less than US$ 2 per capita (WHO, 2015). Although the resources in high income countries may seem a bit better off as opposed to low income and middle income countries, the situation

remains that resources for mental illness are universally inadequate. (Shah & Beinecke, 2009). While mental ill-health constitutes a considerable burden to the World's health, the resources allocated to MHC are derisory, as shown in the above statistics. Therefore, studies that investigate ways of improving MHC provision with the resources available according to each context's economic stability are required.

Taking into account the shortages in mental-health care expenditures worldwide, the WHO-HEN (2003) suggested that depending on the financial resources, the priorities and policy goals in low income countries should mainly focus on establishing and improving MHC delivery within primary care settings, using specialists as a backup; and that medium-resource countries seek to provide outpatient treatment centres, community-based MHC , acute inpatient care, occupational and long-term community-based residential care. Additionally, the WHO-HEN (2003) report recommended that high-resource countries, in addition to such services provided in low income countries and middle income countries, should provide specialized ambulatory clinics and community mental health teams, long-term community residential care together with vocational rehabilitation, as well as assertive community treatment and alternatives to acute inpatient care (Thornicroft & Tansella, 2003). This study thus aims to explore whether the types of treatment strategies used and researched in the past thirteen years in low-, medium-, and high-income countries, have answered to this call in improving the provision of MHC.

Clinical and community-based mental care strategies have historically been treated as two different approaches, in that the former focuses more on hospital-based in-patient medical types of intervention and the later more on out-patient non-medical forms of care (Drake et al., 2001). The WHO- HEN (2003) encourages the adoption of balanced care, which combines aspects of both community and clinical-based models, as a more holistic approach to MHC. The balanced care model that integrates key elements of both clinical and community-based mental health services is thus necessary in facilitating the continuity of care and in stimulating the adoption of a holistic and flexible approach to the treatment of patients with mental illness (Thornicroft & Tansella, 2002). Therefore, this study investigates the adoption of balanced care in the last thirteen years as a more holistic approach to mental health treatment, arguing that the provision of acute and intensive mental health treatments whether in hospitals or community settings are not incompatible (Thornicroft & Tansella, 2002).

In addition, not many studies have particularly investigated the evidence of the adoption of the balanced care model for mental illness in improving mental health treatment provision. Studies that have investigated treatment provision for mental illness have mostly focused on the effectiveness of either hospital-based or community-based types of treatments separately and usually in relation to re-admission rates and cost-effectiveness (Barker, Robinson & Brautigan, 1999; Burns, 2010; Kallert et al., 2007; Marshal et al., 2003; Schene, 2004; Uttley, Stevenson, Scope, Rawdin & Sutton, 2015; Van Veen et al., 2015). Other studies have compared the effectiveness of medical and/or community models of treatment in improving symptoms of mental illness (Gary et al., 2001; Grano et al., 2016; Livingston, 2012; Mueser, Gottlied, Xie, Lu & Yanos, 2015; Padgett, Stanhope, Henwood & Stefancic, 2011; Zatzick et al., 2011). This study examines literature-based evidence of the adoption of the balanced care model, comparing the types of balanced mental health intervention that have been most used and reported in South Africa versus internationally, in relation to the promotion of mental health and prevention of mental illness.

Mental health promotion and the prevention of mental disorders are two interrelated public health concepts. While prevention of mental disorders aims to reduce the prevalence, prognosis, and incidence of these disorders, mental health promotion essentially aims to promote optimal psycho-physiological development as well as mental and behavioural health in the public, and is not primarily concerned with the amelioration of symptoms and deficits (Petersen et al., 2010). This study adopts a mental health promotion and prevention framework in investigating the content and trends of publication in the field of MHC. With the burden of mental illness predicted to reach 20% of the burden of disease worldwide, it is crucial to study if and how the provision of MHC is aimed at reducing risk factors for mental ill-health as well as strengthening protective factors for mental well-being.

Looking into the literature from 2004 to 2016 with the lens of a public health framework, this study hopes to highlight the gaps in the treatment strategies as represented in the literature, and to further make suggestions for improvement in policies with regards to mental health prevention, promotion, and care provision.

1.2. Research Aims

The primary aim of this study is to investigate the evidence of the use of balanced care in the treatment of mental disorders in the timeframe from 2004 to 2016. In doing so, this study intends to assess how the trends in MHC are responding to the increased health burden of mental disorders. Moreover this study intends to unravel the types of mental health treatment that are the most prominent in high, middle and low income countries, comparing the trends of balanced care between each of these contexts. Therefore, using the public health's framework of mental health promotion and prevention, this study focuses on analysing the evidence of balanced-care for mental illness in the last thirteen years, with the argument that using a balanced-care model will improve the promotion of mental health, which will then have an effect on reducing the incidence of mental disorders.

Finally, this study examines if and how these trends in balanced care are consistent with the core-components suggested by the WHO-HEN report of 2003.

1.3. Chapter Organisation

This thesis is divided into six chapters, comprising 1) the introduction; 2) the literature review; 3) the methodology; 4) the presentation of findings; 5) an overall discussion; and 6) a general conclusion. The current chapter, *Chapter One*, provides a general introduction to the study, and a rationale of the value of this study. *Chapter Two* situates this study within the mental health literature, introducing a debate on the conceptualisation of mental disorders, as well as issues of classification of mental disorders. This chapter also discusses the issue of MHC and the barriers to effective provision of treatment services, introducing and explaining the different types of treatment that exist. *Chapter Three* introduces the research questions that this study investigates, and describes the methods used to address these questions. Chapter three also provides an in-depth explanation of the approach that this study adopts, which falls within the pragmatic paradigm, using a mixed methods design. The details regarding the type of mixed-methods design employed in this study are also presented in this chapter, as well as the steps used in analysing the data. The coding framework used in this study is introduced, and an explanation of the variables of interest is also provided. Chapter three concludes with a discussion of issues of self-reflexivity and ethical considerations. The results are then presented

in the subsequent chapter, *Chapter Four,* paying particular attention to the description of the trends in the data. This chapter makes use of graphs and tables to illustrate the findings. These results are further discussed in *Chapter Five* which also provides a deeper insight into the pattern of relationships within the data. *Chapter Six* addresses the limitations of this study, and highlights directions for future studies.

1.4. Conclusion

This chapter has provided the rationale for why this research is important, laying a solid foundation for carrying out this study. The prevalence of mental disorders and the extent of the impact of these disorders have been highlighted, and the next chapter elaborates these further.

CHAPTER TWO. LITERATURE REVIEW

2.1. Introduction

The purpose of this chapter is to provide a conceptual background in which this research can firmly be located. This chapter begins with the conceptualization of mental disorders and an engagement with the debates surrounding the definitions and classification of mental disorders, followed by a discussion of the prevalence and incidence of mental disorders worldwide. The discussion then addresses the issues of mental health legislation and distribution of MHC resources worldwide, stressing the role that they play in constituting barriers to effective MHC delivery. The types of mental health treatment approaches are then discussed, with particular attention paid to community-based, clinical and balanced treatment strategies, as well as other non-conventional types of mental health treatment. This chapter concludes with a discussion of the theoretical framework of the study.

2.2. Mental Illness

The concept of MI has long been at the heart of the debates and disagreements in both psychology and medicine (Millon, 1991). One challenge, argues Millon (1991) is the complexity of the natural world which makes it difficult, not only to establish definite observable phenomena, but to find unpretentious ways of classifying and grouping these phenomena. For some authors, like Rosenhan (1973) and Szasz (1974), mental illnesses are fictitious illnesses, because, they argue, it is almost impossible to draw boundaries between the normal and the abnormal, and it is impossible to assume a general universal definition of abnormality. This is in no ways to deny the existence of mental ill-health, but to question the power of psychiatric diagnoses, ‘’especially when their subjective and biased nature are taken into account’’ (Dammann, 1997, p. 740).

Wakefield (2013) wonders what is meant when a problematic mental condition such as intense sadness or an adolescent antisocial behaviour is said to be indicative of psychiatric disorder, and not merely a form of normal human functioning, albeit undesirable and painful? Which conditions should be classified as mentally pathological and which as normal problems of living? Although psychiatry provides treatment for both normal and disordered conditions, the

credibility and coherence of psychiatry as a medical discipline, argues Wakefield (2013), depends on this field's ability to provide persuasive answers to these questions, if a consensus on the meaning of ''mental disorder'' is to be reached. Therefore, adds Millon (1991), the concepts and categories that scientists construct to classify mental disorders are "only optional tools to guide the observation and interpretation of the natural world" (p. 245).

Mental illness can have different definitions according to different approaches. In psychiatry, the Diagnostic and Statistical Manuel of Mental Disorders (DSM) produced by the APA, and chapter V of the International Classification of Diseases (ICD) produced by the WHO, are the two widely used mental illness classification systems, and as Wakefield (2007, p. 149) puts it, they are the "primary arbiters of what is disordered vs. non-disordered" human functioning. The ICD is the official classification tool used worldwide to primarily classify medical disorders; it includes a section that is solely concerned with psychiatric disorders, exclusively called 'Mental and Behavioural Disorders' (Tyrer, 2014). The DSM on the other hand is an American-based tool, developed using western notions of disease to determine the clusters of symptoms that categorise disorders (WHO, 1992). These classification systems are the basis of the authority that psychiatry holds in commanding MHC policies, and in determining the expenditures required for mental health service delivery (Wakefield, 2007). If these diagnostic tools are compromised, then the whole field of mental health may be at risk of being transformed into an epistemic barrier that could obstruct scientific evolution (Hyman, 2010).

The label attributed to a mental condition is both a powerful element that defines a patient in almost all social contexts, and the commander of the types of treatment that is provided to the diagnosed patient (Byrne, 2000). It has for instance been noted that where mental illness has been defined as a condition that has a life-time prognosis and that is manageable rather than curable, misconception of the sufferers' behaviours and mistreatment of them can occur, because the label used to describe certain behaviours becomes the cause of the behaviours it describes (Szasz, 2011). Hence, these classification systems regularly revise the criteria that define mental disorders, in order to validate their legitimacy in identifying psychiatric disorders from normal problematic mental conditions, and to guide proper treatment (Achenbach, 2001; McLeod & Lang, 2010). In both the DSM and ICD diagnostic systems, the criteria for clinical significance of a disorder generally include harm and negative valuing of the symptoms (Achenbach, 2001).

The discussion here again remains about discriminating potential negative symptoms that are disorders from those that are not, because, as noted by Dammann (1997), notions regarding proper treatment of MI are affected by the increasing medicalization of mental health in both the DSM and ICD systems.

2.2.1. Defining MI.

In the clinical sense, and according to the fifth edition of the DSM a mental disorder is a behavioural or psychological syndrome characterized by clinically significant disturbances in an individual's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying functioning, and which is primarily not a result of social deviance or conflicts with society (APA, 2012). Mental disorders are usually associated with significant distress in social, occupational, or other daily activities, which is not an expectable response to common stressors or a culturally appropriate response to a particular event (APA, 2012). Mental disorders comprise a broad range of issues, with varying symptoms generally characterised by irregular thoughts, emotions, behaviour and relationships with others (WHO, 2001). Unlike the DSM, the ICD does not consider interference with social behaviour and relationships as diagnostic criteria for mental disorders (WHO, 1992). The ICD defines a mental disorder as a condition that contains a set of clinically recognisable symptoms or behaviours that cause distress and interference in a person's functioning (WHO, 1992). Although these two classification systems categorize certain types of behaviour as 'disorders', they do not provide conceptual definitions of the boundaries that separate syndrome from normality (Millon, 1991; Wakefield, 2007). The question thus remains, as Wakefield and Schmitz (2012) pose, what is a disorder and what is not?

Defining MI has been an evolving struggle in psychiatry, and the definition of mental disorders offered by the DSM has been criticized for allowing the erosion of the distinction between psychopathology and normal psychological responses such as grief, sadness or shyness (Horwitz & Wakefield, 2007). Defining the concept of MI is an ongoing debate within the field of psychiatry (Rounsaville et al., 2002). A hybrid account of the concept of mental disorder suggested by Wakefield (2007) defines a disorder as a condition judged negative by the sociocultural standards in which they occur, and which, in the scientific factual term is a dysfunction or failure of biologically-defined functions of the brain. This paper therefore adopts

the criteria for MI defined by: impairments in daily functioning in contexts such as work, self-care and inter-personal relationships, disability caused by a psychiatric condition and characterised by abnormal thoughts, emotions, behavioural and interpersonal relations as suggested by the WHO (2001), and particularly mental conditions that require intensive psychiatric and community help for a significant length of time (Schinnar, Rothbard, Kanter & Jung, 1990).

Another area to point with regards to the classification of mental disorders is the assessment of the source or aetiology of the condition since what is believed to cause a certain disorder influences the choice of treatment that is most appropriate (Dammann, 1997). Thinking of a patient's condition as a mental disorder for instance, suggests that the locus of treatment should target the client's internal functioning, rather than his/her relationship with the environment, whilst both could be active players in causing the condition (Thakker & Ward, 1998). Therefore, confusion in understanding the aetiology of a disorder may lead to misclassification, misdiagnosis, and ineffective treatment.

As mentioned earlier in this chapter, the classification in the DSM is dominated by Western conceptualisation of disease, which reduces the validity of their universal applicability (Takker & Ward, 1998). Although efforts have been made in later editions of the DSM such as DSM-5 to include criteria for culture-bound syndromes, considerations for age, gender and culture, and a discussion of cross-cultural differences in the symptom-presentation of certain disorders, used in conjunction with the DSM-IV Axes (APA, 2012; Ehret & Berking, 2013), there is still scepticism in believing that these added cultural components incorporate the diversity in presentation of particular disorders across cultures; the expression of behaviour and sanctioning of deviant conduct are highly dependent on the socio-cultural environment, and what is considered right or wrong in a particular context (Alarcon, 1995; Fabrega, 1994; Thakker & Ward, 1998; Wakefield, 2013). It is commendable to analyse some of the changes introduced in the latest version of the DSM, DSM-5, in order to note the improvements (if any) in the reliability and validity of this diagnostic tool.

2.2.2. DSM-IV versus DSM-5.

The DSM-IV was a multiaxial system divided into five Axes, where Axis I comprised Particular clinical syndromes, Axis II personality disorders, Axis III- general medical conditions, Axis-IV- psychosocial/environmental problems, and Axis V covered global assessment of functioning (APA, 1994). The major structural change in the DSM-5 is the revised order of categories, and the discontinuation of the DSM-IV multiaxial system (Ehret & Berking, 2013). The DSM-5 is a monoaxial system (it combines Axis I-III of DSM-IV into one axis) that proposes a definition of MI that links the biomedical and bio-psychosocial components, allowing an individual's functioning to be captured on a continuous quantitative dimension of severity and associated symptoms, in addition to whether or not the person has a mental disorder as in the DSM-IV (Ehret & Berking, 2013).

The DSM-5 reflects considerable inclusions and exclusions of certain disorders. The DSM-5 for instance introduces Major and Mild Neuro-cognitive Disorders, Agoraphobia, Binge-Eating Disorder, Premenstrual Dysphoric Disorder, Disruptive Mood Deregulation Disorder, Excoriation Disorder, Caffeine Withdrawal, and Hoarding Disorder, as distinct disorders (APA, 2013). Disorders that existed in the DSM-IV and which have been eliminated from the DSM-5 include: Sexual Aversion Disorder and Undifferentiated Somatoform Disorder. Bereavement, as an exclusion criterion for Major Depressive Disorder in DSM-IV, has also been eliminated in DSM-5 (Wakefield & Schimtz, 2012). DSM-5 replaces the bereavement criteria with a vague footnote that acknowledges that normal grief can be accompanied by depressive symptoms, and that it is to the clinician to judge the diagnosis (APA, 2012). DSM-5 further distinguishes between ''uncomplicated'' grief-related episodes that include general distress symptoms which quickly remit; versus ''complicated'' episodes after a recent loss which are classified as Major Depression, if the grief-related episodes include motor retardation, sense of worthlessness, or suicidal ideation over a lengthy period (Wakefield & First, 2012). This note in the DSM-5 however lacks any guiding criteria, increasing the risk for a false positive diagnosis of normal grief (Wakefield, 2013).

The diagnostic criteria and nosological information for almost all the disorders were updated as well (Ehret & Berking, 2013). The DSM-5 also introduces a distinction between Unspecified Disorders and Other Specified Disorders (the DSM-IV only had the category Not

Otherwise Specified) in order to increase the reasons for diagnosis (Ehret & Berking, 2013). Moreover, the DSM-5 has converted from Roman to Arabic numbers, underlining a starting point for further development. Although the DSM-5 has been appreciated as a far superior manual compared to its predecessors for decision-making processes, and in improving treatment (Regier, Kuhl & Kupfer, 2013), it has not been met without criticism. Frances and Widiger (2012) for instance voice their concern with the DSM-5 manual's reduction of thresholds criteria for diagnosis, which they fear may lead to excessive treatment using drugs, increased stigmatisation of the affected population, and faulty distribution of the scare treatment resources. The elimination of bereavement as an exclusion criterion for Major Depression has also been criticised for causing possible increases in the false diagnosis of normal grieving (Wakefield, 2013).

The above noted changes in the DSM-5 highlight some great differences from DSM-IV; however, the differences between the DSM-IV and ICD-10 are even more prominent and as discussed in the paragraphs below, can lead to completely different diagnoses and different epidemiological estimates.

2.2.3. ICD-10 versus DSM-IV Classifications of Certain Mental Disorders

There are notable similarities and discrepancies between the DSM and ICD diagnostic systems. Some of these and their implications for diagnosis and treatment are discussed below with regards to particular disorders.

1. ***Substance abuse.*** The ICD-10 concept of harmful use and the DSM-IV concept of abuse differ significantly in that the ICD-10 requires that the use of substances result in actual psychological or physical harm to the user, including impaired judgment or dysfunctional behaviour, further leading to disability (WHO, 1992). The DSM-IV diagnostic criteria for substance abuse on the other hand requires that the use of substances occur in situations that may be physically hazardous, or may lead to legal, social, interpersonal and occupational problems (APA, 1994). It is clear that the concept of harmful use in these two classification systems is different. In addition, the DSM-IV relies on the condition that there be a pattern of use that causes recurrent problems to the user for at least 12-months; whereas the ICD-10 specifies that the pattern of use has occurred repeatedly and has persisted for at least a month. Therefore, while all cases of DSM-IV substance abuse will satisfy criteria for ICD-10 harmful substance use, the

same cannot be said about all cases of ICD-10 harmful use, as most would not meet criteria for DSM-IV abuse (Cottler et al., 1995). This inconsistency may lead to an over-diagnosis of the condition if one is using the ICD-10, whereas the prevalence of occurrence of substance abuse may be under-estimated if the DSM-IV criteria are used (Cottler et al., 1995). It is also worth noting that the DSM-IV conceptually distinguishes Substance Use Disorders (SUDs such as Dependence and Abuse) from Substance-Induced Disorders (SIDs e.g. Substance-Induced Psychotic Disorder, Withdrawal, Intoxication), encouraging diagnosis of comorbid SUD and SIDs. In ICD-10 however, a co-morbid diagnosis of Harmful Use is only possible if patients meet criteria for Substance Dependence (Michael, 2007).

2. Psychotic Disorders. Psychotic Disorders are labelled 'Acute and Transient Psychotic Disorders in the ICD-10 and include four disorders (based on whether they are with or without symptoms of schizophrenia, and whether or not they are polymorphic), whereas in the DSM-IV Brief Psychotic Disorders comprise only one disorder, characterised by psychotic presentations for one day in a period less than a month (Michael, 2007).

3. Schizophrenia. The ICD-10 and DSM-IV are believed to share a number of similarities in Schizophrenia symptom patterns, although they differ in form and content of symptom definitions (Michael, 2007). For instance, they both require one symptom from a list of especially characteristic symptoms (the symptoms comprising the lists differ though), or two psychotic symptoms to satisfy the diagnosis of schizophrenia (Michael, 2007). The most significant difference between the systems concerns the duration of the symptoms. While patients with a first onset of psychotic symptoms lasting a month (but less than 6 months) are diagnosed as suffering from Schizophrenia according to ICD-10, the DSM-IV requires that the total duration of the psychotic symptoms extends for at least 6 months, and that the functioning of the patient be markedly impaired (Michael, 2007). In other words, patients who present with psychotic symptoms lasting for a month would be diagnosed with Schizophreniform Disorder according to the DSM-IV, but with Schizophrenia in the ICD-10. These inconsistencies, like with SUDs, may result in deceptive epidemiological data on the prevalence of mental disorders, yielding inflated estimates of the social and economic costs for treatment (Wakefield, 2013).

4. Bipolar Disorders. The diagnosis of Bipolar Affective Disorder (BAD) in the ICD-10 requires the presence of recurrent mood episodes, and there is no distinction whether they include manic or mixed episodes, which distinction is fundamental in the DSM-IV. In the DSM-

IV, cases of BAD that include a mixed episode or at least one manic episode are called Bipolar I Disorder, whereas cases that include major depressive and hypomanic episodes are called Bipolar II Disorder. Moreover, the diagnosis of Hypomania (F30.0) in the ICD-10, does not qualify as a mental disorder in DSM-IV as it does not meet the basic DSM prerequisite of clinical significance (Michael, 2007). These inconsistencies may affect estimates of the impact of BAD, and may mislead the focus and planning of interventions.

5. Depression. The ICD-10 and DSM-IV both define the criteria for Major Depression with a shared list of eight symptoms (including depressed mood, loss of interest, fatigue, suicidal ideation, reduced concentration, psychomotor retardation, sleep disturbances, and loss of appetite), with the ICD-10 list including an additional two items (reduced confidence or self-esteem), and the DSM-IV one item (that combines excessive guilt with feelings of worthlessness) which are qualitatively different (APA, 1994; WHO, 1992). The ICD-10 divides these ten items into two separate sets, one containing depressed mood, loss of interest, and reduced energy (Set 1) and the other set containing the remaining items (Set 2); and determines the diagnostic threshold according to the number of items per each set, where four out of ten items (with two out of the three items from set 1) represent mild depression, six out of ten items (with a minimum of two out of the three type 1 items) being moderate depression, and severe depression represented by eight to ten out of ten items with all three of the type 1 set (WHO, 1992). DSM-IV on the other hand requires that at least five of the single nine-item list be present in order to satisfy the diagnostic criteria for Major Depression. Severity in DSM-IV criteria for Major Depression is determined by the number of symptoms in excess of five that are present, with five symptoms representing Mild Depression and nine symptoms Severe Depression (APA, 1994).

Despite the overlap in the eight symptoms shared by both the ICD-10 and DSM-IV in diagnosing Major Depression, the differences in the criteria for diagnosis lead to prominent incongruence such that certain cases such as those of Mild Depression meet criteria under ICD-10 and not in the DSM-IV, as they do not satisfy the minimum five symptoms requirement in DSM-IV. This again implies that the statistics that show prevalence of Major Depression are not consistent when using the DSM-IV or ICD-10, and that this difference may lead to an over- or under- estimation of the required treatment investments.

6. Post-Traumatic Stress Disorder (PTSD). The DSM-IV and ICD-10 present a number of incongruence in their definitions of diagnostic criteria for PTSD and of the qualifying stressor. The DSM-IV for instance suggests that the stimulus that results in PTSD should be of a traumatic nature, involving serious injury or a threat to the individual's physical well-being, and that the person's response to this stimulus is characterised by intense fear and persistent avoidance of the stimulus (APA, 1994). The ICD-10 on the other hand only requires that the stimulus be of an exceptional nature, such that it could always cause pervasive distress in any human being (WHO, 1992).

In terms of symptom specification and onset, the DSM-IV requires that three out of a list of seven *Criterion C* symptoms (which include avoidance of trauma-related thoughts and conversations, lack of interest in daily activities, a sense of foreshortened future, detachment from others, loss of memory of the trauma, and reduce affect) and a minimum of two *Criterion D* symptoms (including difficulty falling or staying asleep, difficulty concentrating, hyper-vigilance, irritability and heightened fear response) be present and persist for at least one month for less or more than 3 months, specified as acute or chronic respectively (APA, 1994). The ICD-10 on the other hand only requires that the individual persistently avoids circumstances resembling or associated with the stressor, and inability to recall memories associated with the trauma, within six months of the occurrence of the traumatic event (WHO 1992). Therefore a person that meets criteria for PTSD according to the ICD-10 would not satisfy DSM-IV criteria for diagnosis, further compromising prevalence estimates of the disorder (Michael, 2007).

7. Anxiety. The difference between the DSM-IV and ICD-10 in defining the criteria for Generalised Anxiety Disorder (GAD) is quite remarkable. While the ICD-10 presents a list of twenty-two symptoms, of which four are required for a diagnosis of GAD (with one symptom being indicative of autonomic arousal), the DSM-IV has a list of six symptoms (five of which are included in the ICD-10 twenty-two symptoms), of which three have to be present alongside excessive anxiety and worry for at least 6 months, in order to meet a diagnosis of GAD. It would be sensible to believe that a person diagnosed with GAD using the ICD-10 criteria would essentially meet DSM-IV diagnostic criteria since the DSM-IV list of six symptoms is embedded in the ICD-10 list of twenty two items. It should however be highlighted that the requirement in the DSM-IV that the anxiety and worry be excessive and difficult to control, and the specification that these symptoms be present more days than not for at least a period of six

months, makes the DSM-IV criteria for GAD much narrower than those of the ICD-10 (Slade & Andrews, 2001).

Taking into consideration the variations in the *DSM-IV* and *ICD-10* classification systems mentioned above, this study chose to note the diagnosis and nomenclature of the types of MI as they appeared in the data set, focussing primarily on the cluster of mental disorders that group together a variety of psychosis-related conditions (such as schizophrenia and psychosis), substance-related disorders, as well as mood disorders (Anxiety, Bipolar disorders, and Depression).

The above mentioned mental disorders are the most prevalent types of MI reported worldwide (WHO-HEN, 2003). These disorders thus require particular attention because, as discussed above, the prevalence estimates may be misleading when using different classification systems (DSM or ICD), which may impact the forecast of intervention strategies and budgets required to address them.

2.3. Prevalence and Incidence of Mental Disorders

Mental ill-health has been reported to constitute one of the biggest threats to human well-being, being the second cause of disability in developed countries and the fourth in the entire world (Lopez & Murray, 1996; WHO, 2013). Mental ill-health is one of the main causes of the burden of disease worldwide, accounting for over 7.4% of the disease burden worldwide in 2010 (Whiteford et al., 2013), 15 percent of the total burden in the US and 28% in the UK in 2013 (Mental Health Foundation, 2015), representing more than burden of disease caused by all cancers combined (Mental Health Foundation, 2015; National Institute of Mental Health, 2006).

Statistics reported by the WHO (2011) reveal that mental health problems cost developed nations between three and four percent of their gross national product in 2011. When MI expenditures and loss of productivity are both taken into account, the WHO (2001) estimated that mental disorders represent an approximate global cost of US$2.5 trillion, constituting the largest single source of world economic burden annually. It has been predicted that as the world population ages, and the conquest of infectious diseases increases, psychiatric and neurological conditions could increase their share of the total global disease burden by almost half, from 10.5 percent of the total burden in 1990 to almost 15 percent in 2020 (Murray & Lopez, 1996).

The WHO (2001) also predicted that at least one in four people in the world will suffer from a mental or neurological disorder during their life time, and recent statistics show that at least 450 million people suffer from a mental disorder worldwide (WHO, 2015) .

A study by Polanczyck, Salum, Sugaya, Caye and Rohde (2015) indicates that the prevalence of mental disorders in children and young people is of 13.5 percent. This fact is particularly concerning because, as Wolpert et al. (2015) observe, the long-term effects of such early onset mental health issues include emotional instability, increased chance of developing other (comorbid) disorders in adulthood, poor academic performance as well as unemployment, which could cost a country's expenditure and productivity.

Researchers have often blamed a number of factors for the increasing prevalence of mental disorders in this century's younger generation (Greig, MacKay, Roffey & Williams2016; Hagell, 2004). These factors usually include broader cultural, economic and societal changes, increased rates of separation and divorce in family life, easy accessibility of substances such as alcohol and recreational drugs which is increasingly the norm amongst today's youth (Hagell, 2004), impact of social media which, argue Greig et al. (2016), affects young people's sleep patterns as they game obsessively, and are attracted by Ethernet bullying, as well as unregulated and mentally disturbing images. Although psychiatric disorders seem to be highly prevalent in the youth, research has shown that this group is the most reluctant to seek mental health treatment (Goguen et al., 2016; Gonzalez, Alegria & Prihoda, 2005).

2.4. Treatment-seeking Behaviours

In the past 50 years, mental health treatment has seen an unprecedented revolution in terms of quality and effectiveness (Corrigan, 2004). Despite the increase in the availability of treatment options and awareness of MI in the twenty first century, many people who are affected by MI do not seek treatment and others do not adhere to the services once initiated (Goguen et al., 2016). Nearly two-thirds of the affected population have been reported to never seek professional MHC (WHO, 2001). The question then is why people affected by mental health problems refuse to pursue or fail to engage in treatment? The WHO (2001) reports that stigma, discrimination, and limited resources could be some of the factors that affect help-seeking behaviours amongst patients with mental disorders.

Throughout human history, MI and its treatment have been more of emotional issues than health issues because of the prevailing negative attitudes towards people with mental ill-health (Bhugra, 1989). MI has historically been associated with religious possession, witchcraft or sorcery, outcome of poor living conditions or punishment for sin (Dain, 1980). People with MI were usually treated with fear, distrust and dislike, and even in the modern society, they are still socially devalued as potential employees, spouses, or partners because of the societal stigma the diagnosis of a MI continues to carry (Goguen et al., 2016). Many of the cultural stereotypes portray people with mental disorders as dangerous, socially undesirable, unpredictable, which often lead to responses of rejection and avoidance by others, explaining the loss of social status and of their place in community these individuals often suffer (Szasz, 2011). Such stigmas are deplorably observed even in the mental-care environment where the relationship between care-givers and patients is often characterised by negative regard and power-relations on the part of the care-givers (Corrigan, 2004; Rosenhan, 1973).

By definition, stigma is a mark that links in this case a person with mental disability to undesirable characteristics, setting him/her apart from others, resulting in rejection and isolation of this individual (Byrne, 2000; Corrigan, 2004; Farina, Hastorf, Hazel, Miller & Scott, 1984). Some mental disorders are more stigmatised than others, and stigma is usually linked with hospitalisation for MI after which the patient is assumed to be incompetent, dangerous, and untrustworthy (Link, Struening, Rahav, Phelan & Nuttbrock, 1997). Stigma has been reported to affect patients' social interactions, erode their self-esteem and self-confidence, and impair their quality of life, occupational functioning, and employment opportunities among many other aspects of life (Corrigan, Morris, Larson, Reface & Michaels, 2010; Link et al, 1997). However, there are controversies surrounding the perceived effects of MI labelling and stigma, and the magnitude and duration of these effects, as researchers have observed that diagnostic labelling can simultaneously lead to effective treatment results and negative stigmatising effects (Rosenfield, 1997). Researchers supporting the argument that the effect of stigma is small and transitory, often rely on the substantial body of evidence supporting the effectiveness or positive benefits of mental health treatment following effective diagnostic labelling (Smith, Gene & Miller, 1980). On the other hand, other researchers argue against the dehumanizing effects of psychiatric labelling, suggesting that the process of psychiatric diagnostic, which is a pre-requisite for mental health treatment, is in itself a cause of stigma (Goguen et al., 2016; Corrigan

et al., 2010; Rosenhan, 1973; Scheff, 1966). Therefore many people who could otherwise benefit from MHC choose not to seek treatment or refuse to stay in therapy once initiated to avoid the harm that MI labelling may cause to their social functioning (Corrigan, 2004; Goguen et al., 2016). Stigma has also been reported to have long-lasting effects in the patient's life even after the symptoms of their diagnosed mental disorder have subsidised (Rusch, Corrigan, Todd & Bodenhausen, 2010). For instance, the labelled person may continue to be rejected even when symptoms have improved, they may be haunted by the trauma of past rejection which may produce further negative outcomes throughout their life, they may internalise expectations of rejection even when rejection by others is not directly experienced (Pedersen & Paves, 2014; Rusch et al., 2010), or patients may adopt coping strategies which may lead to other potential harmful results (Link et al., 1997). Coping mechanisms that the affected individuals may develop include secrecy, where the treatment and diagnostic history is concealed from others to avoid rejection, or withdrawal where the patient willingly limits social interactions to avoid the possibility of rejection (Link & Phelan, 2001; Livingston, 2012). With the increasing prevalence of MI globally today, these negative attitudes toward MHC may cause significant functional impairments as well as negative outcomes in communities (Glied & Cuelar, 2003).

Stigma can thus constitute a significant barrier to help-seeking behaviours, treatment provision, management, promotion and prevention of mental disorders as well as to community reintegration of the affected individuals (Corrigan, 2004; Goguen et al., 2016). In addition, stigma could cause an influx of untreated psychiatric disorders and of psychiatric symptom severity due to absence of treatment. While this could be used as an argument to justify the increased prevalence of psychiatric disorders in the current century, it also calls for a need of awareness campaigns to reduce stigma and educate communities about the facts of MI (Byrne, 2000).

Reducing stigma will require exploring effective strategies to target negative attributes associated with MI, and public discrimination of people with mental disorders. A study conducted by Chronister, Chou and Liao (2013) for instance found strong links between absence of social support and high levels of societal and internalised stigma, and low chances of recovery and quality of life in adults with SMI. Therefore, programmes that emphasise aspects of community support in addition to psychiatric care will be beneficial in reducing stigma associated with MI (Drake, Green, Muesser & Goldman, 2003). Balanced care, which is

discussed later in this paper, is a similar programme that incorporates aspects of both psychiatric care and community support in treating mental disorders, and which is particularly appropriate to reduce MI related social stigma.

Some attempts to remediate the issues associated with stigma of MI are reflected in Meyerian theorisation of MI which suggests a move from a naturalistic categorization of MI to a more bio-psychosocial approach that compromises the role of inherited psychological tendencies as aetiology of MI by studying mental illnesses as reactions to atypical biographical circumstances (Pilgrim, 2002). In this sense, if the term MI is used only for treatment reasons, but the causes of the conditions are understood to be bio-psychosocial, chances are that the pejorative nature of the label will be reduced, and the need for informed person-centred care will be voiced. However, though this view has its own benefits as it promotes a context-based study of MI, it also limits or thwarts a scientific study of the incidence and prevalence of MI and a mapping of professional intervention and treatment. If there is no definition that classifies MI as a set of conditions that require some form of intervention, then meeting the needs of the affected population would be made difficult.

Other attempts have been made to reduce MI labelling stigma; the movement toward person-first language when referring to people affected by mental disorders for instance emerged from concerns about the devaluing and biasing effect that the use of labels to refer to individuals with MI promotes, and as a mechanism to separate individuals' identities from any clinical diagnosis or disability they suffer (APA, 1992). Therefore, instead of saying a ''mentally ill individual'', person-first terminology suggests using ''individual with mental illness'' when referring to a person affected by a mental disorder to avoid defining people by reference to their disability (Granello & Gibbs, 2016) and to minimise the focus on the disability. The use of person-first terminology is believed to promote the respect, dignity, and sensitivity toward the individual (Halmari, 2011). Moreover, in a study by Granello and Gibbs (2016, p.36), it was observed that "language and labels had a significant effect on tolerance toward people with mental illness" as participants showed more restrictive and authoritarian attitudes when using the term "the mentally ill" as opposed to the term "people with mental illnesses". Therefore, the use of person-first language when referring to individuals affected by mental disorders is a step further into reducing mental health stigma, which this project is cautious of, when referring to individuals with mental disorders.

In addition to stigma and discrimination, there are other factors that have been reported to thwart the effective provision of MHC worldwide. These include limited resources available for MHC, scarcity of psychiatric professionals, and inadequate governmental dedication to issues related to mental health (Saxena et al., 2007; Saraceno & Saxena, 2005; WHO-HEN, 2003). In addition to these, language and cultural beliefs constitute further challenges in Psychiatric care in non-Western contexts because, as was discussed earlier in this chapter, psychiatric models of diagnosis and symptom presentation are largely informed by Western behavioural norms and Western concepts of disease, and are not necessarily relevant cross culturally (Akyeampong, Hill & Kleinman, 2015).

2.5. Mental Health Legislation.

The 2003 WHO-HEN report suggested that it was paramount that states around the world provide not only an accessible medical support budget, but also finance the training and sustenance of the active providers of the medical care, including professional mental-health care providers, since the competency of the care providers is an important need for the recovery of individuals with mental disorders. Recovery here refers to ways in which an individual with MI experiences and copes with the disorder in the course of claiming his or her community life (Werner, 2012). Research in the vein of mental health recovery has demonstrated the importance of the role the MHC providers and state-based mental health service delivery policies play in achieving or attempting to achieve efficient service delivery for MI (Street et al., 2013). There is a common consent amongst community psychologists that the more efforts the state policy puts in providing necessary services for individuals with mental disorders, the more likely it is to advance the quality of life of this population, especially if their underlying mental problems are medically addressed. (Chen, Krupp, Watt & Henderson, 2013; Saavedra et al., 2014; Street et al., 2013; Tondora & Davidson, 2006). Therefore the commitment of governments and international agencies to provide adequate funding for MHC and training of human resources is crucial in the treatment and prevention of mental ill-health (Whitford et al. 2013).

In assessing the amount of effort the USA put into addressing the delivery of recovery-oriented services for people with SMI, Street et al. (2013) investigated the provision of MHC in several American-based nursing homes for individuals with MI. These authors reported that at

least 18 American states make no specific reference to SMI in their nursing home regulations, which resulted in noticeable absence of appropriate care strategies and poor quality MHC in most nursing homes. This is symptomatic of larger issues of neglect in the provision of MHC worldwide.

The South African legislation has also been particularly criticized for its low concern on MI, both at national and provincial levels (Lund, Kleintjes, Kakuma & Flisher, 2010). Despite the fact that South Africa has one of the most advanced pieces of mental health legislation, which has agreed to uphold and ensure human rights of individuals with mental impairments, the needs of the population with mental disorders continue to remain unmet (McCrea, 2010). Burns (2011) has termed this MHC gap in South Africa a human rights issue.

While it is acknowledged that recovery-oriented service delivery for MI is a great step toward improving the lives of both the directly affected patients and their communities, it is important that there exist a policy that governs the process of addressing the medical needs for individuals affected by MI. It is thus worthwhile that future studies analyse state legislations that guide the delivery of mental health services in states around the world, especially in those that have the highest rates of SMI. Future research should also consider investigating the reasons why mental health legislations in most states around the world remain ineffective.

2.6. Mental Health Resources

While MI has been declared a threat to the well-being of communities globally, care services for MI remain universally inadequate. The mental health sector is a neglected area almost worldwide. Burns (2011) observes that while progress has been made in general health prevention and promotion, the same cannot be assumed for mental ill-health. Treatment rates for MI are low worldwide, and even worse in developing countries where the treatment gape amounts to 90% (Wang et al., 2007). In addition to stigma attached to mental disorders, the scarcity of available human and financial resources and ineffective mental health policies have been pointed to be the reasons for mental health treatment gaps worldwide (Saxena et al., 2007).

While most low and middle income countries (African countries in particular) have been reported to have a median number of 5 beds and below per 10 000 population with mental illnesses (most of which are placed in psychiatric hospitals), the mean is of at least 50 beds per

10 000 population in high-income countries (WHO, 2015). In terms of trained mental health professionals, statistics show that the global median number of mental health workers is of 9 per 100 00 population, varying from below 1 per 10 000 population in low-income countries to over 50 in high-income countries (WHO, 2015). Levels of public expenditure on MHC are even worse off in low and middle-income countries, reported to be less than US$ 2 per capita.

South Africa, which is classified as a low income country by the World Bank, continues to experience multiple barriers to the financing and development of mental health services. Burns (2011) suggests that barriers to the financing and improvement of mental health services have affected the arena of care provision so that psychiatric hospitals in South Africa have remained outdated, community and psychological rehabilitation services remaining undeveloped so that patients end up institutionalised, with no future hope of reintegration into their communities; as well as a deplorable shortage of mental health professionals in the existing mental health facilities. WHO (2014) Statistics have for instance shown that the density of psychiatrists per 100 000 population in South Africa is less than 0.05, with an average of 22.7 psychiatric beds per 100 000 population, 63 mental hospitals and 37 psychiatric units in general hospitals. Community services have been reported to be even worse off, with only 80 community-based day treatment facilities around the country (Burns, 2011).

Professional psychiatrists are generally very few, with the number varying considerably from region to region, most of them concentrated in urbanised regions. A South African national survey revealed that the country only has an average of 0.28 psychiatrists, 0.32 psychologists, 0.4 social workers, 0.13 occupational therapists and 10 nurses, per 100, 000 population. (WHO, 2005). MHC is usually more dependent on trained human resources for effective care provision, and the density of psychiatrists is the most widely available and reliable indicator of the human resource available for MHC, which provides a rudimentary representation of the capacity of a particular mental health system (WHO, 2015).

The above cited statistics with regards to available human resources (psychiatrists and psychologists) and infrastructure for MI reveal that the proportion of resources allocated to MHC is poor worldwide. Given the burden of disease that mental ill-health constitutes, which is indisputably increasing by socio-economic conditions of inequality, unemployment, violence, poverty and infectious diseases (Burns, 2011), it is clear that mental health resources are derisory

worldwide, and that there is a considerable breach between needs and available services. Although the resources in high-income countries may seem a bit better off, as opposed to low and middle income countries, the situation remains that resources for MI are universally inadequate (Shah & Beinecke, 2009).

Taking into account the fact that mental ill-health constitutes a big threat to global health today and yet the scarcity of MHC resources worldwide, it would be of great interest to analyse how care providers have tried to counter such shortages in mental health resources in order to address the burden of MI. One productive way of investigating this would be to assess the evidence of integrated service provision that makes use of available resources to maximise the quality of care provided to the affected population. Integrated service provision is the type of MHC that combines aspects of both clinical/psychiatric treatment and community-based care, and simultaneously addresses two or more co-existing conditions of MI (Drake et al., 2003; Thornicroft &Tansella, 1999). The next section defines what the two types of treatment (community-based and clinical) encompass, and what the balanced care model that combines the two represents.

2.7. Mental Health Treatment

Mental health treatment has a long and complex history that dates as far back as 5000 B.C.E (Franz & Selesnick, 1966). MI, which was believed to be caused by supernatural phenomena, was treated through a method called 'trephine', which involved drilling a hole into the patient's skull through which the evil spirit was believed to be released, freeing and healing the patient (Butcher, Mineka & Hooley, 2007). Many other techniques such as, electro-shock therapy, exorcism, isolation, purification etc., were used to cure MI, until Hippocrates' studies deviated the superstitious beliefs about the nature and causes of MI towards more biological understandings (Foerschner, 2010). Hippocrates suggested that MI was caused by imbalances of fluids (blood, phlegm, bile and black bile) in the body, and that treatment involved restoring the balance of these fluids. Different treatment methods were then developed, including purging, phlebotomies, bloodletting and diets, in attempting to restore the balance of bodily fluids (Foerschner, 2010). Although this biological understanding of the aetiology of MI gained momentum, many cultures still believed in the supernatural roots of MI, and many people

affected by mental disorders were often stigmatised, abandoned and forced to live on the streets, or in jail, as they were deemed dangerous and unmanageable (Foerschner, 2010). Patients who were admitted into madhouses and asylums or psychiatric wards were subjected to inhuman treatment, were abused, and sometimes tied with iron collars because of the negative perceptions held against MI (Dain, 1980).

Many movements advocated for the respect and positive treatment of persons with MI, and the 18th century saw an increase in the creation of psychiatric hospitals across the world (Drake et al., 2003). With the advent of psychoanalytic and other psychological theories, the understanding of MI became primarily psychosocial, emphasising intra-psychic and parental influences as primary causes of mental disorders (Bellak, 1958). The treatment of MI became primarily 'psychiatric-based' and included somatic treatment such as psycho-pharmacology, psychosurgery, and electroconvulsive therapy among others (Foerschner, 2010; Lehman, Thompson & Scott, 1995). The negative attitudes towards MI have however survived into modern society, and as mentioned earlier in this paper, stigma is still a barrier to the management and treatment of mental disorders in the twenty first century.

Over the past four decades, the bio-psychosocial model has taken over as the dominant paradigm for understanding MI. This paradigm emphasises the interplay between biological and psychosocial factors in understanding MI, and values a more community-based intervention approach to the management and treatment of mental disorders (Drake et al., 2003). The next section discusses modern psychiatric and community-based treatment approaches and how they are provided, as well as the emergence of a balanced care model that combines aspects of both psychiatric and community strategies as a more holistic approach to the treatment of mental disorders.

2.7.1. Clinical/Psychiatric Treatment for MI

Psychiatric treatment for MI is the type of treatment that is devoted to the diagnosis, treatment and prevention of mental disorders, through a number of clinical, hospital-based and psychiatric techniques (Nathan & Gorman, 2002). This type of treatment usually combines psychiatric medication and psychotherapy, as well as Neuro-imaging and neuro-physiological techniques occasionally. Psychiatric/clinical care includes a variety of therapeutic techniques, such as: Behaviour Therapy, Cognitive Behavioural Therapy, Cognitive Therapy, Group Therapy or Group Psychotherapy, Intensive Short-Term Dynamic Psychotherapy,

Pharmacotherapy, In-patient Services, Psychiatric Evaluation, Psychoanalytic Treatment, and sometimes Electroconvulsive Therapy, though in rare occasions (Nathan & Gorman, 2002). Although studies have shown positive results of clinical treatment on a range of outcome measures, such as improved clinical functioning, cost-effectiveness analyses have shown that hospital-based treatment for MI is usually costly and inaccessible to populations from low socio-economic backgrounds (Uttley et al., 2015).

This type of treatment, when considered on its own, excludes a great part of the affected population who are in need of mental health intervention, due to its costly nature. Therefore a more cost-effective treatment approach, such as non-hospital-based care, that affords psychiatric treatment to most if not all of the affected population is in demand, especially in low resource countries such as South Africa, where 12 million live in extreme poverty, yet at least 16.5% of the population suffer from mental disorders (Inge et al., 2009; Stats SA, 2014; WHO, 2013).

2.7.2. Community-based Treatment for MI.

Community-based treatment for MI is often defined as out-of-hospital treatment that provides patients with treatment, rehabilitations, and support services (Drake et al., 2001). Community-based services are offered in a variety of settings, ranging from the general community, institutional and non-institutional community homes, ambulant care, to residential care (e.g. at the patient's home). The focus of community-based treatment extends beyond addressing the symptoms of a mental disorder, to improving the patient's skills, quality of life and re-integration into the community (Bond, Drake, Mueser & Latimer, 2001). It has been argued that community-based treatment is more effective in improving the lives of patients with mental disorders, and especially of those with severe forms of MI. (Drake et al. 2001; Leff, Trieman, Knapp & Hallam, 2000; Mueser, Bondo, Drake & Resnick, 1998).

Leff et al. (2000), for instance, conducted a study with more than 1100 long-stay patients who were discharged from two psychiatric hospitals in the United Kingdom, and whom they followed up for 13years. They amazingly found that these 'former' patients experienced increased skill in using community facilities, ameliorated daily living activities, better relationships with members of their extended communities, improved quality of life, and 84% chance of community re-integration based on their improvements, after receiving community-based treatment. These researchers also observed that community-based care was more cost-

effective than hospital care. The authors advocated based on these results that community-based treatment for MI was preferable to clinical in-patient care because of the above-mentioned benefits. While such arguments could result in considerable cost savings to the overall health care system, they are misleading in suggesting a preference for community-based treatment as more effective than the medical model. Although community-based treatment is an effective type of treatment for MI, it should not be considered effective in isolation. As Thornicroft and Tansella (1999) have suggested, a model of treatment that combines aspects of both clinical and community-based care is preferable and could prove more effective than each of these types of treatment in isolation.

The models of community-based treatment for MI this research focuses on include:

1. ***Assertive Community Treatment (ACT).*** ACT is an individualised approach to Treating long term mental illnesses by helping patients achieve optimal integration into normal community life. ACT adopts a holistic approach to service delivery for MI, providing medication, housing, finances and helping with everyday problems in living to the patients (Bond et al., 2001). This type of community treatment is said to substantially reduce psychiatric hospital use, while moderately improving symptoms and the stability of the patients, as well as their quality of life. The applications of the ACT model can be adapted to specific geographical settings and politico-economic circumstances in order to meet the needs of specific patient populations. The cost of provision of the ACT varies as well, depending on the economic status of a particular context (Bond et al. 2001).

2. ***Rehabilitation.*** Just as clinical interventions focus on helping patients manage their illness, rehabilitation helps them lead satisfying lives and succeed in their daily functional roles (Anthony, Cohen, Farkas & Gagne, 2002). The rehabilitation model is a type of community-based care that focuses primarily on improving the individual patient's functioning and quality of life rather than alleviating the symptoms of the disorder (Drake et al., 2003). Rehabilitative interventions are delivered on a needs-basis, and intend to improve patients' skills and attainment of personal goals (Mueser et al., 1998), while emphasising the importance of providing case management services based on every individual patient's needs and goals, rather than on goals defined by the MHC system. Rehabilitation targets behavioural areas such as social functioning, education, work, family relations, and involves helping the patient build skills needed to

establish supports necessary for functioning (Anthony et al., 2002). Rehabilitation interventions have however been reported to be more effective when integrated with clinical treatment than when provided on their own (Bond & Resnick, 2000).

3. Social/Peer support interventions. These programmes focus on strengthening the immediate social environment to help patients modify their behaviour. Such programmes recognise the role of social networks in patients' recovering and enhance social interactions with significant others, facilitating the development of unconditional networks necessary for the patient. Family interventions are also valued in this method of community intervention (Drake et al., 2001).

4. Acute and Intensive home care. This type of community-based treatment provides efficacious and rapid intervention to patients suffering from acute and severe psychiatric crisis in their usual residential places. This excludes foster care, day care or community residential services in that, acute treatment nurses are available 24hours or at least long working hours to provide patients with maximum treatment in their home (Cathy, Burns, Knapp, Watt & Henderson, 2002).

2.7.3. Balanced Care

Whilst the argument about whether hospital care or community-based mental health treatment is better is an ongoing debate, the last two decades have seen a third alternative to MHC emerging, which is a balanced care model that utilises both community services and hospital-based care in providing treatment for MI (Nathan & Gorman, 2002; Thornicroft & Tansella, 1999). The focus of this model is said to be on "providing services in normal community settings close to the population served, while hospital stays are as brief as possible, promptly arranged and used only when necessary" (Thornicroft & Tansella, 2003, p. 5).

Earlier in the 1980s, the high rate and clinical consequences of comorbid conditions among persons with mental disorders called for the attention of mental health practitioners and policy makers to extend treatment interventions to address comorbid conditions (Drake et al., 2003). Initial efforts which included treating comorbid mental disorders by different independent specialist clinicians failed due to limited service access, poor treatment coordination, and treatment costs which most of the affected patients could not afford (Ridgely, Goldman & Willen, 1990). Integrated care, which is the model of treatment that simultaneously addresses

two or more co-existing conditions, started to emerge. This type of care involves a multidisciplinary team of clinicians with expertise in different areas combining their approaches in a coordinated fashion to help patients meet their needs and pursue recovery on multiple comorbid conditions (Drake et al., 2003).

Providing care and specific treatment to the needy population with mental disorders can be challenging because needs depend on the social, political and environmental contexts of the individual (Ridgely et al. 1990). Treatment options for MI can as well be diverse, considering the different aspects and symptoms of MI. Different populations of individuals with MI will require different treatment strategies based on their specific symptoms and identified needs. It would be misleading to suggest that certain treatment strategies are the best or worst interventions for MI simply because they have worked or not on a certain particular sample of patients. Identifying the context-specific risk factors and risk outcomes for MI is therefore a great step in care provision (Drake et al., 2003).

The WHO-HEN (2003) synthesis reported that depending on the financial resources, the priorities and policy goals in low income countries should mainly focus on establishing and improving mental health service delivery within primary care settings, using specialists as a backup; that medium-resource countries seek to provide outpatient treatment centres, community-based MHC, acute inpatient care, occupational and long-term community-based residential care. Additionally, this report suggested that high-resource countries, in addition to such services provided in low income and middle income countries, should provide specialized ambulatory clinics and community mental health teams, long-term community residential care together with vocational rehabilitation, as well as assertive community treatment and alternatives to acute inpatient care (Thornicroft & Tansella, 2003). A study investigating clinical course, accessibility and improved quality of life among individuals with MI who received a combination of community and psychiatric treatment in a rural area observed that patients, especially those which psychotic and affective types of MI, experienced improvements in psychiatric and affective symptoms, less use of primary care and mental health services, greater satisfaction with outpatient than hospital inpatient services and with programmes that emphasised relationships and social support, and which were offered in their usual (rural) community-settings (Ruud et al., 2016). Although not many studies have reported the cost-

effectiveness of the balanced care approach, the study by Ruud et al. (2016) which was conducted in a rural area suggests the feasibility and affordability of this type of treatment in low resource settings, which could specifically benefit low-income countries such as South Africa.

This study thus seeks to analyse evidence of the implementation of such types of treatment in low (South Africa in particular), middle and high income countries in published literature from 2004 to 2016, in order to assess the evolution or lack thereof in the global legislation for effective treatment of MI, following the 2003 WHO-HEN report that encouraged the adoption of balanced care as a more holistic MHC approach. The aspects of a balanced care approach this review is focussing on include an integration of aspects of both clinical/psychiatric and community-based mental health treatment mentioned earlier, and the assimilation of other forms of treatment such as traditional or indigenous care in mainstream MHC.

2.7.4. Complementary Interventions

Traditional care: Cultural and traditional beliefs in most indigenous communities have been reported to constitute an obstruction to modern psychiatric treatment because standard psychiatric models of diagnostic and treatment of MI are based on European and North American norms and do not readily apply cross-culturally (Kirmayer & Minas, 2000; Mohatt, Fok, Henry, People Awakening Team & Allen, 2014). The behavioural manifestation of mental disorders can be diverse and characterised in diverse ways in different settings and may not necessarily reflect the symptom-criteria that inform modern psychiatry. In addition, even when the symptoms are identified and the people suffering from MI can be accurately spotted, determining the aetiologies of the symptoms can be further complicated by cultural beliefs, and may require intimate knowledge of local cultural practices (Aina, 2004; Burns, 2011). Studies conducted with Ghanaian and Nigerian patients diagnosed with Schizophrenia for instance found that the causes of psychotic conditions were often attributed to evil endeavours, or demonic possession (Heward-Mills, 2005; 0haeri & Fido, 2001). In the South African traditional belief systems as well, mental problems are often attributes to ancestral influence or bewitchment (Sorsdahl et al., 2010).

Gureje et al. (2015) argue that a traditional or complementary system of medicine has been shown in evidence around the world, in low- and middle-income countries specifically, to be commonly used by a large number of people affected with MI where traditional practitioners

fill a major gap in MHC delivery. Burns, Jhazbhay and Emsley (2010) for instance reported that in a sample of patients with first-episode psychosis, at least 38.5% had consulted a traditional healer for their condition, before making contact with formal mental health services. Some studies that have examined culturally tailored interventions in different communities have reported that participants who received effective dosages of culturally competent interventions showed more favourable outcomes (Allen, Mohatt, Fok & Henry, 2009; Mohatt et al., 2014). Therefore, it could be argued that culturally grounded treatment programmes are indispensable in addressing certain treatment needs of indigenous populations affected by mental disorders.

This study looks at the extent to which traditional forms of treatment have been used in South Africa specifically, while analysing the argument presented in literature of its effectiveness. This paper also investigates the possibility of integrating traditional healing into a mixed model care solution in order to develop a responsive and culturally-appropriate system which does not replicate Western psychiatric models, but rather reflects the multiplicity of cultural realities.

***Psychiatry of the elderly*:** While psychiatric emergences are common among the elderly, diagnosis and treatment are significantly challenging because of the high incidence of co-occurring medical and neurological deteriorations, adverse effects of medication, as well as other psychosocial adversities (Piechniczek-Buczek, 2010). In a consensus statement in 1996, the WHO acknowledged that the intensity of mental health problems in persons above the age of 65 is alarming and requires the development of specific diagnostic and therapeutic strategies within the field of geriatric psychiatry (WHO, 1996). Geriatric psychiatry, which first surfaced in the 1950s, has progressively continued its devotion to the mental health of the elderly, becoming the basic field of speciality for physicians and health workers who are entirely devoted to providing mental care to the elderly (WHO, 1996). Psychiatry of the elderly, otherwise referred to as geriatric psychiatry, delivers multidisciplinary mental health assessment, diagnosis and treatment to older people, often in the form of collaborations between family, professional, social carers and volunteer organizations (Piechniczek-Buczek, 2010). The objectives of geriatric care therefore focus on restoring the patients' lives and improving their quality of life, reducing the risk of disability, and providing the necessary emotional support to the patient (Wattis & Fairbairn, 1996).

Restraints: Gates, Ross and McQueen (2006) observe that it is quite common for patients to be agitated and violent in psychiatric facilities and emergency departments, further endangering the wellbeing of psychiatrists and emergency physicians. There are three main categories of restraints that are commonly used in psychiatric management, which include: (i) environmental restraints, which consist of limiting the patient's free movements by confining him/her to specific areas such as seclusion rooms; (ii) physical restraints, where physical holders are used to inhibit the patient's physical movements and prevent him/her from escaping or detaching from the holding appliances; and (iii) chemical restraints, where pharmaceutical tranquillisers are prescribed to the patient in order to inhibit aggressive behaviours (Moosa & Jeenah, 2009; Schwartz & Park, 1999). Restraint as a method of psychiatric management raises serious social and ethical issues as it has been historically associated with punishment, institutional abuse and neglect, as well as stigma associated with MI labelling (Westermeyer & Kroll, 1978). Hence, the use of restraints is confined to only specific emergency circumstances and is legally regulated (Espinosa et al., 2015).

This form of psychiatric management is used as last resort in cases where other less restrictive forms of intervention (such as medication or therapies) have failed to contain potentially violent patients (Gates et al., 2006). The incidence and duration of environmental and physical restraints vary widely across countries, and are regulated by legal and treatment factors more than by patient attributes (Soliman & Reza, 2001).

2.8. Theoretical Framework.

The issue of mental ill-health has attracted increasing attention from researchers and various relevant stakeholders who have voiced the need for performance measurement in the provision of evidence-based mental health treatment (Miller, Moore, Richards & Monk, 1994). This interest has particularly been centred on improving the relationships between different forms of organizational structures and clinical practices that are essential for the delivery of evidence-based care (Petersen et al., 2010). This movement toward evidence-based MHC has however not resulted in one cohesive conceptual framework for assessing the performance of MHC delivery. A variety of grand theories, such as the developmental, behavioural, cognitive, social, and public health theories, provide conceptual frameworks that allow the understanding of

the issue of mental health and MHC from different angles, with some focussing on internal processes (e.g. development and cognitive theories), while others emphasise the impact of environmental factors on functioning (Thakker & Ward, 1998).

The wide recognition of mental health as a major public health issue has resulted in increased efforts to prove that performance measurement is not only required but worthwhile in studying ways of providing public MHC that is suitable and cost-effective (WHO, 2011). Researchers have used several concepts, such as treatment program evaluation research, health services development, recovery research, or promotion and prevention, to assess and enhance the performance of the public MHC delivery system, and to evaluate the relationship between public health delivery and mental health outcomes (Miller, 1994; WHO, 2011). Public mental health service delivery has been suggested by the WHO (2001) to be a method that is not only effective in providing cost-effective mental health treatment options, but also as a method that allows services to reach a wider population.

The public health system is organized into various components that provide a science base for assessing the public health system performance (Miller et al., 2001). Mental health promotion and the prevention of mental disorders are two interrelated public health concepts that are commonly used in the public mental health system (WHO, 2011). While prevention of mental disorders aims to reduce the prevalence, prognosis, and incidence of mental ill-health, mental health promotion essentially aims to promote optimal psycho-physiological development as well as mental and behavioural health in the public, and is not primarily concerned with the amelioration of symptoms and deficits (Petersen et al., 2010). These two concepts are inter-related in that promoting mental health may result in the decrease of the incidence of mental disorders, which in return strengthens factors of well-wellbeing, further preventing negative mental health (WHO, 2004). Both concepts may thus produce complementary outcomes in the same intervention.

The public health concepts of prevention and promotion are informed by a number of other concepts that focus both on the individual's intrapersonal and interpersonal levels. These concepts that inform promotion of mental health and prevention of mental disorders encourage reciprocal relationships between service providers from multiple systems, in providing intervention that moves beyond mere intrapersonal care to include socio-cultural, structural and

policy-level entities (Pertersen et al., 2010). The public health system is characterized by a variety of components (e.g. mission, structural capacity, processes, and outcomes) that enable researchers and care-providers to measure the performance of public health strategies in providing effective health care services (Handler, Issel & Turnock, 2001).

2.8.1. Mission. The primary mission of public health is to promote conditions of good health, and to ensure the prevention of conditions that are threatening to general health (Handler et al., 2001). This mission is structured through policy development, as well as through development of effective prevention and promotion treatment strategies, which can be individual- or population-based (Miller et al., 2001). Based on this, the performance of the public health system can be assessed to determine the extent to which it achieves its mission (Institute of Medicine, 1988).

2.8.2. Structural Capacity. The structural capacity of public health refers to resources such as health networks, as well as organisational, physical, human and fiscal resources that are available in a particular context. This is assessed through the examination of economic and health expenditures available for public health in a specific context (Handler et al., 2001). Such assessment is important for identifying areas of capacity that require improvement.

2.8.3. Processes. Public health involves processes of identifying, addressing, and prioritizing the most pressing health problems, in order to dispose essential services (Harrell & Baker, 1994). These processes range from investigating and identifying health problems, mobilizing and empowering communities to resolve these health problems, developing treatment plans and enforcing protective health regulations, evaluating accessibility and effectiveness of essential health service, to conducting evidence-based research and developing new treatment strategies (Harrell & Baker, 1994).

2.8.4. Outcomes. The outcome refers to the immediate or long-term health changes experienced after the processes of public care described above are achieved (Handler et al., 2001). Outcomes thus provide information about the effectiveness and performance of the public health system as a whole. Based on measures of outcome, the contributions of particular treatment programs will be established, and the strength of the public health system as a whole will be enhanced.

These concepts however, are influenced by social, political, and economic factors, which are forces external to the mission of the public health system, but which exert the most pressure

on its performance (Institute of Medicine, 1988). Economic factors for instance limit the availability of MHC infrastructures, the affordability of care expenses, and consequently the outcome of treatment methods. Therefore, cognisant of this, the WHO-HEN (2003) plan recommends promotion and prevention as treatment priorities, depending on the contextual socio-economic status of a country. The WHO-HEN (2003) synthesis thus suggested that due to the reduced socio-economic resources in low-income countries, the priorities and policy goals in these contexts mainly focus on establishing and improving MHC delivery within primary care settings, using specialists as a backup. Medium-resource countries on the other hand, provide outpatient treatment centres, community-based MHC, and acute inpatient care, occupational and long-term community-based residential care, in addition to mental health treatment in primary care centres, because of their higher economic resources as compared to low-income countries. Furthermore, this report suggested that high-resource countries, in addition to such services provided in low- and middle-income countries, provide specialized ambulatory clinics and community mental health teams, long-term community residential care together with vocational rehabilitation, as well as assertive community treatment and alternatives to acute inpatient care.

Therefore, this study uses the public health concepts of promotion of mental health and prevention of mental ill-health, to evaluate the state of public MHC in high-, middle-, low-income, and the South African contexts, based on the WHO-HEN (2003) treatment suggestions.

2.9. Conclusion

This chapter has located the current study within a context of literature that also reveals the state of knowledge pertaining to mental health. The issue of mental health and the debate around the conceptualisation and classification of mental disorders have been thoroughly discussed. A comprehensive look at the state of MHC within the mental health literature has been presented, highlighting the distribution of resources for MHC worldwide and how they reflect the level of negligence of mental expenditures around the world. Focussing the discussion on the WHO-HEN (2003)'s suggestions for improving MHC around the world, the rationale for carrying out the present study was presented. Some types of treatment approaches were outlined, and an evaluation of their effectiveness and applicability was provided. This chapter has also explored the public health approach to MHC as the theoretical foundation of the current study,

and has allowed the research questions that this study investigates to emerge. The next chapter describes the methodological approach this study adopts in answering its research questions.

CHAPTER THREE: METHODOLOGY

3.1. Introduction

The WHO (2013) has predicted that the burden of disease caused by MI will reach 20% by 2020 globally. Embedded within a public health conceptual framework, this study aims to analyse if and how the provision of MHC is aimed at reducing mental ill-health, and at strengthening the necessary preventive measures for MI. This chapter begins with a further elaboration of promotion of mental health and prevention of mental disorders as the conceptual foundation for the methodological aspects of the present study. A description of the research design and a rationale for using a mixed method approach will then be discussed. The chapter then describes the research questions that emerged from the literature on MHC, and which this study aims to investigate. Proceeding to a description of the data set, this chapter justifies the choice of journals that constitute this study's dataset. An overview of the distinctive attributes of these journals will be provided in order to delineate the appropriateness of these journals in responding to this study's focus. This chapter then provides a detailed discussion of the coding frameworks that were applied to the data, as well as a description of the variables of interest. Issues of reflexivity and ethical considerations are then engaged with.

3.2. Research Design

This study is located within the pragmatic tradition. This paradigm is real-world oriented and aims to provide solutions to problems by focusing on the what and how of the research method (Creswell, 2003; Feilzer, 2010). The pragmatic paradigm is also seen as the framework that provides the underlying philosophical framework for mixed-methods research, because it argues that all approaches be applied to understanding the problem which is central for research (Somekh & Lewin, 2005). Mixed methods approach in this paradigm is defined as a research design that uses both quantitative and qualitative approaches at multiple phases of the research process, such as data collection and analysis (Creswell, 2003). The multi-purposed nature of the pragmatic paradigm is particularly relevant to the current study because it allows me as the researcher to address this study's questions, some of which do not sit comfortably within a wholly qualitative or quantitative approach.

Pragmatism argues for the compatibility of qualitative and quantitative methods in understanding and studying a phenomenon, and in exploring the possible solutions to the problem that is at the heart of an investigation (Barnes, 2012). The research design used in this study therefore falls within the methodological framework of mixed methods research. Mixed methods research involves the collection, analysis or interpretation of both quantitative and qualitative data in investigating a phenomenon, thus challenging the qualitative/quantitative divide, and maximizing the strengths and value of both of these approaches (Armitage & Ruskin, 2007). The mixed methods approach, by combining the complementary aspects of both qualitative and quantitative approaches, minimises the limitations of each, further strengthening their contribution, thus providing adequate explanations of social phenomena (Stange, Crabtree, & Miller, 2006). This research approach is less restrictive and provides the researcher with a broader range of research tools in responding to social issues, allowing in-depth engagement with research questions that arise from either qualitative or quantitative results and from their interactions (Creswell, 2009). Mixed methods research also offers the possibility to not only quantify variables and the relationships between them, but also to explore, explain, and validate the findings in a single study (Barnes, 2012). This method thus promotes a richer understanding of social phenomena.

Moreover, the pragmatic paradigm has an intuitive appeal, as suggest Tashakkori and Teddlie (1998), which allows for findings to be used in a positive manner and in harmony with the value of the specific conceptual area of the study, particularly for the purpose of social and management research endeavours (Feilzer, 2010). In the case of this study for instance, the use of a mixed methods approach to studying trends in MHC aligns with the values of mental health promotion and the prevention of MI, as this works in harmony with the objectives of improving the quality of life of populations affected by mental disorders. Promotion and prevention are two interrelated public health concepts. While prevention of mental disorders aims to reduce the prevalence, prognosis, and incidence of mental disorders, mental health promotion essentially aims to promote optimal psycho-physiological development as well as mental and behavioural health in the public (Petersen et al., 2010). With the burden of MI predicted to reach 20% of the burden of disease worldwide by 2020, it is crucial to study how and if the provision of MHC aims to reduce mental ill-health risk factors and to strengthen protective factors for mental well-being.

However, mixed methods research is not without its challenges. Firstly, this research method requires a solid understanding of both qualitative and quantitative research methods (Cresswell, 2009).The theoretical challenges of combining qualitative and quantitative methods may also be daunting. While qualitative methods have a far more analytical style, as they rely on a variety of iterative procedures of data collection, quantitative research is more linear and relies on statistics and quantification to reach conclusions (Barnes, 2012). Therefore, the differences in qualitative versus quantitative underlying assumptions and epistemology may, as argues Borkan (2004), make true integration challenging. Using mixed methods research also requires extensive data, and the analysis of both textual and numeric data can be time-consuming (Cresswell, 2009). Despite these weaknesses, using mixed methods designs is commendable, because their benefits outweigh their challenges.

Various mixed methods research designs have been proposed, differentiated on a continuum from partially to fully mixed studies. Depending on the degree of mixing that occurs in a single study, mixed methods can be integrative, connecting or embedded (Borkan, 2004; Tashakkori & Creswell, 2007). Mixed methods designs are also differentiated on the dimensions of *time ordering*, where we have sequential qualitative-then-quantitative, sequential quantitative-then qualitative , or concurrent nested designs, determined by the sequential progression of phases of data collection; and *weighting/emphasis/status*, which refer to the significance attributed to the different forms of data, thus distinguishing between equal, qualitative dominant, or quantitative dominant studies (Cresswell, 2009; Johnson, Onwegbuzie & Turner, 2007). The type of mixed methods design this study adopts is sequential qualitative then quantitative, quantitative dominant, and integrative. This study is sequential in that the data from the qualitative phase was used to develop the quantitative phase, and is quantitative dominant because the results are primarily reported in a quantitative format, although qualitative results are also reported. This study is integrative since both qualitative and quantitative methods are used to examine the data and to generate deep and informed conclusions.

3.3. Research Questions

Research questions generally reflect the aims and objectives of a study (Onwuegbuzie & Leech, 2006), and in mixed methods research, they inform the methodological decisions

regarding sampling, sample size, and analytic techniques, as they need to include quantitative and qualitative components in a single study (Graham & Ismail, 2011). The rationale for mixing quantitative and qualitative methods is further justified by the overall aim of this study, which is to provide a broad overview of treatment patterns in MHC as well as the specific types of mental care strategies used in different contexts through an empirical review of published work.

The research questions listed below informed the current study:

1. What are the types of treatment that have been reported the most in the past thirteen years?
2. How common is the use of balanced care as treatment for MI?
3. Are the aspects of balanced care similar or different between South African and other international contexts?
4. How are treatment trends responding to the increasing burden of MI both nationally and internationally?
5. Are the types of balanced care strategies used in high, medium, and low-income countries consistent with the core-components suggested by the World Health Organization?

3.4. Dataset

A field's commitment to a particular area is usually reflected by consistent and increasing publication of particular types of content or subject matter relevant to that area, further highlighting the significance of that area at a specific historical time (Loo, Fong & Iwamasa, 1998). The field of MHC is a complex area which is said to have its primary focus on providing a combination of well-targeted public strategies such as prevention and promotion programmes to communities affected by or at risk of MI, in order to reduce disability and death, stigma attached to mental disorders, to increase social capital, and to promote a country's development (WHO-HEN, 2003). Examples of effective programmes often reported in MHC literature include community- and clinical-based strategies, as well as many other culturally-tailored interventions. The selection of an appropriate sample of articles published in the field of mental health is critical for ascertaining the nature of content that covers at least most of these effective MHC strategies, in order to address the aims of this study.

This study therefore investigates the content of articles published within the MHC sector, in order to examine the field's commitment to its objective of insuring that effective MHC is provided to population affected by MI. The *AJCP, AJP, CMHJ, SAJPs* and *SAJP* were particularly selected for the purpose of this study because of their dedication to publications concerning mental health issues, providing advanced knowledge in understanding MI and in evaluating effective MHC programmes. The two South African- based journals were exclusively selected to provide local articles that emphasise trends that are prevalent in South Africa, while the *AJCP, AJP* and *CMHJ* were used to source international-based studies. A description of each of these journals is provided in the section below.

3.4.1. American Journal of Community Psychology *(AJCP)*

The *AJCP* is the official journal of the Society of Community Research and Action that focuses on publishing a range of different article types such as qualitative, quantitative, mixed methods research, theoretical articles and empirical reviews, reports of community interventions and policies, as well as autobiographical accounts of parties involved in community-based research, intervention and policy. Research in the *AJCP* range from topics related to individual and community mental and physical health and wellness, assessing and developing the quality of MHC through intervention planning, advocacy, training of care providers, advancing processes necessary for establishing social welfare, justice and education of individuals and communities at large, and to provide evaluations of care provision policies and interventions (Novaco & Monahan, 1980).

3.4.2. American Journal of Psychiatry *(AJP)*

The *AJP* is the official monthly peer-reviewed journal of the American Psychiatry Association which is committed to covering all aspects of the field of psychiatry, keeping the field vibrant and relevant through publications of the latest advances in MI diagnosis and treatment (Freedman, 2017). This journal is reported to be the most read psychiatric journal worldwide with the latest impact factor being 15.298, and is reported to be essential and indispensable for virtually every aspect of mental health and psychiatry. The *AJP* was specifically selected for the purpose of this study because of its exclusive coverage of psychiatric topics, and in order to retrieve articles that focused exclusively on psychiatric mental health treatment.

3.4.3. Community Mental Health Journal *(CMHJ)*

Unlike the *AJP*, the *CMHJ* is a periodical journal that is committed to evaluating and improving public mental health services for individuals and communities affected by mental and emotional disturbances (Springer, 2016). This journal was particularly selected because of its pertinence to the public health sector, and because of its coverage of intervention research that analyses benefits and effectiveness of different treatment programmes, not limiting to any particular treatment strategy. Moreover, the CMHJ is the only periodical sponsored by the American Association of Community Psychiatrists that is devoted to improving community mental health, social and community-based interventions, crisis interventions, and social welfare amongst others (Springer, 2016). Articles retrieved from this journal provided data on community-based, clinical-based, and balanced care for MI that was fundamental for analysis.

2.4.4. South African Journal of Psychiatry *(SAJPs)*

The *SAJPs* is the leading journal in the field of psychiatry in Africa that provides publications on psychiatric conditions and treatment approaches prevalent in South and Southern Africa. Although this journal publishes mental health contents from around the world, it makes special provision for the publication of research that is exclusively from Africa (ASSAF, 2014). Based on this reputation, the *SAJPs* was included in this study in order to source articles that were specific but not limited to the South African and other South Saharan low-income countries.

3.4.5. South African Journal of Psychology *(SAJP)*

The *SAJP* is the official journal of the Psychological Society of South Africa and is the prime research journal in South African psychology which covers an extensive range of topics. Although less representative of national policy-driven research, the *SAJP* covers methodological issues in research, psychological measurement and assessment, clinical-based services, as well as philosophical issues relevant to the field of psychology, amongst other topics (ASSAF, 2014).

This study's dataset thus comprise MHC-related articles published within the above mentioned journals over a thirteen-year period, from 2004-2016, in order to assess how the suggestions from the WHO-HEN (2003) regarding the provision of effective and cost-effective mental health services have been implemented.

3.5. Procedures

After identifying key journals, the electronic research databases of the University of the Witwatersrand (Wits) were used to source articles from journals (namely *AJCP, AJP, CMHJ, SAJP*s, and *SAJP*). No special permission was required to access the dataset as this institution has subscriptions for these journals. The above mentioned journals were searched for the period 2004- 2016, using the search terms '*mental illness'*, '*mental health care'*, '*community mental health care', 'psychiatric/clinical mental health treatment'*, and '*balanced mental healthcare*'. Article titles were manually searched in order to identify those that could be considered for inclusion in the study. Relevant articles published within the specific time period were retrieved from each journal and archived electronically in categories organized by journal name and year of publication. Once relevant articles were selected and saved, the abstracts and method section in each article were reviewed for coding. The researcher reviewed the main body of the article to facilitate comprehensive coding of certain variables that were not readily elaborated in the abstract (e.g. sample characteristics, types of intervention used, etc.). A comprehensive description of the coding process and the coding categories are explained in the next section of this chapter. These coding categories were further checked and approved by the supervisor. After qualitatively coding the data, codes were assigned numerical values, and descriptive and other statistical analyses were run to enable a critical engagement with the findings. These findings are described and discussed in the next chapters.

3.6. Coding

Once retrieved and organized, the dataset was ready for coding and analysis. Articles were coded manually using a combination of both inductive and deductive coding strategies. "Inductive coding allows codes to emerge while examining the data", and "deductive coding involves coding data according to predefined categories" (Epstein & Martin, 2005, p. 324). This section provides the details of the coding parameters of each variable, both inductive and deductive. First, the characteristics of articles will be provided, proceeding with the methodological variables for empirical studies, then the different types of MI and mental health theories will be outlined. The characteristics for the types of mental health treatment will also be presented, and lastly the coding characteristics for participants in the data set will be detailed.

3.6.1. Article Characteristics

Publication type. Drawing on the categories outlined by Graham (2014), articles were considered: (1) *empirical* if they were original research and included data collection, or presented a novel secondary data analysis, and included an introduction, method, results, and discussion section; (2) *review* if the study was a critical evaluation or synthesis of previously published research. Both literature review and systematic review articles were coded as *review***.** Articles were considered to be (3) *methodological* if they focused primarily on developing new methodological approaches, or modifying existing methods of studying mental health. Articles were coded as (4) *case study* if they included reports of specific individuals, communities, organizations or groups that were subject to investigation or treatment of any type of mental disorder. (5) *Theoretical* studies focused on the promotion, discussion and advancement of a particular theoretical issue, specifically with regards to a particular type of MHC, illuminating problems, and highlighting areas for future research (APA, 2010). Articles were classified as (6) *other* if they did not conform to any of the above mentioned types of publication. Book reviews, editorials, tributes, commentaries, conference reports and errata were not included in the data as these types of publication did not provide the depth of content required for analysis in the current study.

3.6.2. Methodological Characteristic

1. Primary approach. Drawing on the works of Graham (2014) and Graham and Ismail (2011), the primary approach in empirical studies was coded as (1) *positivist,* if data was collected through quantitative methods, and if data was analysed using statistical methods. Empirical studies were coded (2) *interpretive* if qualitative methods (such as interviews, naturalistic observations, or focus groups) were used to collect data on participants' subjective experiences. Articles were coded as using a (3) *critical* approach if they aimed to uncover and rectify power asymmetries (Swart & Bowman, 2007). The approach was coded as (4) *mixed methods* if it contained more than one primary approach. Empirical studies were coded as employing an (5) *applied method* if the research approach involved: (5.1) *programme evaluation;* or (5.2) a *participatory action research.* The primary approach was coded (6) *other* if it did not fit in any of the above mentioned categories.

2. Primary method. The categories used to code the manner in which empirical data was collected were drawn from those described by Graham (2014)**.** These methods of data collection were: (1) *experimental;* (2) *quasi-experimental;* (3) *survey* or *structured questionnaire;* (4) standardized *test* or *scale;* (5) *archival* for data that were pre-existing records from participants' hospital profiles, national health statistics, police statistics, reports, and other such sources; (6) *qualitative* methods such as interviews and focus group discussions; (7) *multiple-methods* which included more than one primary method of data collection; and (8) *other* for methods that did not fall into any of these categories. This included the use of video footage, telephonic recordings and other technological methods.

3. Context. To facilitate a comparative analysis of trends in MHC between contexts, it was necessary to have different categories for high, middle, and low income contexts. The context of the study was coded based on the 2016 World Bank classification, according to which a country is characterized as being a low-income country if its Gross National Income (GNI) per capita is of $1, 045 or less. Middle income economies are defined as those with a GNI per capita of more than $1/ 045 but less than $12, 736; whereas high income economies are those with a GNI per capita of $12,736 or more. Lower-middle income and upper-middle-income economies, which are separated at a GNI per capita of $4, 125 according to the 2016 World Bank classification, were grouped into the category middle-income economies for the purpose of this study. The list of countries based on these categories was consulted and the context of a study was coded as (1) *international* (if a study used participants from different international countries, and no participants were from South Africa); (1.1) *high income* countries; (1.2) *middle income* countries; or (1.3) *low income* countries. The context was coded as (2) *South Africa* if the data was collected in South Africa or using participants originally from South Africa. If the data was collected from more than one context, this was coded as (3) *multiple* contexts. Studies that failed to identify the context of data collection were coded as (4) *not specified.*

4. Setting. Distinguishing between clinical and community based settings has been noted by Hennessy and Greenberg (1994) to be important in mental health research. This study therefore intended to observe the types of settings that were most used in the specific time-frame (2004-2016). The setting of data collection was coded both inductively (using categories emerging from the data) and deductively (using predefined categories drawn from those outlined

by Graham, 2014) using multiple-response format in order to report multiple settings that emerged from a single study. The settings were: (1) *outpatient psychiatric clinic;* (2) *community mental health centre*; (3) *general community*; (4) *community-based organisation/NGO*; (5) *private practice*; (6) *welfare facility/residential care* (old age home, shelter, children's home); (7) *participants' home*; (8) *prison/correctional centre*; (9) *workplace*; (10) *rural settings*; (11) *not specified*; (12) *religious/spiritual settings*; (13) *other* (social network, and telephonic conference); (14) *rehabilitation centre*; (15) *camp*; (16) *university*; (17) *school/crèche*; (18) *primary care centre*; (19) *inpatient psychiatric ward*. For articles that did not use multiple settings, a code such as (20) *none* was used for setting 2 and 3.

5. Sample size. The sample size was divided into categories of (1) *1-10*; (2) *11-30*; (3) *31-100*; (4) *101-500*; and (5) *more than 500*. These categories were selected to distinguish between studies that used smaller versus larger data sets. The sample size was coded as (6) *not specified* if the numerical size of the sample was nowhere identified in the study.

6. Mental health theories. It is important to identify the theories that have been used in mental health in order to understand mental health problems and to explore how different theories have influenced the trends in mental health treatment options (Thakker & Ward, 1998). Mental health and the treatment of mental disorders have a long and broad history of historical, cultural and religious aetiology and treatment approaches. This study is embedded within the social theories and specifically public health approaches to mental health and MHC. Although the promotion of mental health and prevention of mental ill-health are the main aspects of public health theories that this study focuses on, the focus was extended to include other theories as well. The categories for the theories used in a study were thus drawn from the literature in mental health and from the data, and were coded using multiple response formats to allow for more than one theoretical framework in a single article to be captured. These are described in Table 1 below.

Table 1

Description of theories

Theoretical framework	Description
Treatment programme evaluation	Evaluating the effectiveness of mental health programmes and considering better ways of implementing them.
New treatment programme	Drafting and/or piloting new treatment programmes, or implementing new programmes in certain settings for the first time.
Promotion and prevention	Use of public health, social action or community awareness and educational perspectives, to promote mental health in communities and prevent the prevalence of mental ill-health
Empowerment	Inviting persons affected by mental disorders in the process of their healing and in taking decisions regarding their treatment choices.
Traditional clinical individual-based therapies	Use of theories that are individual-based and not concerned with the participation of the community in the process of treatment
Sense of community	Theories that attribute the process of mental health treatment as a responsibility of both the community and the health care system as a whole.
Community integration	Theories about additional support systems to help people affected by mental disorders claim back their positions in their communities, after being socially excluded due to the illness-related stigma, or after long time spent in in-patient treatment centres or in prison.
Recovery/quality of life	Theories that look at services that are delivered on an individual patient-needs- basis, in order to build his\her strength in taking full responsibility of his/her life, and in order to improve the quality of life of the patient.

The theory was coded as (9) *other* if the type of theory used did not fit within the above mentioned categories, leaning towards needs analysis or studies of trends in service use. For articles that did not use multiple theories, the category for theory 2 and/or theory 3 were coded as (20) *none.*

7. Type of MI. The DSM-IV, DSM-5 and ICD-10 were the classification systems that were primarily used in the data set. As indicated in the literature review, there are differences in the diagnostic criteria and nomenclature of mental disorders, depending on the classification system used (Wakefield, 2007). Therefore, the categories for the types of MI reported were generated from the data in order to account for the various nomenclatures and diagnostic criteria used in different articles. These categories were coded using multiple responses to account for more than one type of MI. These were: (1) *schizophrenia*; (2) *bipolar disorders*; (3) *depression*; (4) *substance use disorders*; (5) *anxiety*; (7) *more than 3 of these*; (8). *psychotic conditions* (unspecified); (9) *mental disorder* (unspecified); (10) *mood disorders* (unspecified); (11) *serious mental illness* (not specified); and (12) *PTSD*. The type of MI was coded as (6) *other* for disorders that did not fit in any of these categories, and for articles that did not explore multiple mental disorders, the categories type 2 and type 3 were coded as (20) *none*.

8. Type of treatment. The type of treatment that participants received or which were investigated and piloted in the dataset were coded deductively as informed by the mental health literature described in Chapter Two. The types of treatment considered in this study are outlined in Table 2

Table 2

Description of types of treatment

Type of Treatment	Description
Clinical	type of treatment that is devoted to the diagnosis, treatment and prevention of mental disorders, through a number of clinical, hospital-based and psychiatric techniques
Community-based	out-of-hospital treatment that provides patients with treatment, rehabilitations, and support services offered in a variety of settings, ranging from the general community, institutional and non-institutional community homes, ambulant care, to residential care
Prison-based mental health care	Mental health services provided to patients with a mental disorder with a history of criminal offending and who are in legal custody or prison settings
Spiritual/religious	Services that are provided in religious settings and using spiritual rather than scientific methods
Mixed/balanced treatment	Integrated mental health services that utilize both community services and hospital care in providing treatment for MI
Psychiatry of the elderly	Branch of psychiatry that delivers multidisciplinary MHC to older people.
Restraints	Form of crisis intervention that includes environmental physical or chemical restrictions used to protect potentially violent patients and the people around them.
Community-based cultural care	Culturally- tailored community-based treatment strategies that are informed by particular cultural beliefs and values, and delivered in community health settings.

Types of treatment such as psychiatry of the elderly and restraints were combined in one category (8) *other* as there were only 2 cases for each**.** If the type of treatment was not specified, this was coded as (7) *not specified.* Where the type of care did not much any conventional form of treatment the code (5) *no formal care* was applied.

9. Community-based treatment. The type of community-based treatment was coded both inductively and deductively. Some categories were informed by the literature in MHC, while others emerged from the data. Table 3 below gives a brief description of the types of community-based treatments.

Table 3

Description of types of community care

Type of Community-based care	Description
Assertive community treatment	This is a holistic approach to MHC that provides services such as medication, housing, finances and assistance with everyday problems to patient in a community care setting.
Rehabilitation(educational and psychosocial)	This type of treatment provides services that restore patients to their normal lives through multiple forms of therapy, training, and community work.
Support groups	Group-based therapy that allows individuals with MI to share their experiences with others (peers of family members) in a therapeutic environment, thus empowering them to develop control over their condition, further boasting their self-confidence and coping skills. This type of treatment helps develop a sense of community and reduce stigma associated with MI.
Acute and intensive home care	When MHC is provided in the patient's home. This type of treatment is usually provided by psychotherapists, social workers, counsellors, or community organizations to patients who may experience difficulty accessing treatment, or if home-based treatment is most beneficial to the patient.
Supportive housing	A combination of housing and mental care services delivered to individuals with MI who are homeless, in order to improve their chances of recovery and of reaching stability. These programmes are believed to be cost-effective ways of preventing MI relapse and homelessness in individuals with or at risk of developing mental disorders.
Cessation programmes	Programmes that help patients discontinue harmful use of substances
Psychoeducation	Process of providing education to individuals with MI or communities at large, with the aim of raising mental health

	awareness, reducing stigma, and improving coping strategies and treatment-seeking behaviours.
Transitional services	These are services that prepare individuals who have been diagnosed with a mental disorder and underwent treatment to reclaim their social roles and life in the real-world environment.
Culturally-tailored interventions	Interventions that were specifically developed to fit certain cultural beliefs, and applied to a certain group of individuals with MI
Wraparound and diversion services	These services are strengths-based, individualized, family-driven, culturally competent community-based services that are provided to children and adolescents (in most cases) with mental and behavioural problems or at risk of legal institutionalization and their families. These services aim to strengthen the natural and community support systems necessary to ensure optimal development of the affected child/adolescent, and prevent future involvement with the justice system.
Recovery residences	These are resources of sobriety offered to patient who have completed intensive treatment programmes, in order to provide them with further support needed to ensure an optimal transition and reintegration into their community lives.
Psychosocial interventions	Their goal is to improve the quality of life of the patients, minimize the symptoms of the illness, improve communication and coping skills, as well as to enhance treatment adherence
Vocational services	This is a set of services that are designed to enable individuals with MI achieve skills and expectations required to get and keep a job, in order to maintain a lifestyle of independence and integration at the workplace.
Community outpatient services	Community-based services such as counselling, pharmacotherapy, support groups, evaluations, that are offered to patients who are residing in their usual homes, and only come to the treatment centre on a need-for treatment basis
Residential services	Treatment method that offers mental health treatment in a home-like environment, where a medical staff assists patients on a daily basis, but not as intensely as in inpatient settings. This type of treatment has the potential to be on-going, depending on the patient's response to treatment.

Crisis intervention	Method used to provide emergency short-term treatment to individuals experiencing acute mental crisis or a traumatic event that result in loss of coping skills and a sudden mental breakdown.
Intensive case management	Individual-based intensive care that is provided to patients with severe MI who are at high risk of hospital readmission. This type of treatment is provided by a nurse, social worker or case manager who constantly assess the patient's needs, and ensure that they are met.

Where the type of community-based care did not fit any of the above mentioned categories, this was coded as (5) *other*; and if it was mentioned that a type of community treatment was used, but this was not specified the code (7) *unspecified* was applied. The types of community-based care were coded into a multiple response format to allow for more than one type to emerge in a single study.

10. Clinical-based care. Similar to community-based care, the categories for the type of clinical care were developed using a combination of prearranged codes that were informed by the literature, and other codes that emerged through the examination of the data set. These categories are described in Table 4.

Table 4

Description of types of clinical care

Clinical Care	Description
Electroconvulsive therapy	Procedure that involves causing changes in brain chemistry through passing small electric current through certain areas of the brain in order to prompt brief seizures, which are believed to reverse symptoms of certain mental disorders.
Pharmacotherapy	Form of therapy that uses pharmaceutical drugs to alleviate or treat symptoms of certain mental conditions.
Behaviour therapy	Therapy that targets potentially self-destructive and unhealthy behaviours, aiming to change or improve them through therapy.
Psychiatric outpatient care	Psychiatric care that is provided on a periodic visits-basis, where the patient consults with the psychiatrist for assessment and or therapy sessions, but is not hospitalized for this matter.
Psychiatric in-patient care	Psychiatric treatment that requires hospitalization of the patient who is deemed in need of intensive psychiatric attention
Interpersonal psychotherapy	This type of therapy is a structured time-limited (12-16 weeks) approach that adopts an attachment style of therapy, aimed at resolving the patients' interpersonal relationships, and at improving the symptoms of the disorder.
Electronic psychotherapy/ tele-psychiatry	Provision of psychiatric services through telecommunications technology.
Mobile psychiatry/psychiatric outreach	Psychiatric services that aims to breach the gaps in mental health treatment, by providing cost-effective patient-centred psychiatric care in the general community, especially in impoverished communities.

Where the type of clinical care was not specified a code such as (7) *psychiatric services (unspecified)* was applied. Clinical treatment was also coded using multiple response formats to allow more than one type to be captured in a single study.

11. Balanced care. The type of balanced care was coded inductively, as they emerged from the data. This included a combination of community- and clinical- based categories, as well as other categories. Below is a list of the coding categories for balanced care that emerged from

the dataset: (1) *Outpatient care plus support groups*, (2) *inpatient plus assertive community treatment*, (3) *rehabilitation plus pharmacotherapy and outpatient care*, (4) *CBT and social support services*, (5) *CBT plus other treatments*, (6) *system of care*, (7) *evidence-based psychotherapy*, (8) *Case management, ACT and housing*, (9) *alternative medicine*, (10) *psychiatric treatment plus vocational services*, (11) *CBT plus psychosocial rehabilitation interventions*, (12) *pharmacotherapy and interpersonal psychosocial interventions*, (13) *Practice-based/Telemedicine-based collaborative care*, (14) *CBT plus vocational/employment service*, (15) *pharmacotherapy and residential inpatient services*, (16) *pharmacotherapy, clinical outpatient, community inpatient care and psycho-education*, (17) *outpatient psychiatric care and assertive community care*, (18) *assertive community treatment and physical care*, (19) *psychiatric services in primary mental health care centres*, (20) *psychiatric care and spiritual/traditional practices*, (21) *pharmacotherapy and community outpatient care*, (22) *rehabilitation (educational and psychosocial) plus psychiatric inpatient care*, (23) *Dialectical Behaviour Therapy plus ACT*, (24) *integrated dual diagnosis treatment* , and (25) *CBT plus ACT*.

3.6.3. Participant Characteristics.

1. Age. The age categories were constructed following the classifications used by Graham (2014) and Graham and Ismail (2011). These categories were (1) *early childhood* if participants were 5 years of age or below; (2) *middle childhood* if they were aged between 6 and 12 years; (3) *adolescent* if they were between the ages of 13 to 17 years; (4) *adult* if they were above 18 up to 64 years old. Participants were classified as being (5) *elderly* if they were over the age of 65 years old. If the sample included participants from several different age groups, the age category was coded as being (6) *mixed*. The age category was coded as (7) *unspecified* if there was no reference to the age of the participants.

2. *Gender*. Following the categories described by Graham (2014), the gender of participants was coded as (1) *female* (for studies that used female participants only); (2) *male* (for studies that only used male participants); (3) *mixed* (if the sample included both male and female participants); (4) *other* (for studies that used intersex or other gender categories, e.g. LGBTI); and (5) *not specified* (if the gender of the participants was not reported in the study).

***3. Level of education*.** The categories used to characterise the level of education of the participants were formulated with reference to the ones used by Graham (2014). The level of education was thus coded: (1) *preschool* if participants only received formal preschool education or day care; (2) *primary school* if participants partially or fully completed primary school only; (3) *secondary school* if participants reached and completed secondary school; (4) *tertiary education* if participants completed undergraduate university degrees/diplomas or any other post-matriculation qualification; (5) *postgraduate* if participants had fully or partially achieved Honours, Masters or Doctoral degrees. If participants in one study had different levels of education, this was coded as (6) *mixed*; and if no specification of the level of education of the participants was provided a code such as (7) *unspecified* was applied. For adult participants who had never attended school or had not received any form of vocational training, the level of education was coded as (8) *no formal education*.

4. Employment status. Employment status was coded to assess whether employment is considered in mental health research overall. Categories were predefined following the example used by Graham (2014)**,** and included: (1) *unemployed* (if participants were of working age but were unemployed); (2) *employed* (if participants were of working age and were employed); (3) *mixed* (used for studies that included both employed and unemployed participants); (4) *university/college student* (used to describe individuals who were still completing their post-matriculation qualifications at university, colleges or other training institutions); (5) *child/scholar* (used for participants under the age of 18 who were still attending school); (6) *retired* (to categorize individuals who had formally retired, e.g. veteran). If no reference was made to the employment status of the participants, this was coded as (7) *unspecified*, and if participants' employment status did not fit within any of the above mentioned categories, the employment status was coded as (8) *other*.

***5. Marginalised groups*.** The categories of marginality were coded in a multiple response format both deductively (following examples outlined by Graham, 2014) and inductively (based on characteristics emerging from the data). These included: (1) *race* (if participants were disadvantaged based on their skin colour); (2) *gender or sexual orientation* (if participants were disadvantaged because they were female, cross-gendered/intersex, homosexual or bisexual); (3) *psychological condition* (if participants were limited because of their mental condition); (4)

socio-economic status (if participants' access to treatment was limited by the virtue of being poor, unemployed or socio-economically disadvantaged); (5) *disability* (if participants had physical, intellectual, or social disability which constituted a disadvantage to their mental health state or access to treatment); (6) *geographical location* (if participants were drawn from rural, or farm areas where access to treatment facilities is limited); (8) *HIV/AIDS* (If participants were HIV positive); (10) *migration status* (if participants were displaced, refugees or migrants); (11) *minority groups* (if participants were classified as constituting minority groups based on their race, ethnicity, or religious belief); (12) *criminal history* (if participants had a history of involvement in any type of illegal activities that resulted in arrest, and which consequently led to them being socially scrutinized or excluded from their respective communities); (13) *age* (if participants were 65 years or older, which reflected their developmental, physical and social vulnerability). Marginality was coded (7) *other* if the category did not match any of the aforementioned characteristics (e.g. political affiliation…), and (9) *unspecified* if participants experienced forms of social exclusion which were not deliberately mentioned.

***6. Life challenges*.** Participants were further categorized into groups according to the types of life challenges they experienced. Participants were said to experience life challenges if they were (1) *homeless,* (2) *orphaned;* if they experienced (3) *scare treatment resources/access to facilities, (4) limited capital;* if they were exclusively classified as (5) *at risk* (e.g. adolescents)**,** or (6) *socially excluded;* and if they were victims of (9) *negative life events* such as war, natural disasters, or loss of a significant other**.** If participants experienced challenges which were not named in the study, this was coded as (7) *unspecified;* and if the type of life challenges reported did not fit within the above mentioned categories, this was coded as (8) *other.*

***7. MI labelling*.** To analyse if attempts at reducing MI labelling stigma have been made in the past 13 years, the trend of person-first language used in mental health research were coded for analysis. These were (1) *person-first,* (2) *condition-first* or (3) *mixed* in articles where both of these trends were used in the abstract. As outlined in the literature review, language and labels have a significant effect on tolerance towards people with MI (Granello & Gibbs, 2016), and the use of person-first language when referring to individuals affected by mental disorders is a step further into reducing mental health stigma, which this project is cautious of when referring to individuals with mental disorders

3.7. Data Analysis

This study uses a multi-method approach to data analysis, combining elements of both qualitative and quantitative analysis**.** In this study, a thematic content analysis was used to code and analyse the data qualitatively. Thematic content analysis is, according to Braun and Clarke (2006), a method for identifying, analysing and reporting patterns of themes within the data, while minimally organising and describing the dataset in rich detail. While this type of analysis condenses the data into a more manageable size, it also allows for themes to arise in a more qualitative manner (Lal Das & Bhaskaran, 2008). Braun and Clarke (2006) suggest six steps of conducting a thematic analysis. These steps include (1) the researcher familiarising himself/herself with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report**.** Following these steps, I familiarized myself with the data through frequent reading of the articles in the data set, extending beyond the abstract and method section to include the whole body of the article sometimes, while identifying key themes that appeared relevant and significant to this study. I meanwhile engaged in reading and reviewing the coding procedures and categories used in other published empirical studies both in the field of mental health, community psychology, and other fields of public health. As suggested by Braun and Clark (2006), key conceptual areas from the literature that were relevant to this study were reflected in some coding categories, while other codes were generated from the close reading of the data. This allowed for the modification of pre-arranged coding frameworks in order to capture other interesting features of the data.

These coding categories were continually polished throughout the coding process until a final coding framework that covered all the variables of interest was derived. The final coding framework was used to generate major themes that were relevant to the aims of the study. The coding system was in this sense both data- and theory-driven. Therefore, inductive and deductive coding strategies were combined in the thematic data coding and analysis used in the study. Codes were then assigned meaning to generate themes that were relevant to the interest of the study, and were then applied consistently and systematically across the dataset. Once finalised, these codes were assigned numerical values and were further converted into a quantitative format to reveal common trends within the data. The data was subsequently checked and cleaned before proceeding with the quantitative analysis. Statistical analyses were then run using SPSS Version 23 to analyse the quantitative data. These included basic descriptive statistics such as

frequencies, percentages, and multiple response frequencies, which were computed to reveal the content trends in the data. A thematic interpretation was also applied to elucidate the descriptive results with a conceptual interpretation. La Das and Bhaskaran (2008) suggest the use of cross tabulations in examining relationships within the data that may not be apparent when analysing the data as a whole. Therefore, a cross-tabulation comparative analysis was conducted to compare the types of MHC strategies that emerged in the different contexts (high-income, middle income, and low income countries). This was done to address one of the aims of this study which was to compare mental health treatment models that have been used in different contexts, and if and how they answer the WHO-HEN (2003)'s calls for improvement in the provision of MHC.

3.8. Self Reflexivity

Finlay (2003) notes that research is inherently indissoluble from the researcher's subjectivity and that his/her worldview impacts on the formulations and interpretations of the findings. Reflexivity thus involves the researcher's awareness of his/her personal, conceptual and methodological orientations, as well as how they impact on his/her attitude to knowledge (Guillemin & Gillam, 2004). At a personal level, my interest in abnormal psychology and my passion for mental health in general position me with a certain mind-set that is more oriented towards positive mental health and an appreciation of the clinical or medical stance to MHC. This worldview limits me with a single interest in a particular treatment strategy which is clinically-based. By approaching this research with an open awareness of difference, it has allowed me to take interest into other approaches to MHC, and to closely analyse their benefits. My interest in international and South African literature is also linked to my experience of living in different contexts, and my fascination with how different cultures and policies address social issues, and particularly issues related to health and mental health. My position as an outsider in different contexts has often motivated me to emphasise differences more than similarities. Therefore my approach to this research, which involves comparing international versus South African literature on mental health, has cautioned me to be neutral in the interpretation of the results in order to consider the patterns as they arise, and not overemphasise differences over similarities. This reflexivity is thus infused throughout this study.

3.9. Ethical Considerations

The use of articles as data sources in this study raises ethical issues that are slightly atypical to the nature of psychological research**.** This study did not necessitate ethical approval as it deals with textual data in the form of published articles. Ethical concerns regarding confidentiality and anonymity were also not contended as the study did not make direct use of human subjects. However, because this study is a review of mental health research, there is an inherent value judgment involved. This may invoke the ethical issue of misinterpretation of other authors' works (Sixsmith & Murray, 2001). To ensure that no misinterpretation occurred, abstracts and the body of articles that were included in the data set were read and re-read for clarification and confirmation of the coded variables.

3.10. Conclusion

This chapter has presented the methodological approach used in this study, through a description of the research questions posed, the approach employed, the procedures of data collection, and the analytical tools used in answering the questions. This chapter also provided the rationale for the choices of the research design and analysis used, as well as a description of the codes and the coding process employed. Issues of reflexivity and ethical considerations were also acknowledged. The next chapter proceeds with the presentation of this study's results.

CHAPTER FOUR: RESULTS

4.1. Introduction

This chapter presents the findings of the analyses that were conducted using the methods described in the previous chapter. Firstly, a description of the dataset is provided, followed by the results of the methodological frequencies and multiple response frequencies where applicable. Results from the cross-tabulation analysis are also provided. The patterns of participant characteristics are then presented, with the frequency of occurrence of each variable illustrated in tables and graphs where necessary. In order to facilitate comparison between contexts (*High-income, Middle-income, Low-income, and South Africa*) the *international* and *unspecified* contexts are not represented where results are presented by context, the only exception being where trends in balanced care are illustrated across contexts.

4.2. Description of the Dataset.

This study used journal articles published between 2004 and 2016, which focused on mental health treatment strategies. A total of 222 articles were retrieved from 5 journals, and as illustrated in Table 5 below, most of them (47.3%, n=105) came from the *CMHJ*, followed by the *AJCP* which produced at least 36 (16.2%) articles related to MHC in the time frame from 2004 to 2016. While the *SAJP* produced the least studies (8.1%, n=18) on MHC in the last thirteen years, articles from the *AJP* and *SAJPs* were also less frequent, representing a frequency of 32 (14.4%) and 31 (14.0%) each respectively.

Table 5

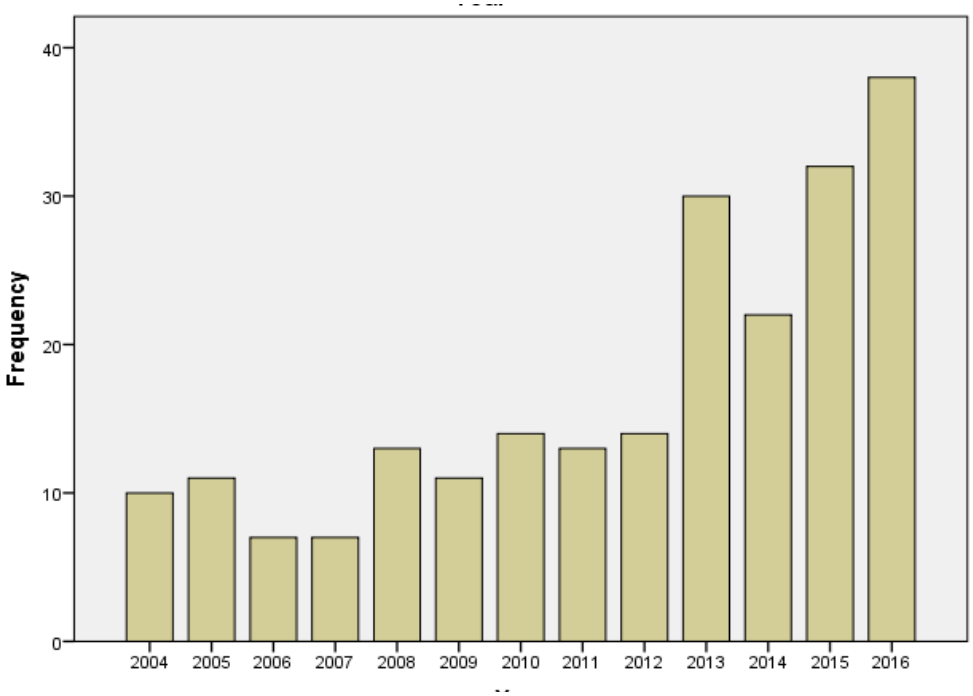
Publication trends by year

Year	AJCP n (%)	AJP n (%)	CMHJ n (%)	SAJP n (%)	SAJPs n (%)
2004	1 (05)	1 (0.5)	7 (3.2)	0 (0.0)	1 (0.5)
2005	3 (1.4)	4 (1.80	4 (1.8)	0 (0.0)	0 (0.0)
2006	0 (0.0)	3 (1.4)	3 91.4)	1 (0.5)	0 (0.0)
2007	1 (05)	1 (0.5)	4 (1.8)	0 (0.0)	1 (0.5)
2008	5 (2.3)	1 (0.5)	2 (0.9)	0 (0.0)	5 (2.3)
2009	3 (1.4)	2 (0.9)	3 (1.4)	1 (0.5)	2 (0.9)
2010	2 (0.9)	2 (0.9)	6 (2.7)	1 (0.5)	3 (1.4)
2011	1 (0.5)	4 (1.8)	4 (1.8)	4 (1.8)	0 (0.0)
2012	5 (2.3)	1 (0.5)	6 (2.7)	0 (0.0)	2 (0.9)
2013	5 (2.3)	3 (1.4)	15 (6.8)	3 (1.4)	4 (1.8)
2014	1(0.5)	2 (0.9)	10 (4.5)	3 (1.4)	6 (2.7)
2015	9 (4.1)	4 (1.8)	11 (5.0)	2 (0.9)	6 (2.7)
2016	0 (0.0)	4 (1.0)	30 (13.5)	3 (1.5)	1 (0.5)
Total	36 (16.2)	32 (14.4)	105 (47.3)	18 (8.1)	31 (14.0)

Moreover, it is revealed in the graph below (Figure 1) that most of these articles were published in the year *2016* (n=38), followed by the years *2015* (n=32) and *2013* (n=30). Less articles were published in *2014* (n=22), and the least number of articles were published between *2006* and *2007*, with a frequency of 7 articles each. The years *2010* and *2012* (n=14 each), as well as *2008* and *2011* (n=13) produced roughly the same amount of articles on MHC. Similarly, *2005* and *2009* (n=11 each), as well as *2004* (n=10) produced a marginally similar number of studies in the dataset.

Figure 1

Trends in year of publication

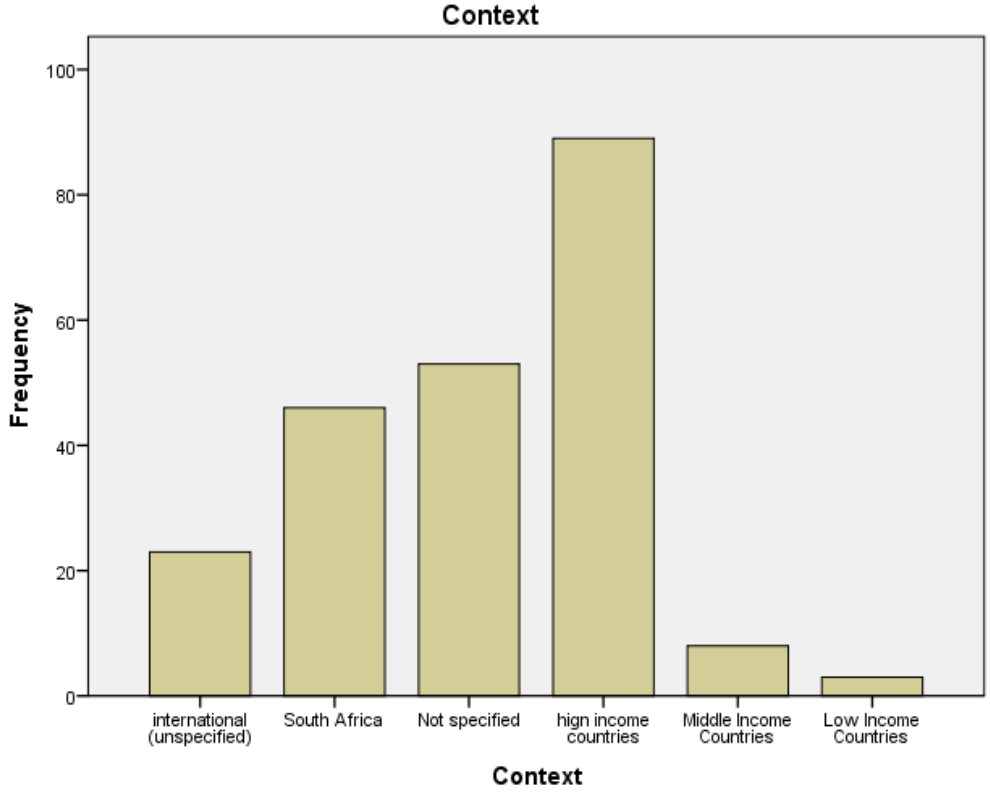


4.2.1. Context

An important aspect of this study was to differentiate between high, middle and low income contexts, in order to compare the trends in MHC between these contexts and against the ones suggested by the WHO-HEN (2003). Therefore, the context in which a study was conducted was coded as *international (unspecified), high, middle, low- income,* or *South African.* The results, as illustrated below (Figure 2), indicate that most studies in the dataset were conducted in *high income countries* (n=89), whereas *low income countries* produced the least number of articles (n=3). At least 53 articles *did not specify* the context of the study, and 23 studies were conducted in contexts that were *international* (outside South Africa) but not explicitly specified. At least 46 studies were conducted in the *South African* context, and 8 were from *middle income* contexts.

Figure 2

Publication trends by context



4.2.2. Publication Type

The type of publication was coded according to the APA (2010) criteria, and includes categories such as *empirical, review, methodological, theoretical,* and *case studies*. As defined in Chapter Three, empirical studies were studies that addressed specific hypotheses and included an introduction, method, results and discussion section. *Review studies* were those that evaluated already existing published research. A study was *methodological* if it focused on developing or modifying methods of researching mental health-related issues, and *theoretical* studies focused on advancing particular theories of MHC. An article was coded as *case study* if it included reports of specific individuals that were subject to mental health treatment.

Table 6 below shows the trends in publication in this study's dataset, revealing that the majority of articles were *empirical,* representing 76.6% (n= 170) of the total data set, followed by *review*

studies which represent 22.1%. (n= 49). 0.5% (n= 1) of articles were *case study* articles and 0.9% (n=2) were *theoretical*. There were no *methodological* studies represented in the dataset.

Table 6

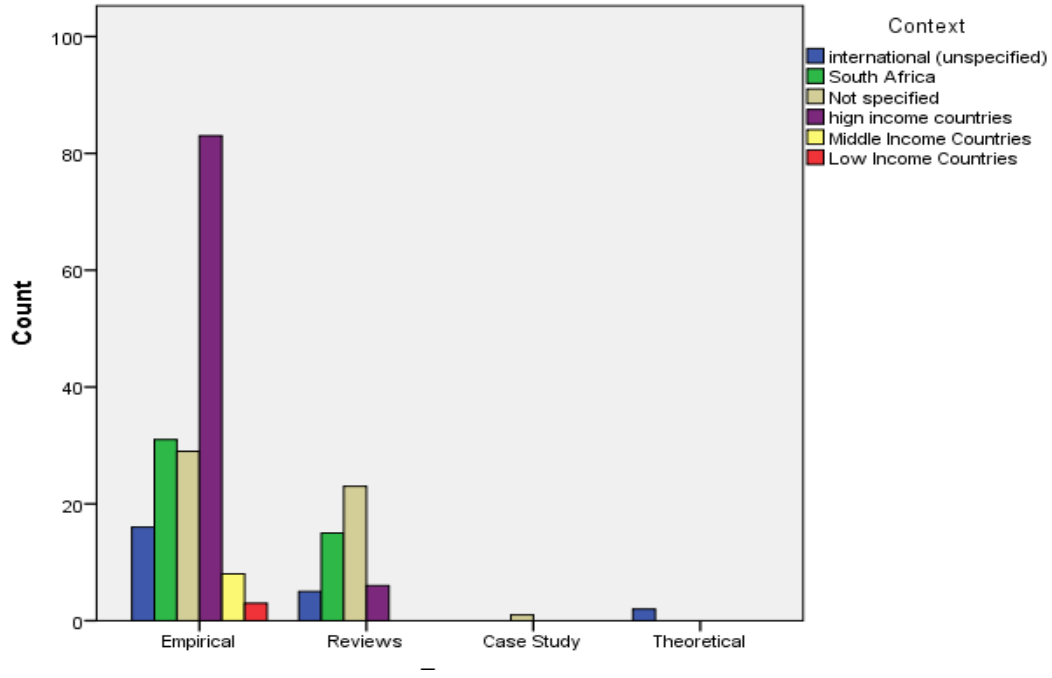
Trends in publication type

Type of publication	n	%
Empirical	170	76.6
Reviews	49	22.1
Case Study	1	.5
Theoretical	2	.9
Total	222	100.0

The distribution of publication type across contexts was quiet uneven. The chart below (Figure 3) shows that *empirical* studies were most common in *high income* countries, least common in *low income* countries, minimally present in *middle income* contexts, and almost equally frequent in *South Africa* and in other *unspecified (not mentioned)* contexts. *Review* articles on the other hand dominated *South African* and other *unspecified (not mentioned)* contexts. The chart also shows that no *review* articles were published in *low* and *middle income* countries. Most *reviews* came from *unspecified* contexts and some from *international but not specified* countries. The context where the *case study* article was conducted was *not specified*, and *theoretical* articles were published in *international* contexts where no particular country was mentioned.

Figure 3

Publication type by context



4.3. Methodological Characteristics

4.3.1. Primary Approach

As discussed in the previous chapter, the primary approach in empirical studies was *positivist* (if the methodology involved scientific measurement and statistical methods to analyse the data), *interpretive* (if quantitative methods were used to collect and interpret the data), *critical* (if the study aimed to uncover power asymmetries), or *applied methods* (if the research approach was a *community needs analysis, policy analysis, treatment programme evaluation*, or was a *participatory action research*). Studies that involved more than one of these approaches were coded as mixed *methods*, or *other* if the approach did not fit in any of the above mentioned categories. For articles that were neither empirical nor case studies, the method was considered *not applicable*. Table 7 presents the trends related to the overall methodological approach used in *empirical* and *case study* articles in the current dataset.

Table 7

Trends in primary research approach

Research approach	n	%
Positivist	61	35.7
Programme evaluation/comparative effectiveness research	47	27.5
Interpretive	31	18.1
Mixed methods	17	9.9
Participatory action research	11	6.4
Applied methods (unspecified)	2	1.2
Critical	1	.6
Other	1	.6
Total	171	100.0

The *positivist* approach was the most used, representing 35.7% of the dataset (n=61), followed by *programme evaluation,* which represents 27.5% (n=47) of the total dataset. At least 18.1% (n=31) of articles were *interpretive*. Of the articles that used *applied research methods*, 27.5% (n=47) used *programme evaluation (comparative effectiveness research),* 6.4% (n=11) used *participatory action research*, and 1.2% (n=2) did not specify the type of *applied methods* used. At least 9.9% (n=17) of studies used *mixed methods* approaches, and 0.6% (n=1) used *other* approaches that were not mentioned here. The least used approach was the *critical approach*, representing only 0.6% (n=1) of the total dataset.

4.3.2. Primary Method of Data Collection

The results for the primary method of data collection are illustrated in Table 8 below. These results show that most data in experimental articles was collected using *multiple methods* (22.2%, n=38), followed by *experimental* methods (17.5%, n=30). *Quasi-experimental* methods were the least used, representing 3.5% (n=6) of the total dataset. At least 26 articles (15.2%) used *tests, scales* and *inventories,* 25 (14.6%) used *qualitative* methods, 24 (14.0%) employed *archival* methods, and 19 (11.1%) used *surveys/questionnaires* as primary methods of data

collection. Methods that did not fit in any of the above mentioned categories, *other*, were minimal and represented 1.8% (n=3) of the total dataset.

Table 8

Trends in primary method

Method	n	%
Multiple methods	38	22.2
Experimental	30	17.5
Test/Scale/inventory	26	15.2
Qualitative	25	14.6
Archival	24	14.0
Survey/questionnaire	19	11.1
Quasi-experimental	6	3.5
Other	3	1.8
Total	171	100.0

4.3.3. Trends in Setting of Data Collection.

This study was interested in observing the trends in setting of mental health research, in order to analyse if the setting was decentralized (out of hospital) or primarily clinical or hospital-based. Table 9 illustrates the trends in setting of data collection that were most and least prevalent in the dataset.

Table 9

Trends in setting of data collection

Setting	n	%
Community MHC centre	53	24.0
Outpatient psychiatric clinic	29	13.1
Outpatient-community-based organisation/NGO	19	8.6
Participant's home	17	7.7
Welfare facility/residential care centre	13	5.9
Inpatient psychiatric ward	10	4.5
Primary care centre	10	4.5
General community	8	3.6
Rehabilitation centre	8	3.6
Prison/correctional-centre/police station	7	3.2
Rural settings	2	0.9
Camp	1	0.5
Private practice	1	0.5
University	1	0.5
Workplace	1	0.5
Other	27	12.2
Not specified	14	6.3
Total	221	100.0

As shown above, research published in the *AJCP, AJP, CMHJ, SAJP*s, and *SAJP* between 2004 and 2016 were primarily conducted in *community-based mental health care centres* (24%), followed by *outpatient psychiatric clinics* (13.1%). 12.2% of research in the dataset was conducted in *other* settings, 8.6% in *NGOs,* 7.7% at the *participant's home,* and 5.9% in *welfare facilities or residential care centres. Impatient* and *primary care centres (general hospitals)* were equally prevalent in the dataset, each representing 4.5% of all settings used, followed by *rehabilitation centres* and *general community settings* which represent 3.6% of the responses each. C*orrectional centres* (3.2%) and *rural settings* (0.9%) were less used, and the least used

research settings were *private practice offices, workplaces, camps,* and *universities*, representing 0.5% of the responses each.

4.3.4. Theoretical Trends.

Following the categories described in chapter three, the trends in MHC theories that were most reported in the five journals being examined in the time frame from 2004 to 2016 are presented in Table 10.

Table 10

Trends in theory

Mental health theory	n	%
Treatment programme evaluation	138	31.9
Recovery/quality of life	87	20.1
Promotion and prevention	71	16.4
Development of new treatment programmes	35	8.1
Empowerment	30	6.9
Community integration	23	5.3
Sense of community	17	3.9
Traditional individual-based	11	2.5
Other	20	4.6
Total	432	100.0

The type of MHC theory that dominated research within the *AJCP, AJP, CMHJ, SAJCP, and SAJPs* from 2004 to 2016 was *treatment programme evaluation* representing, 31.9% of responses in the dataset. The *recovery and quality of life* framework followed with a frequency of 20.1%. Next is *promotion and prevention* framework which followed with a prevalence of 32%. Less but not least frequent theories were: *development of new treatment strategies* (8.1%), *empowerment* (6.9%), *community integration* (5.3%), and *sense of community* (3.9%).

Individual-based theory was the least used framework in the dataset, with a frequency of 2.5% of responses. At least 4.6% of the dataset did not match any of the above mentioned categories.

4.3.5. Type of MI

Observing the types of MI that were most investigated in the dataset was crucial to understanding and analysing the treatment options that would prove most effective in addressing these mental disorders. Therefore, the trends in mental disorders most reported are illustrated in Table 11. These results show that *schizophrenia* (17.7%) and *substance use disorders* (17.4%) were the most researched mental disorders, followed by *serious mental disorders* (14.9%) and *depression* (14.6%). *Unspecified psychotic conditions* (9.8%) and *bipolar disorders* (8.7%) were the next frequently research types of mental disorders in the dataset. *Anxiety* (4.5%), *mood disorders* (3.9%), *unspecified mental disorders* (3.4%) and *PTSD* (3.1%) followed with lower frequencies, while *other disorders* (1.4%) were the least reported in the dataset.

Table 11

Trends in types of MI

Type of MI	n	%
Schizophrenia	63	17.7
Substance use disorder	62	17.4
Serious mental illness	53	14.9
Depression	52	14.6
Psychotic conditions	35	9.8
Bipolar disorders	31	8.7
Anxiety	16	4.5
Mood disorders	14	3.9
PTSD	11	3.4
More than 3 disorders	2	0.6
Not specified	12	3.4
Other	5	1.4
Total	356	100.0

Moreover, it is illustrated in Table 12 below that *schizophrenia, substance use disorders, bipolar disorder, depression,* and *other psychotic conditions* were the most researched types of MI in high income contexts, while *depression* and *substance use disorders* dominated in low- and middle income contexts. *Schizophrenia* and other *serious mental* d*isorders* were also frequent in middle-income contexts, as well as some evidence of *bipolar disorders* and *PTSD. Depression* was also the most common type of MI reported in the South African context, followed by *psychotic conditions, schizophrenia,* and other *serious mental disorders*.

Table 12

Trends in type of MI by context

Type of MI	High income n (%)	Middle-income n (%)	Low-income n (%)	South Africa n (%)
Schizophrenia	34 (13.5)	2 (0.8)	0 (0.0)	9 (3.6)
Substance use disorder	32 (12.7)	2 (0.8)	2 (0.8)	8 (3.2)
Serious mental illness	17 (6.8)	2 (0.8)	0 (0.0)	10 (4.0)
Depression	17 (6.8)	2 (0.8)	3 (1.2)	13 (5.2)
Psychotic conditions	14 (5.6)	0 (0.0)	1 (0.4)	11 (4.4)
Bipolar disorders	18 (7.2)	1 (0.4)	0 (0.0)	6 (2.4)
Anxiety	7 (2.8)	0 (0.0)	2 (0.8)	3 (1.2)
Mood disorders	6 (2.4)	0 (0.0)	0 (0.0)	4 (1.6)
PTSD	4 (1.6)	1 (0.4)	1 (0.4)	2 (0.8)
More than 3 disorders	1 (0.4)	0 (0.0)	0 (0.0)	1 (0.4)
Not specified	6 (2.4)	0 (0.0)	0 (0.0)	5 (2.0)
Other	3 (1.2)	0 (0.0)	0 (0.0)	1 (0.4)
Total	159 (63.3)	10 (4.0)	9 (3.6)	73 (29.1)

4.3.6. Type of Treatment

Central to this study is the question of which types of mental health treatment strategies were most delivered or researched in the past thirteen years, in order to understand how different contexts have particularly addressed the mounting burden of MI. As such, results found here and reported in Table 13 below reveal that *balanced care* was the most studied and reported type of MHC in the time frame from 2004 to 2016 in the five journals, representing a frequency of

32.9% (n=73) of the total dataset. *Community-based care* was the next often reported, with a frequency of 31.5% (n=70), while *clinical care* strategies were even less frequent, representing 25.7% (n=57) of the dataset. *Other* types of care, *informal care, spiritual/religious* care and treatment strategies that were not *specified* were marginally reported, covering 1.8% (n=4) of the total dataset each, while *prison-based* care and *community-based cultural* care were the least reported types of MHC, each representing 1.4% (n=3) and1.8% (n=4) respectively.

Table 13

Trends in type of treatment

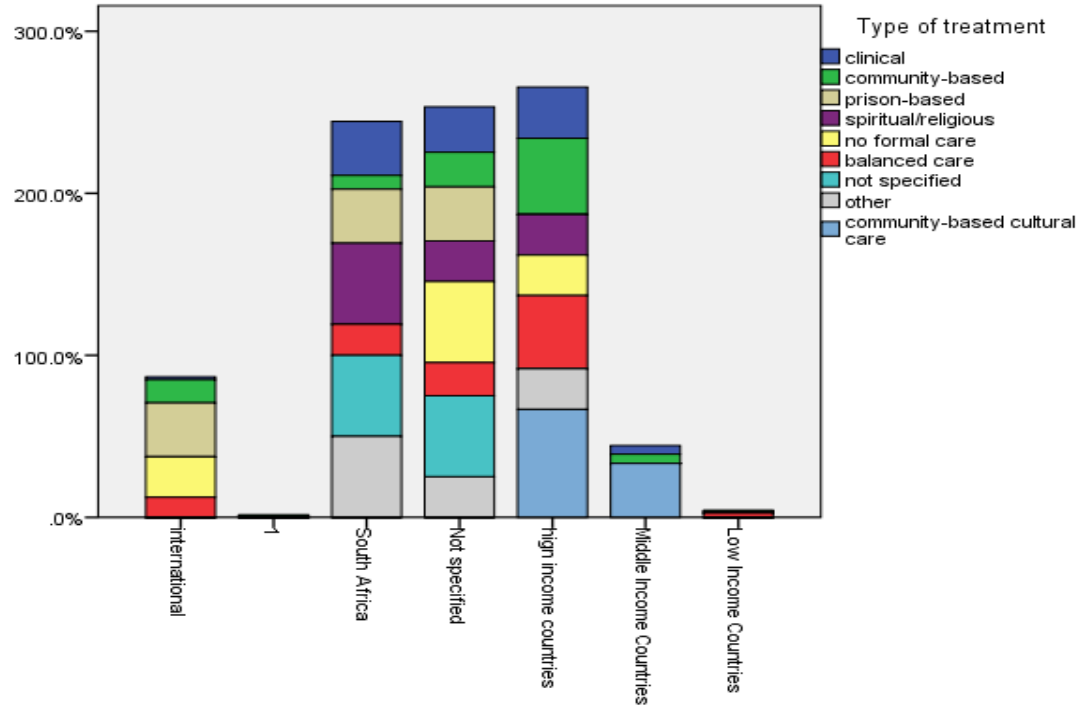
Treatment type	n	%
Balanced care	73	32.9
Community-based	70	31.5
Clinical	57	25.7
Spiritual/religious	4	1.8
No formal care	4	1.8
Prison-based	3	1.4
community-based cultural care	3	1.4
Not specified	4	1.4
Other	4	1.8
Total	222	100.0

The distribution of the type of treatment across contexts (illustrated in Graph 4 below) was also remarkable. While *balanced care* and *community-based* treatment equally dominated *high-income contexts* (representing 14.9%, n=33 of the treatment each), *clinical* care was the most frequent in the *South African* context, representing 8.6% (n=19), followed by *balanced care* with 6.8% (n=15), while community-based care was less reported with only 2.7% (n=6) of occurrence. Other forms of treatment reported in the *South African* context included, *culturally-tailored* care (0.9%, n= 2), *other treatments* (0.9%, n=2), as well as *prison-based* MHC (0.5%, n=1). The results in Graph 4 also show that *community-based* care (6.8%, n=15), *clinical* and *balanced* care (representing 6.8%, n=15 each) were prevalent in contexts that were *not specified*, while *balanced care* alone dominated in *other international* contexts which were not explicitly

named. *Community- based, clinical,* and *culturally-tailored* care were also reported in *middle-income* contexts (with 1.8% n=4, 1.4% n=3, and 0.5% n= 1, respectively), while *balanced* care and *community-based* treatment were the only treatment strategies observed in *low-income* contexts.

Figure 4

Treatment trends by context



4.3.7. Community-based Care

As shown in Table 14, the most common type of *community-based care* reported in the dataset was *social support care,* representing 21.4% (n=39) of responses, followed by *assertive community treatment,* which represents 18.1% (n=33) of all responses in the dataset. *Rehabilitation* was also reported in the dataset, with at least 9.9% (n=18) of responses. *Housing (*6%, n=11), *other* types of treatment (6%, n=11), *culturally-tailored interventions* (4.9%, n=9), *psychosocial interventions* (4.4%, n=8), *cessation programmes* (4.4%, n=8), *transitional services* (3.8%, n=7), *intensive case management* (3.3%, n=6) and *psycho-education* (3.3%, n=6) were next with less frequencies, while *recovery residences*(2.7%) and *vocational services* (2.2%)

followed with even minimal frequencies. The least used types of community-based treatment were *community outpatient care, residential inpatient services* and *crisis intervention,* representing 1.1% (n=2) of responses each, as well as *acute and intensive home care, wraparound and diversion services* which represented 1.6% (n=3) each. The type of community-based treatment was *not specified* in 0.8% (n=5) of the responses.

Table 14

Trends in community- based care

Community care	n	%
Social support care	39	21.4
ACT	33	18.1
Rehabilitation	18	9.9
Supportive housing	11	6.0
Culturally-tailored interventions	9	4.9
Cessation programmes	8	4.4
Psychosocial interventions	8	4.4
Transitional services	7	3.8
Intensive case management	6	3.3
Psychoeducation	6	3.3
Recovery residences	5	2.7
Vocational services	4	2.2
Community outpatient care	2	1.1
Crisis intervention	2	1.1
Residential inpatient services	2	1.1
Not specified	5	2.7
Other	11	6.0
Total	182	100.0

ACT (n=25) was the most reported type of community care in *high-income* contexts, followed by *rehabilitation* (n=11), *social support treatment* (n=9), and *housing* (n=7). Despite the low frequency of studies in middle and low income contexts, it was observed that *social support services* and *other* types of treatment were reported in middle income contexts, while the types of

community-based treatment in low-income contexts included *psychoeducation, community outpatient care*, as well as *psychosocial* interventions. In South Africa, *social support services* (n=4) prevailed, followed by *psychoeducation, rehabilitation*, as well as some evidence of *ACT, culturally-tailored interventions, vocational services*, and *cessation programmes*. Table 15 below illustrates these results.

Table 15

Trends in community care by context

Type of Community care	High-Income n (%)	Middle-Income n (%)	Low-Income n (%)	South Africa n (%)
Assertive community treatment	25 (21.7)	0 (0.0)	0 (0.0)	1 (0.9)
Rehabilitation (educational and psychosocial)	11 (9.6)	0 (0.0)	0 (0.0)	2 (1.7)
Social support care	9 (7.8)	2 (1.7)	0 (0.0)	4 (3.5)
Acute and intensive home care	2 (1.7)	0 (0.0)	0 (0.0)	0 (0.0)
Supportive housing	7 (6.1)	0 (0.0)	0 (0.0)	0 (0.0)
Transitional services	4 (3.5)	0 (0.0)	0 (0.0)	0 (0.0)
Culturally-tailored intervention	4 (3.5)	1 (0.9)	0 (0.0)	1 (0.9)
Wraparound/diversion services	1 (0.9)	0 (0.0)	0 (0.0)	0 (0.0)
Recovery residences	2 (1.7)	0 (0.0)	0 (0.0)	0 (0.0)
Psychosocial interventions	3 (2.6)	0 (0.0)	1 (0.9)	0 (0.0)
Vocational services	3 (2.6)	0 (0.0)	0 (0.0)	1 (0.9)
Community outpatient care	1 (0.9)	0 (0.0)	1 (0.9)	0 (0.0)
Residential inpatient services	2 (1.7)	0 (0.0)	0 (0.0)	0 (0.0)
Crisis intervention	2 (1.7)	0 (0.0)	0 (0.0)	0 (0.0)
Cessation programmes	5 (4.3)	0 (0.0)	0 (0.0)	1 (0.9)
Psychoeducation	1 (0.9)	0 (0.0)	1 (0.9)	2 (1.7)
Intensive case management	4 (3.5)	0 (0.0)	0 (0.0)	0 (0.0)
Not specified	1 (0.9)	2 (1.7)	0 (0.0)	2 (1.7)
Other	3 (2.6)	2 (1.7)	1 (0.9)	0 (0.0)
Total count	90 (78.3)	7 (6.1)	4 (3.5)	14 (12.2)

4.3.8. Clinical-based Care

The results of the types of clinical-based care that were frequently reported in the dataset are presented in Table 16 *below*.

Table 16

Trends in clinical care

Clinical-based care	n	%
Behavioural therapy	32	23.7
Pharmacotherapy	30	22.2
Psychiatric outpatient care	22	16.3
Psychiatric inpatient care	16	11.9
Individual psychotherapy	14	10.4
Psychiatric care unspecified	10	7.4
Tele-psychiatry	7	5.2
Electroconvulsive therapy	2	1.5
Mobile psychiatry	2	1.5
Total	135	100.0

The results illustrated above indicate that *behaviour therapies* (23.7%, n= 32) were generally the most reported type of clinical care, followed by *pharmacotherapy* (22.2%, n=30). As illustrated in Table 17 below, these two types of clinical care were also the most reported in high-income contexts. *Psychiatric outpatient care* was the next frequent in the dataset with 16.3% (n=22) of responses, followed by *psychiatric inpatient care* (11.9%, n=16). These two equally dominated the types of clinical care in the South African context, followed by pharmacotherapy and *interpersonal psychotherapy*, which was also fairly frequent in the dataset as a whole, representing 10.4% (n=14) of all cases. *Biomedical/psychiatric care* (7.4%, n=10) and *tele-psychiatry* were marginally represented (5.2%, n=7) in the dataset, while *electroconvulsive* therapy and *mobile psychiatry* were the least reported types of clinical care, representing 1.5% (n=2) each. *Pharmacotherapy* was the only type of clinical care reported in low-income contexts, while middle-income contexts had evidence of *interpersonal psychotherapy*, *tele-psychiatry* as

well as *mobile psychiatry* in addition to *pharmacotherapy*. The distribution of clinical care across contexts is illustrated in Table 17.

Table 17

Trends in clinical care by context

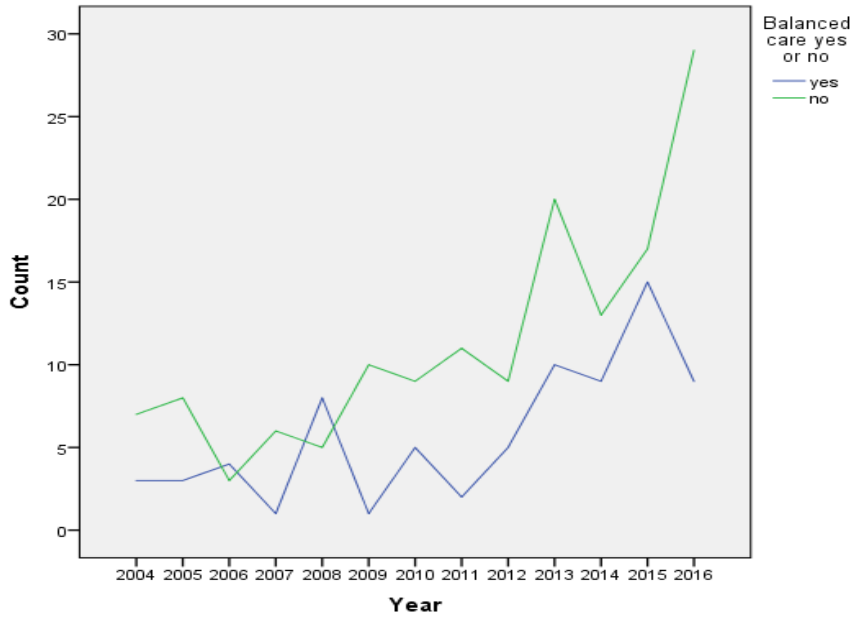
Type of Clinical Care	High-Income n (%)	Middle-Income n (%)	Low-Income n (%)	South Africa n (%)
Pharmacotherapy	13 (14.3)	1 (1.1)	1 (1.1)	5 (5.5)
Behavioural therapies	13 (14.3)	0 (0.0)	0 (0.0)	4 (4.4)
Psychiatric outpatient care	9 (9.9)	0 (0.0)	0 (0.0)	7 (7.7)
Psychiatric inpatient care	6 (6.6)	0 (0.0)	0 (0.0)	7 (7.7)
Biomedical/psychiatric care unspecified	6 (6.0)	0 (0.0)	0 (0.0)	3 (3.3)
Individual/interpersonal psychotherapy	3 (3.3)	1 (1.1)	0 (0.0)	5 (5.5)
Tele-psychiatry	3 (3.3)	1 (1.1)	0 (0.0)	2 (2.2)
Mobile psychiatry	0 (0.0)	1 (1.1)	0 (0.0)	0 (0.0)
Total count	53 (58.2)	4 (4.4)	1 (1.1)	33 (36.3)

4.3.9. Balance Care

This study aims to investigate if and how balanced care has been used in the last thirteen years, following the WHO-HEN (2003) report which suggested ways of improving MHC delivery. The use of balanced care from 2004 to 2016 was strikingly varied. As is illustrated in Figure 5 below, no studies investigating balanced care were published in *2007*, *2009*, and *2011*, while most research on balanced care in the current dataset was published in 2015.

Figure 5

Trends in Balanced care by year of publication



This graph also shows that there has been an inconsistent interest in studying balanced care in the past thirteen years, as it is shown that some years such as *2004*, *2005*, *2006*, *2010*, *2012* produced marginal numbers of studies related to balanced care in the five journals, with frequencies ranging between n=3 and n=5, while others, such as *2007* and *2009* have produced almost no studies investigating balanced care, with frequencies of n=1 study per each of these years. The year where balanced care was the object of most studies was *2015* where a total of 15 articles were reported in the current dataset. The years *2013* (n=10), *2014*, *2016* (n=9 each) and *2008* (n=8) also published a fair amount of studies on balanced MHC. The years *2013* up to *2016* also had the highest prevalence of theories such as *treatment programme evaluation, development of new treatment strategies, promotion and prevention* of mental disorders, as well as *recovery and quality of life*.

The results elucidated in Tables 18 and 19 show the types of balanced care that were researched and reported in the dataset, as well as the representation of these patterns across contexts

Table 18

Trends in balanced care

Balanced care	n	%
Psychiatric services in PCCs	12	16.0
Evidence-based psychotherapy	11	14.7
IDDT	9	12.0
CBT+ rehabilitation	6	8.0
CBT+ social support	6	8.0
System of care	3	4.0
ACT+ physical care	2	2.7
ACT+ intensive care	2	2.7
ACT+ case management+ outpatient care	2	2.7
Case management+ clinical care+ ACT+ housing	2	2.7
Psychiatric care+ traditional care	2	2.7
CBT+ Cessation care	2	2.7
Pharmacotherapy + community care	2	2.7
CBT+ ACT	2	2.7
CBT+ psychoeducation	2	2.7
Alternative medicine	1	1.3
Psychiatric care+ vocational services	1	1.3
Pharmacotherapy+ psychosocial interventions	1	1.3
Telemedicine-based collaborative care	1	1.3
CBT+ vocational services	1	1.3
Pharmacotherapy+ clinical outpatient+ community inpatient+ psychoeducation	1	1.3
Rehabilitation+ psychiatric inpatient care	1	1.3
DBT + ACT	1	1.3
Psychiatric outpatient car+ support group therapy	1	1.3
Outpatient care+ rehabilitation+ pharmacotherapy	1	1.3
Total	75	100.0

Table 18 above shows that in the 75 studies where balanced care was reported in the dataset, *psychiatric services in primary care centres* were the most researched with a frequency of 16%, followed by *evidence-based psychotherapy* with a frequency of 14.7%. *Individual dual diagnosis treatment* (12.0%), *CBT+ social support* (8.0%), and *CBT+ rehabilitation* (8.0%) followed with less frequencies, while the rest of balance care strategies were least used, some representing 2.7% each, and others 1.3%.

Moreover, the distribution of the types of balanced care across context was quite complex. While *psychiatric services in primary care centres* was most common in *South Africa* (n=8), least so in *high-income* contexts (n=2) and not reported at all in *low-income* contexts (n=0), *evidence-based psychotherapy* was most reported in *unspecified* contexts (n=5) and *high-income* contexts (n=3), minimally frequent in *South Africa* (n=2), and not present in *low-income* contexts (n=0). *Individual dual diagnosis treatment* on the other hand was mostly present in *high-income* contexts (n=8), and exclusively absent in the other contexts. *CBT + rehabilitation* was equally frequent in *high-income* and *South African* contexts with counts of 2 each, and was not reported in *middle* and *low-income* contexts, while *CBT and social support* was most common in *high-income* contexts (n=3) and marginally reported in *South African* and *low-income* contexts with a frequency of n=1 each. While *psychiatric care and spiritual/traditional practices* were equally prevalent in *South African and high-income* contexts (1.3%, n=1 each), *rehabilitation and psychiatric inpatient care* were reported in *South Africa* alone (1.3% n=1), whereas *pharmacotherapy and community outpatient care* was evident in *low income* contexts alone (1.3%, n=1). The rest of the types of balanced care which were least reported in the dataset were mostly reported in *high-income* or *unspecified* contexts in some cases. Remarkably, no balanced care was reported in *middle-income* countries, while *pharmacotherapy and community care*, as well as *CBT and social support services* were the only types of balanced care reported in *low income* contexts. These results are illustrated in Table 19.

Table 19

Trends in balanced care

Balanced care	International n (%)	High-income n (%)	low-income n (%)	South Africa n (%)	Not specified n (%)
Psychiatric services in PCCs	0 (0.0)	2 (2.7)	0 (0.0)	8 (10.7)	2 (2.7)
Evidence-based psychotherapy	1 (1.3)	3 (4.0)	0 (0.0)	2 (2.7)	5 (6.7)
IDDT	0 (0.0)	8 (10.7)	0 (0.0)	0 (0.0)	1 (1.3)
CBT+ rehabilitation	0 (0.0)	2 (2.7)	0 (0.0)	2 (2.7)	2 (2.7)
CBT+ social support	1 (1.3)	3 (4.0)	1 (1.3)	1 (1.3)	0 (0.0)
System of care	2 (2.7)	0 (0.0)	0 (0.0)	0 (0.0)	1 (1.3)
ACT+ physical care	0 (0.0)	1 (1.3)	0 (0.0)	0 (0.0)	1(1.3)
ACT+ inpatient care	1 (1.3)	1 (1.3)	0 (0.0)	0 (0.0)	0 (0.0)
ACT+ case management+ outpatient care	0 (0.0)	2 (2.7)	0 (0.0)	0 (0.0)	0 (0.0)
Case management+ clinical care+ ACT+ housing	0 (0.0)	2 (2.7)	0 (0.0)	0 (0.0)	0 (0.0)
Psychiatric care+ traditional care	0 (0.0)	1 (1.3)	0 (0.0)	1 (1.3)	0 (0.0)
CBT+ Cessation care	1 (1.3)	1 (1.3)	0 (0.0)	0 (0.0)	0 (0.0)
Pharmacotherapy + community care	0 (0.0)	1 (1.3)	1 (1.3)	0 (0.0)	0 (0.0)
CBT+ ACT	0 (0.0)	2 (2.7)	0 (0.0)	0 (0.0)	0 (0.0)
CBT+ psychoeducation	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (2.7)
Alternative medicine	0 (0.0)	1 (1.3)	0 (0.0)	0 (0.0)	0 (0.0)
Psychiatric care+ vocational services	1 (1.3)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Pharmacotherapy+ psychosocial interventions	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Telemedicine-based collaborative care	0 (0.0)	1 (1.3)	0 (0.0)	0 (0.0)	0 (0.0)
CBT+ vocational services	0 (0.0)	1 (1.3)	0 (0.0)	0 (0.0)	0 (0.0)
Pharmacotherapy+ clinical outpatient+ community inpatient+ psychoeducation	0 (0.0)	1 (1.3)	0 (0.0)	0 (0.0)	0 (0.0)
Rehabilitation+ psychiatric inpatient care	0 (0.0)	0 (0.0)	0 (0.0)	1 (1.3)	0 (0.0)
DBT + ACT	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (1.3)
Psychiatric outpatient car+ support group therapy	1 (1.3)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Outpatient care+ rehabilitation+ pharmacotherapy	1 (1.3)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Total	9 (12.0)	33 (44.0)	2 (2.7)	15 (20.0)	75 (100.0)

4.4. Participant Characteristics

Participants' characteristics were coded for empirical and case studies only. These included participants' *age, gender, level of education, employment status, life challenges and marginalised status*. *Sample size*, and *MI labelling* were also observed in relation to the studies' sample. The patterns of results for these categories are presented in the sections below.

4.4.1. Age

As discussed in chapter three, participants in *empirical* and *case* studies were categorized according to their age, in groups ranging from *early childhood, middle childhood, adolescence, adulthood*, to *elderly* age. If the sample size comprised more than one age category, this was coded as *mixed*, and if the participants' age was not mentioned a code such as *unspecified* was applied. Results for the distribution of age in the dataset are presented in Table 20.

According to these results, *adult* participants were the most studied in the dataset, representing the largest proportion of participants (65.5%, n=119). The age category was *not specified* for at least 14% of the population in the dataset, whereas *mixed ages* and *adolescence* categories represented a roughly similar proportion of the sample in the dataset, with a frequency of 8.2% and 7.6% each respectively. The *elderly* age group was marginally represented, with a frequency of 4.1% of the population in the dataset, whereas *early childhood* was the least represented age group, which covered 0.6% of the total sample age in the dataset.

Table 20

Trends in participants' age

Age category	n	%
Adult	112	65.5
Mixed age categories	14	8.2
Adolescence	13	7.6
Elderly	7	4.1
Early childhood	1	0.6
Not specified	24	14.0
Total	171	100.0

4.4.2. Gender

Gender was coded according to whether participants were *all-female, all-male, mixed* or *unspecified*. As the results show in Table 21 below, most studies were conducted using *mixed* gender categories covering 64.9% of the gender in the dataset. *Female and male* samples were equally used in the dataset, with a frequency of 6.4% (n=11) each, while the *LGBTI* gender category was the least represented (1.8%). 20.5% (n=35) of studies did *not specify* the gender of the participants.

Table 21

Trends in participants' gender

Gender	n	%
Mixed gender categories	111	64.9
Female only	11	6.4
Male only	11	6.4
LGBTI	3	1.8
Not specified	35	20.5
Total	222	100.0

4.4.3. Level of Education

Level of education was coded according to whether participants received *preschool, primary, secondary, tertiary or postgraduate* education. The results for participants' level of education are elucidated in the table below.

Table 22

Trends in participants' level of education

Education	n	%
Mixed levels of education	54	31.6
Secondary school	12	7.0
Tertiary education	5	2.9
Postgraduate	3	1.8
No formal schooling	2	1.2
Not specified	94	55.0
Total	222	100.0

These results reveal that the level of education of the participants in the dataset was *unspecified* in most cases (55.0%, n=94), and *mixed* (31.6%, n=54) in other. Other studies focused on participants who studied up to *secondary school* (7.0%, n=12), while fewer studies used participants who received up to *tertiary* (2.9%, n=5) or *postgraduate* education (1.8%, n=3). At least 1.2% (n=2) of the sample had *no formal schooling*.

4.4.4. Employment Status

Participants were further categorised according to their occupation and employment status, depending on whether they were *unemployed, employed, university/college students, child/scholar* or *retired*. If the employment status was not mentioned, this was coded *unspecified*, and if the sample comprised participants with different employment statuses, this was labelled *mixed*. If the employment status did not match any of the above mentioned categories, it was coded as *other*. The overall distribution of occupation and employment status in the dataset is presented in Table 23 below.

Table 23

Trends in participants' employment status

Employment status	n	%
Mixed employment status	36	21.1
Unemployed	8	4.7
Employed	7	4.1
Child/scholar	7	4.1
Retired	5	2.9
University/college	1	.6
Not specified	107	62.6
Total	171	100.0

As indicated in the table above, most studies *did not specify* the employment status of the sample (62.6%), and those that did had a dominant sample with *mixed employment* status (21.1%). The frequency of *unemployed*, *employed* and *scholar* participants was roughly the same, representing 4.7%, 4.1% and 4.1% respectively. Participants who had *retired* were marginally represented (2.9%), while participants who were *university/college students* were the least frequent (0.6% n=1) in the dataset.

4.4.5. Life Challenges

People with mental disorders often experience extensive challenges in their daily lives. The results presented in Table 24 below highlight the challenges experienced by participants in the dataset. These results reveal that of 79 participants who experienced life challenges, most were faced with difficulties *accessing treatment resources* (27.8%), and at least 20.3% (n=16) were *homeless.* A substantial proportion of the sample was classified as *at risk* (16.5%, n=13), and 13.9% (n=11) experienced *negative life events.* A marginal number of participants were *socially excluded* (6.3%, n=5), and the least challenge experienced by the sample was *limited social capital* (2.5%, n=2). There was only 1.3% (n=1) of the challenges which were *other* and did not match any of the above categories, and 11.4% (n=9) which were *not specified.*

Table 24

Trends in participants' life challenges

Life challenges	n	%
Access to treatment	22	27.8
Homelessness	16	20.3
At risk population	13	16.5
Negative life events	11	13.9
Socially excluded	5	6.3
Limited social capital	2	2.5
Not specified	9	1.4
Other	1	1.3
Total	79	100.0

4.4.6. Marginalised Status

Participants were categorized into groups of marginality according to whether they were disadvantaged based on *race, sexual orientation, psychological condition, socio-economic status, disability, geographical location, HIV-condition, migration status, identification with a minority group, criminal history, age,* or *other* characteristics which have not been mentioned. Marginality was coded as *unspecified* if participants experienced forms of social exclusion which were not deliberately mentioned in the study.

Table 25 indicates that, at least 23.8% of participants within studies published in the *AJCP, AJP, CMHJ, SAJPs* and *SAJP* over the past thirteen years were marginalised with regards to their *socio-economic status.* 16.8% of the marginalised participants were disadvantaged due to their *geographical location,* 13.9% due to their *psychological condition,* and 11.9% due to *criminal history.* Participants who were marginalised because of their identification with a *minority group* represented 7.9% of the marginalised population in the dataset, while 7.2%% were marginalised because of their *migration status.* Fewer participants (5%) were disadvantaged because they were *HIV positive,* while 3% were marginalised due to *disability* and *sexual orientation* each. Participants who were marginalised because of their *age* and *other* statuses were the least represented groups (2% each).

Table 25

Trends in participants' marginal status

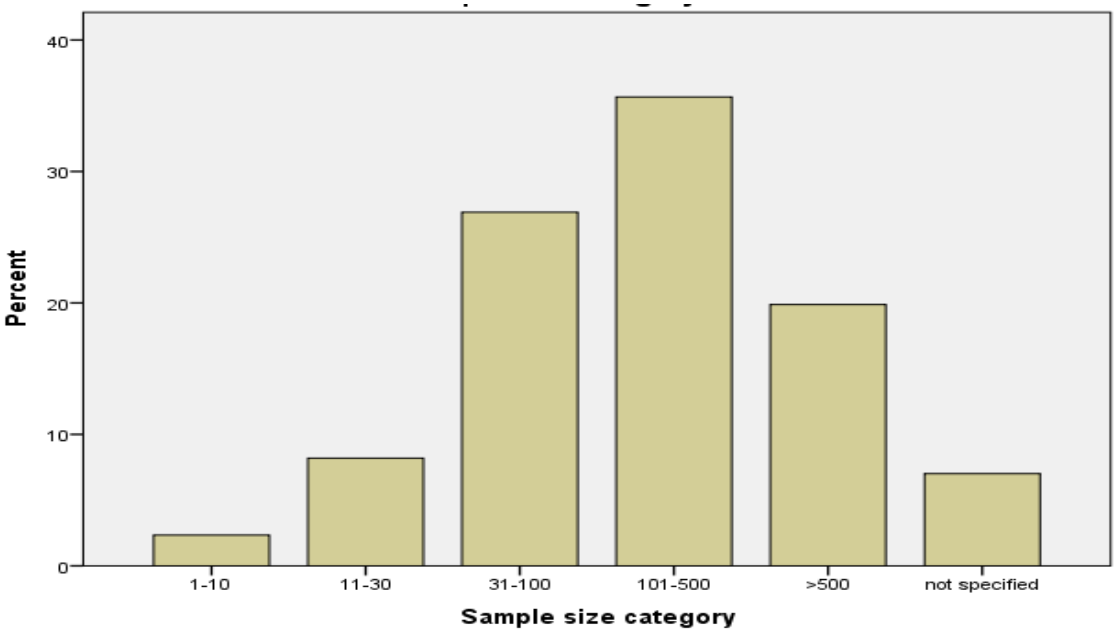
Marginal status	n	%
SES	24	23.8
Geographical location	17	16.8
Psychological condition	14	13.9
Criminal history	12	11.9
Minority groups	8	7.9
Migration status	7	6.9
HIV/AIDS	5	5.0
Disability	3	3.0
Gender/sexual orientation	3	3.0
Age	2	2.0
Not specified	4	4.0
Other	2	2.0
Total	101	100.0

4.4.7. Sample Size

Since MI has been reported to constitute one of the biggest threats to human well-being, and an increasing burden to global health (WHO, 2013), it was necessary to observe and analyse the number of affected populations that research represents, such as in the patterns of sample size used in different studies. It was thus observed that most studies in the current dataset used samples that were large, between *101* and *500* participants (n= 61, 35.7%); while small study samples, between *1* and *10* participants were the least frequent (n=4, 2.3%). 26.9% (n=46) of the study samples in the dataset had between *31* and *100* participants, and 19.9% (n=34) were comprised of *more than 500* participants. At least 7% (n=12) of studies did *not specify* the sample size. These results are also illustrated in Figure 6 below.

Figure 6

Sample size category



4.4.8. MI Labelling

The labelling of individuals affected by mental disorders was also investigated in this study in order to evaluate if attempts at reducing MI labelling stigma have been made in the past 13 years. The results (illustrated in Table 26) show that *person first* language was the most commonly employed in the dataset, with a frequency percentage of 73.9% (n=164). *Condition-first* and *mixed* languages were equally employed in referring to individuals with mental disorders, representing 13.2% (n=29) of the total dataset each.

Table 26

Trends in MI labelling

Labelling	n	%
Person-first	164	73.9
Condition-first	29	13.1
Mixed	29	13.1
Total	222	100.0

4.5. Conclusion

This chapter has provided a comprehensible presentation of the results, making use of descriptive analyses as well as frequencies. A brief description of the coding criteria for each variable was provided before the findings were illustrated, in order to clarify the results obtained. The chapter began with a description of the dataset, proceeded with the presentation of methodological trends and major findings related to MHC, and concluded with a description of the participants' characteristics. A thorough elaboration of the results is provided in the next chapter (Chapter Five).

Table 27

Summary of results: Trends in MHC research across the AJCP, AJP, CMHJ, SAPs and SAJP over the period 2014-2016

Number of articles published per year

Year	Frequency
2004	10
2005	11
2006	7
2007	7
2008	13
2009	11
2010	14
2011	13
2012	14
2013	30
2014	22
2015	32
2016	38

Predominant trends in publication type

Empirical: Total *n*= 170 (76.6%); High-income *n*= 83 (56.8%); South Africa n= 31 (21.2); Middle-income *n*= 8 (5.5%); Low-income *n*= 3 (2.1%)

Predominant methodological approach

Positivist: total *n*= 61 (35.7%)

Predominant trends in primary method

Multiple methods: Total *n*= 38 (22.2%)

Experimental: Total *n*= 30 (17.5%)

Predominant trends in research setting

Community mental health care centre: Total *n*= 53 (24.0%)

Outpatient psychiatric clinic: Total *n*= 29 (13.1%)

Predominant theoretical trends

Treatment programme evaluation: Total *n*=138 (31.9)

Predominant type of MI Schizophrenia: Total *n*= 63 (17.7%);
Predominant types of treatment Balanced care: Total *n*= 73 (32.9%); High-income *n*= 33 (14.9%); South Africa n= 15 (6.8%); Low-income n= 2 (0.9%); Middle-income *n*= 0 (0.0%) Community-based MHC: Total *n*= 70 (31.5); High-income *n*= 33 (14.9%); South Africa n= 6 (2.7%); Middle-income *n*= 4 (1.8); Low-income *n*= 1 (0.5%); Clinical-based MHC: Total *n*= 57 (25.7); High-income *n*= 18 (8.1%); South Africa n=19 (8.6); Middle-income *n*=3 (1.9%); Low-income *n*= 0 (0.0%)
Predominant types of Community-based care Social support care: Total *n*= 39 (21.4); High-income *n*= 9 (7.8%); South Africa n= 4 (3.5%); Middle-income *n*= 2 (1.7%); Low-income *n*=0 (0.0%) ACT: Total *n*= 33 (18.1%); High-income *n*= 11 (21.7%); South Africa n= 1 (0.9%); Middle-income *n*= 0 (0.0%); Low-income *n*= 0 (0.0%);
Predominant types of Clinical-based care Behaviour therapy: Total *n*= 32 (23.7%); High-income *n*= 13 (14.3%); South Africa n= 5 (5.5%); Middle-income *n*= 1 (1.1%); Low-income *n*= 1 (1.1%) Pharmacotherapy: Total *n*= 30 (22.2%); High-income *n*=13 (14.3%); South Africa n=4 (4.4%); Middle-income *n*= 0 (0.0%); Low-income *n*= 0 (0.0%)
Predominant types of Balanced care Psychiatric services in PCCs: Total *n*=12 (16.0%); High-income *n*= 2 (2.7%); South Africa *n*= 8(10.7%); Low-income *n*= 0 (0.0%); International *n*= 0 (0.0%); Unspecified *n*= 2 (2.7%) Evidence-based psychotherapy: Total *n*= 11 (14.1%); High-income *n*= 3 (4.0); South Africa *n*= 2 (2.7%); Low-income *n*= 0 (0.0); International *n*= 1 (1.3%); Unspecified *n*= 5 (6.7%).
Predominant age group of participants Adult: Total *n*=112 (65.5%)
Predominant gender category of participants

Mixed: Total *n*= 111 (64.9%)
Predominant level of education of participants Mixed: Total *n*= 54 (31.6%)
Predominant employment status of participants Mixed: Total *n*= 36 (21.1%)
Predominant life challenges Access to treatment: Total *n*= 22 (22.8) Homelessness: Total *n*= 16 (20.3%)
Predominant trends in marginal status SES: Total *n*= 24 (23.8%)
Predominant sample size category *101-500*: Total *n*= 61 (35.7%
Predominant trend in MI labelling Person-first: Total *n*= 164 (73.9%)

CHAPTER FIVE: DISCUSSION

5.1. Introduction

This chapter provides a critical discussion of the findings described in the previous chapter. The chapter situates and explains this study's results in relation to the existing state of literature on MHC. Through a critical consideration of the trends in MHC research published within the *AJCP, AJP, CMHJ, SAJPs* and *SAJP* over the last thirteen years, this section seeks to illuminate the efforts that have been made to address the issue of MI, which, according to the WHO (2013) constitutes a threat to human and communities' wellbeing worldwide. Moreover, this chapter highlights the similarities and differences between the types of treatment reported in *high-*, *middle-* and *low-income* contexts, to those suggested by the WHO-HEN (2003), taking into account the fact that the dataset used in this study may not be representative of the actual state of MHC provision in these contexts. This chapter's structure begins with an analysis of the dataset, followed by an understanding of the methodological trends, and concludes with a discussion of the implications of this study's findings on the state of MHC.

5.2. Synopsis of Findings

5.2.1. Description of the Dataset

The descriptive results of the dataset revealed that a significant number of studies pertaining to MHC were conducted in the five journals throughout the last thirteen years, although at a different rate each year and in each journal. This suggests that the field of MHC has been dedicated to addressing the issue of MI, which is both a health, social, and economic burden worldwide. The inconsistencies in the number of articles across contexts however were rather striking. While *high-income* contexts published the highest number of studies pertaining to MHC, *low-income* and *middle-income* contexts were almost not represented in the dataset, and produced the least research. This could be explained by the fact that most of the journals in the dataset have a particular focus on the US and South African contexts. The *AJCP* and *AJP* for instance lean more towards publishing research conducted in Western contexts, and the *SAJP* focuses more on publishing South-African based research. Another reason why middle- and low-income contexts were underrepresented in the dataset could be due to the low frequency of

mental health research in these contexts. Harpham (1994) argues that developing contexts do not often conduct applied research to address the issue of MI. Mental health is a sector that is neglected worldwide, and care services for MI remain universally inadequate due to the deficiency of budgets dedicated to researching and improving mental health treatment (Burns, 2011). Research plays a very key role in mental health service policy development and implementation (Thom, 2004). It is thus necessary that national budgets around the world be allocated to mental health research, if the burden of MI is to be addressed.

5.2.2. Methodological Trends

This study classified published articles in categories such as *empirical, literature* and *systematic* review, *methodological*, *case study*, or *theoretical*, based on the type of publication. As observed in the results, the predominant type of publication that was reported in the dataset was empirical in nature, constituting 76.6% of the total dataset. It was also observed that empirical studies dominated the type of publication in all contexts, and were the only type of articles found in low and middle income contexts. This, on the one hand, not only indicates the type of knowledge production that is prioritized, but also highlights the preference for one type of publication over many others, hence a shortage of knowledge that is located in several other paradigms. On the other hand however, empirical research has been acknowledged to be the method of choice in various kinds of research (such as social sciences and health research) because it is based on observed and measured phenomena, allowing the production of knowledge that is driven by actual experience rather than based on theory or beliefs (Gagnon, 1982). The prevalence of empirical research methods has been reported in other trend analysis studies such as the study by Graham and Ismail (2011), which found that at least 61.2% of studies published in the *Journal of Community Psychology* were empirical; or Seedat, Duncan and Lazarus (2001) who found that at least 38.3% of publications in the SAJP and Psychology in Society (PINS) between 1994 and 2003 were empirical.

Rice and Ezzy (1999) argue that the trends of empirical publications are nowhere more evident than in health-related research, because they contribute more towards measurement of risk factors and estimation of incidence of disease. Empirical studies also provide empirical evidence that inform health provision policies and the provision of effective health services (Berkman & Kawachi, 2000). In addition to empirical articles, the South African context had a greater proportion of reviews compared to other contexts. This diversity implies that despite the

emphasis on generation of new research related to MHC, South Africa also stresses the appraisal of previous MHC research in order to improve care provision.

Trends in primary approach in the dataset were overwhelmingly positivist, programme evaluation to some extent, and marginally interpretive. Although the use of the interpretive approach was low compared to positivist and programme evaluation, it should be acknowledged that the presence of as little as 18.1% of interpretive methods reflects increasing efforts of in-depth engagement with the issue of mental ill-health. Interpretive analysis often requires qualitative methods of data collection (Finzen & Hoffman-Richter, 1997), and it was observed in this study that qualitative methods were marginally represented in the dataset. Gove (1970) argues that stigma associated with MI often constitutes a barrier to interactions with the affected individuals, which results in a preference for data collection methods that require minimal contact between researchers and the affected individuals. The increase in the use of qualitative methods of data collection such as interviews and focus groups, as observed in the current dataset (although minimal), theoretically assumes an increase in research contact with people living with mental disorders, and consequently a reduction in mental-health stigma. Future studies should however investigate the nature of increased contacts with the affected population, and if they are suggestive of reducing stigma associated with mental ill-health.

Participatory action research was minimally utilised in the dataset, representing 6.4% of all the approaches used. This shows that there is still scepticism inherent in embracing the knowledge that is possessed by caregivers of individuals affected by mental disorders, which (knowledge) could otherwise produce useful and actionable research findings for the field of MHC (Pullmann, 2009).

Programme evaluation was also used as research approach in the dataset, implying that apart from the production of knowledge about the objective facts of MI, the field of MHC is concerned with investigating effective treatment strategies that would be impactful in addressing the burden of MI. Programme evaluation as an approach in MHC research is important because, as suggests Anderson (1999), it allows improved levels of mental health programme effectiveness to be obtained, and facilitates the establishment of mechanisms for continuous quality improvement of treatment programmes overtime (Anderson, 1999). Anderson also suggests that evaluative approach is one of the most commonly used research methods in MHC

research, and is the most comprehensive and applicable method of determining cause and effect of treatment programmes in natural settings.

Although the research approach in the dataset was primarily positivist, implying a preference for generation of generalisable observations and quantification of information, the presence of other approaches provides a balance in the type of knowledge that is produced in MHC. For instance, where the quantification of information in positivist approaches assumes homogeneity of experience, participatory action research as a research approach emphasises the uniqueness of experiences of each patient and their communities, as it promotes the participation of patients and their caregivers in the process of research, and produces knowledge based on their relative experiences (Minkler, 2000).

5.2.3. Theoretical Trends

Most studies in the dataset were primarily conducted to evaluate mental-health treatment programmes, to investigate ways of improving the quality of life of individuals and communities affected by MI, as well as to find ways of promoting mental health and preventing mental disorders. Mental health promotion is a necessary approach to wellness as it focuses on enhancing individuals and communities' innate abilities to achieve and maintain a positive state of mental health (Herrman, Saxena, Moodie & Walker, 2005). As mentioned in the literature review, health promotion and prevention of ill-health are distinct but complementary concepts, with the previous focusing on strengthening and enhancing the capacity for good health that already exists, while the later concentrates on developing ways of avoiding ill-health (Lahtinen, Joubert, Raeburn & Jenkins, 2005). Although both of these concepts aim to maintain good mental health, it is important to note that good mental health is not the mere absence of MI, and mental health prevention does not guarantee good mental health (WHO, 2001). Promotion of mental health and prevention of mental disorders are theories of public health that work towards raising community awareness on issues of mental health and MHC in order to reduce stigma and prevalence of mental ill-health, by reducing the risk factors for poor health, and enhancing the protective factors that contribute to positive mental health (Barry & McQueen, 2005). Concepts such as *programme evaluation, development of new treatment strategies, recovery/quality of life*, *empowerment, and sense of community*, all inform mental health promotion and prevention of mental ill-health because they encourage reciprocal relationships between different systems of care that are beyond traditional symptom-based intrapersonal MHC (Barry & McQueen, 2005;

Herrman et al., 2005). The presence of these concepts in addition to *treatment programme evaluation* and *development of new treatment strategies* in the dataset, justifies the efforts in the last thirteen years to increase the provision of mixed or balanced types of MHC, which take into account different systems of care, clinical as well as community-based, to provide necessary health resources to the affected population (Petersen et al., 2010; WHO, 2013).

Although the above mentioned theories all inform mental health promotion and prevention of mental disorders, promotion and prevention were coded and investigated as a separate theory in this study, in order to evaluate if studies have looked specifically at risks and protective factors for mental health that can be reduced or enhanced through interventions (Barry & McQueen, 2005). As such the results reveal that there was a high proportion of promotion and prevention theories in the dataset (16.4%), suggesting that researchers have employed prevention and promotion practices in order to study effective risk factors of mental ill-health and to investigate protective factors required to strengthen good mental health (Moodie & Jenkins, 2005). Future studies should aim to investigate what these risk and protective factors are, and if professionals have reached consensus on the best practices to address them.

Empowerment is, as Rappaport (1987) explains, the mechanism through which individuals gain mastery over their lives. Empowerment in mental health is thus concerned with the process of giving the power to decide on their fate, choice, and adherence to treatment of patients and their families (when the patient is not mentally fit to decide). Empowerment in mental health is vital for recovery, as it is linked to the individual patient's perceived ability to heal and consciousness of the necessary conditions that facilitate recovery (Jacobson & Greenley, 2001). Recovery in MHC refers to the continuous process of healing that is informed by the ways in which an individual patient manages the disorder in the course of reclaiming his/her community life (Werner, 2012). Often, issues concerning consent for treatment are ignored in MHC, as independent assessments of capacity of the patient's functioning are not usually undertaken and, as notes the WHO (2004), individuals affected by mental disorders are usually admitted to treatment in mental health institutions against their will. Empowerment theories, which look at mechanisms of enabling patients gain control over their life and recovery, were very marginally used in research in the past thirteen years. This shows that people with mental health problems continue to be silenced, and excluded from decision-making processes regarding their treatment (WHO, 2010).

Yet, if the affected individuals are not empowered to understand the process of treatment and the conditions for effective recovery, efforts made to provide necessary care may be deeply obstructed. Ekeland and Bergem (2006) argue for instance that recovery highly depends on the patient's re-engagement with society, and their ability to take control over their life, and to regain the positive sense of self which might have been lost due to stigma. This, argue Harder, Wagner and Rash (2016), can be accomplished through support programmes such as vocational services, support systems and community reintegration programmes, which not only facilitate the transition back into society, but reduce stigma and isolation of the affected individual by empowering them to take control of their recovery fate. Recovery in this sense is not synonymous with cure; It is rather related to the patients' improved quality of life, as they regain hope, understand and accept their abilities and disabilities, and as they develop a positive sense of self (Harder et al., 2016). The MHC sector should thus strive to improve methods of empowering patients to be active participants in the process of recovery.

Recovery in MHC emphasises the uniqueness of each individual patient in the impact and outcome of treatment, while empowering them to recognise that they are at the centre of the care they receive, and supporting them to build their strengths and take responsibility of their lives at any given time. Therefore recovery-oriented practice in MHC is the evidence of increasing efforts to empower patients and promote and protect their legal, social and human rights (WHO, 2010). Recovery-oriented mental health practice is thus a form of public health in that it challenges discrimination and stigmatization of the affected individuals, as it is sensitive to the patients' identities, and emphasises respect for each individual patient affected by mental disorders, as well as respect of their values, culture, and beliefs (Petersen et al., 2010).

It was also observed that most research in the dataset focused on evaluating established mental health treatment strategies. Evaluation of mental care strategies is an important theory in MHC because it highlights the types of programmes that work for particular groups of patients under certain specific circumstances, and those that don't. This theory thus allows the evaluation of a wider range of mental health programmes, determining the value and worth of particular treatment strategies, leading to better direction in MHC planning, funding and training of relevant professionals (Thom, 2004).

5.2.4. Considerations of Participant Characteristics

The majority of studies in the dataset were conducted with large samples of participants (n between 101 and 500) most of whom suffered from schizophrenia, substance use disorders, SMI, depression, other unspecified psychotic conditions, and bipolar disorders, amongst others. These disorders are amongst the most prevalent mental illnesses worldwide (WHO, 2001). The WHO (2013) reports that schizophrenia, depression, substance use disorders (alcohol-use in particular), and bipolar disorders, are four of the six leading causes of disability and years lived with disability worldwide, with more than 150 million people suffering from depression at some point in time, a further 90 million suffering from substance-related disorders, and 25 million from schizophrenia. Various risk factors such as, insecurity, low education levels, malnutrition, inadequate housing, poverty, unemployment and gender have been identified to contribute to these common mental disorders. The WHO (2013) statistics estimate that depression is about two times more prevalent in low income contexts due to socioeconomic strain and other unfavourable living conditions experienced by majority of the populations. Similarly, depression was the most reported type of MI in low-income contexts and in the South Africa context in particular, while schizophrenia and substance use disorders dominated studies from high income contexts.

Moreover, the fact that the above mentioned factors (poverty, insecurity, malnutrition, unemployment, low education, homelessness, etc.) contribute to the prevalence of mental disorders implies that the group of patients who are disadvantaged or marginalised due to their poor socioeconomic status, are at increased risk of not only suffering from a mental disorder at a point in their lives, but of lacking the means of accessing the required treatment, which may lead to further marginalization (WHO, 2002). In the current sample for instance, most participants were primarily marginalised because of their low socioeconomic status, their geographic location and psychological condition, which determined the type of challenges they experienced in their daily lives which included (but not limited to): difficulties accessing treatment facilities, homelessness, further negative life events, harm (physical, emotional and psychological), as well as social exclusion. This classifies mental ill-health not only as a health issue, but also as a mirror of issues of community inequality, human rights, and social injustice.

The history of people with mental disorders and their families suffering stigma and discrimination dates back in history both in high and low income countries (Bhugra, 1989). The myths and misconceptions associated with MI lead to the affected population being denied the

most basic human rights such as employment and educational opportunities, health insurance and housing (Link et al., 1997; WHO, 2001). Although the overwhelming use of person-first language when referring to individuals with MI (as observed in the dataset) suggests a shift towards minimising the focus on the disability of persons with mental problems, the effects of MI labelling stigma still persist (Granello & Gibbs, 2016). Stigma associated with MI also acts as a precursor to poverty, unemployment or loss of social capital, which are further risk factors for MI.

The relationship between MI and variables such as low education, poverty and unemployment is not a straight forward one, but a vicious circle (Patel, 2001). For instance, people living in financial strain are at higher risk of developing mental disorders due to the ongoing stress of lack, reduced social support, poorer physical health conditions and increased exposure to violence, while on the other hand, those affected by mental ill-health are at greater risk of impoverishment as a result of possible loss of employment and income, reduced productivity, or social exclusion caused by MI-related stigma (Flisher et al., 2007).

Patel and Kleinman (2003) show that there is a significant relationship between the prevalence of mental disorders, unemployment and low education levels, such that MI may impair a person's intellectual ability, placing the individual at a disadvantage of accessing professional jobs, thus contributing to the person's vulnerability, insecurity, and continual loss of social capital. The results of the characteristics of participants in empirical studies in the dataset revealed that the level of education of the participants was not specified in most cases, and where specified, most studies used participants with different levels of education. 7% of participants in the dataset studied up to secondary school while 2.9% reached tertiary education and only 1.8% were postgraduates. This is alarming since most of the participants were adult. While limited literacy curtails a person's access to resources that could allow them to minimise the negative impacts of MI and avoid risks, it presents unique challenges in MHC, and can constitute an insoluble barrier to recovery (Pratt, Dey & Cohen, 2007).

The employment status of the majority of participants was not specified in the dataset, but where specified, the number of participants who were unemployed was slightly higher than that of participants who held a stable career. A study by Miller et al. (2006) reveals that supported employment services are effective in assisting people with psychiatric disabilities obtain employment, and improve their vocational outcomes. This highlights the need for

vocational services for this delicate population of individuals with mental disorders, in order to improve their future economic and psychological stability.

Gender is also conceptualised as a key determinant of susceptibility and exposure to various mental health risks, as it impacts the patient's ability to control the disorder, and confront the socioeconomic determinants of mental ill-health (Afifi, 2007). While significant gender differences exist in the prevalence of disorders such as somatic complaints, anxiety and depression, the WHO (2011) reports that the gender differences in disorders such as schizophrenia and bipolar disorders, is negligible. Although most studies in the dataset used both male and female genders combined, studies that were conducted with either male or female samples were equal in numbers. The LGBTI group on the other hand was not as much represented in the current dataset, despite growing evidence of high rates of depression, anxiety, substance abuse and psychological distress reported among these populations (Jorm, Korten, Rodgers, Jacomb & Christensen, 2002). The high prevalence of these disorders in the LGBTI populations is said to result from stigmatization and marginalization of these individuals' identities (Jorm et al., 2002). The LGBTI populations are usually subject to experiences of social isolation and minority stress such as societal prejudice, stigma, discrimination and rejection simply because they do not comply with the traditionally prescribed dichotomy of male/female identities (Meyer, 2003). The common negative beliefs that societies hold against the LGBTI community constitute barriers to health and health services for these populations. Mental health services that are culturally competent to LGBTI populations are thus needed in order to improve access and quality of MHC to this group (Dobinson et al., 2003; Eady, Dobinson & Ross, 2011).

5.3. Current State of MHC

Mental disorders have been declared to constitute one of the world's highest burden of disease, being responsible for about 12 to 15% of the world's total disability, a burden that is higher than that of all cardiovascular diseases combined (WHO, 2013). Despite the increasing burden of mental disorders, mental health service delivery remains inadequate worldwide (Saxena et al., 2007). Many treatment strategies have historically been employed to treat mental disorders, ranging from bio-psychosocial, somatic, spiritual and psychosocial models (Drake et al., 2003; Lehman et al., 1995). This study found that balanced care was the most researched type of MHC in the *AJCP*, *AJP*, *CMHJ*, *SAJPs* and *SAJP*, between 2004 and 2016. Balanced

care is considered to be a more holistic approach to MHC, as it emphasises the integration of community-based and clinical based treatment modalities, as well as other culturally competent types of care for effective MHC provision (Thornicroft & Tansella, 2013). Community-based treatment modalities such as social support services, assertive community treatments and rehabilitation were also commonly reported in the dataset, as well as clinical strategies such as behaviour therapies, pharmacotherapy, and psychiatric outpatient.

Taking into account the alarming burden of mental ill-health and the shortages in MHC expenditures worldwide, the WHO (2002) suggested that mental health interventions, promotion and prevention programmes within the community sphere and in public health programmes be given priority in order to target individual patients and communities at large. These promotion and prevention strategies were conceptualized to play a key role in reducing stigma attached to mental disorders, years lived with disability, and in improving social and economic environments. Most studies in the dataset were carried out in community care centres, outpatient psychiatric centres, NGOs, or at participants' homes. These trends in treatment settings confirm that MHC has progressively been decentralized from hospital settings. The decentralisation of mental health services and their integration into general health care are very critical for public MHC as this is believed to provide wider treatment options and to enhance the mental health status of populations (Saraceno, Freeman & Funk, 2009).

Although it has been reported that there exist effective treatment programmes targeted at different ages and for different disorders, the gap between the need for mental health treatment and the resources available is enormous worldwide, and the provision of effective care is largely dependent on a country's available financial resources (Saxena et al., 2007). Therefore, based on a country's economic context, the WHO-HEN evidence report (2003) suggested that the priority in low-resource countries be the establishment and improvement of mental health services within primary care settings, using mental health specialist services as a backup to provide training, consultation and specialized treatment that cannot be provided in primary care settings; that medium-income countries seek to develop outpatient clinics, community MHC teams, acute inpatient care, long-term residential care within community settings, as well as occupational care. This report also suggested that in addition to the services provided in middle-income countries, high-resource contexts should provide differentiate care such as long-term community residential care, vocational rehabilitation, alternatives to acute inpatient care, assertive

community treatment, ambulatory clinics and community-based MHC teams. The argument behind the WHO-HEN (2003)'s preference for balanced care is that integrating different approaches of services is more effective than either clinical or community-based care alone because different service components incorporates the key principles of autonomy, accessibility, cost and service effectiveness, continuity of care, equity, and coordination and efficiency of the treatment process (Thornicroft & Tansella, 2013). Although the WHO-HEN (2003) synthesis does not provide socioeconomic criteria to determine which countries fall within low-, medium- or high-income contexts, this study used the 2016 World Bank classification, which distinguishes between low-middle or high-income resource countries based on their GNI per capita.

There were large differences in the types of mental health treatment provided in each context, in the dataset, and balanced care was mostly reported in high income countries than in the other contexts. The absence of balanced care in middle income contexts and the low prevalence of this type of care in low income contexts reported in the dataset could be due to methodological factors rather than structural issues considering that the majority of studies in the current dataset were from high income countries, while low- and middle-income contexts were least represented. Due to the skewed distribution of the current dataset across contexts, optimal conclusions regarding the state of MHC in middle and low income contexts drawn in this research may not reflect the actual state of MHC in these contexts.

It can however be observed that despite the total absence of integrated treatment in middle-income countries, there was evidence of social support services, culturally tailored services, pharmacotherapy, individual psychotherapy, tele-psychiatry as well as mobile psychiatry. While the WHO-HEN (2003) suggested that medium-income countries seek to develop outpatient clinics, community-based MHC teams, acute inpatient care, long-term residential care within community settings, as well as occupational care, the patterns observed in medium-income contexts in this study's dataset reflect a tendency towards outpatient clinical care (provided through pharmacotherapy, tele-psychiatry and mobile psychiatry) and community-based services (such as social support services and community-based cultural care). These types of treatment, although from minimal data, reflect the efforts to decentralize the provision of MHC in hospital settings, and to improve the diversity of mental health treatment, both clinical and community-based, as per the WHO-HEN (2003) treatment suggestions for middle-resource contexts.

The types of mental treatment in Low income contexts on the other hand included pharmacotherapy, psychosocial interventions, some community outpatient care as well as psychoeducation. Integration of CBT and social support services was also evident in low-income contexts in the dataset. These do not reflect the WHO-HEN (2003) treatment plan for low-income countries, which suggested that the priority in low-resource countries be the establishment and improvement of mental health services within primary care settings, using mental health specialist services as a backup. On the contrary, this variety in types of treatment in low-income contexts observed in this study reflects evolving progress in the MHC sector in these contexts, despite the persistent gap in the financial and treatment resources available for mental disorders.

South Africa, which is classified as a low-income country, was revealed in the current dataset to have a primary predominance of clinical-based mental health treatment resources. Moreover, balanced care, as well as a diversity of other treatment strategies (such as community-based care, spiritual/religious interventions, and prison-based MHC) was evident in South Africa. The type of balanced care that was most reported in South Africa was psychiatric services in primary care centres (PCCs), suggesting that PCCs are the first contact for MHC in South Africa. This shows that the suggestions of the WHO-HEN (2003), which were also incorporated in the South African National Mental Health Policy Framework and Strategic Plan 2013-202, are progressively being implemented, suggesting that access to MHC services is being promoted. What this does not prove however, is whether treatment in PCCs is an effective strategy for treating MI or not. Future studies should therefore investigate the effectiveness of MHC provision in PCCs in South Africa. As mentioned earlier in this paper, the WHO- HEN (2003) report suggests the provision of mental care services in PCCs in low-income contexts in order to promote the integration of MHC into general health services, and to address the shortage of mental health specialists. It was however observed in this study that clinical-based care was the most prevalent type of treatment in South Arica, and that in addition to mental services in PCCs, integrated services such as cognitive behaviour therapy and psychosocial rehabilitation, as well as rehabilitation and psychiatric inpatient care, were evident. This suggests that despite the focus on providing mental health services in PCCs, the use of specialist-mental health treatment is more influential. This reflects the needs to broaden the range of MHC specialists, and to

expand the resources for training all other practitioners and other stake holders who play a key role in the promotion of mental health and prevention of mental disorders (Lund e al., 2009).

Furthermore, there was evidence of traditional treatment strategies in South Africa as well as in high-, and middle-income contexts. This is significant because psychiatry and the treatment of psychiatric disorders have their roots not only in biology, but in cultural societies within which they are practiced (Mkize, 2003). African and Western conceptualisations of disease differ widely, yet psychiatric practices are conceptually based on Western values, and are not always applicable in non-Western contexts. There is therefore the need for psychiatric practices that respond to specific contexts and value. The needs for culturally tailored interventions have been voiced by multiple researchers, as these programmes have been proven to produce favourable outcomes when effectively applied (Allen et al., 2009; Mohatt et al., 2014). The evidence of integration of traditional/cultural forms of mental treatment and psychiatric care in high- and middle-income contexts and in South Africa thus challenges the belief that Western and traditional healing systems are irreconcilable (Mkize, 2003), suggesting that although conventional forms of treatment dominate the provision of MHC in these contexts, there are other more culturally-based types of treatment that respond to certain culture-specific mental health needs. It is the duty of future studies to investigate the types of culturally-tailored treatment strategies for MI that are available, effective, and which can be integrated into other conventional mental health treatment strategies.

The WHO-HEN (2003) report also suggested that in addition to outpatient clinics, acute inpatient care, and occupational care, high-resource contexts provide differentiated care such as long-term community residential care, vocational rehabilitation, alternatives to acute inpatient care, assertive community treatment, ambulatory clinics and community-based MHC teams. Various patterns of these treatment strategies were observed in high-income contexts in the dataset, including clinical-based, community-based and balanced care. The types of treatment that were prevalent included but were not limited to pharmacotherapy, psychiatric inpatient and outpatient care, assertive community treatment, educational and psychosocial rehabilitation, social support services, housing, transitional services, culturally-tailored interventions, cessation programmes, intensive case management, as well as vocational services. Most of these strategies reported in high-income contexts follow the WHO-HEN (2003) suggestions, except for ambulatory clinics and community MHC teams which were not observed in the dataset.

The types of balanced MHC observed in high-income contexts in the dataset integrate almost all the aspects of the WHO-HEN (2003) suggestions. The results in this study reported, for instance, that integrated dual diagnosis treatment (IDDT) was the type of balanced care that was most practiced in high income contexts in the dataset. IDDT is an evidence-based treatment programme for individuals who have co-occurring MI and substance-use disorders (Tsai et al., 2009). This practice aims to improve the patients' quality of life through the provision of multidisciplinary services that emphasise symptom management and patients' independent living. IDDT is important for public health and particularly for promotion of mental health and prevention of mental illnesses because it offers comprehensive and individualised services that address an individual patient's circumstances of life. Moreover, this type of treatment combines other strategies such as pharmacotherapy, psychoeducation, psychotherapy as well as social interventions in order to promote the patient's and their family's involvement in the process of treatment. As observed in this study, most people affected by mental disorders are at increased risk of homelessness; IDDT on the other hand provides organised services aimed at improving housing and supported housing for individuals with mental disorders (Rosenberg et al., 2001). This type of treatment thus condenses all services recognised to be necessary for effective treatment of MI as per the suggestions of the WHO-HEN (2003). IDDT has been reported to be effective in improving patients' quality of life, their stability and continuity of care, as well as housing and independent living, and has been shown to reduce hospitalisation rates and relapse of MI and substance abuse (Drake et al., 2001; Tsai et al., 2009). However, the formal integration of the different services (such as housing, psychiatric and substance abuse treatment) provided in this model has not been extensively investigated (Tsai et al., 2009). Future studies should therefore investigate the formal integration of services provided in the IDDT model as well as its applicability in different cultural and economic contexts where the gap of MHC is larger. Studies in the future should also investigate the cost-effectiveness of IDDT.

Other types of balanced care that were reported in high resource contexts includes an integration of cognitive behaviour therapy (CBT) and social support or CBT and assertive community treatment (ACT), ACT with psychosocial rehabilitation or ACT with case management and outpatient care, as well as evidence-based psychotherapy. The variety of treatment strategies offered in high income contexts thus attests to the efforts in these contexts to address the burden of MI, and in most cases align with the WHO-HEN (2003) suggestions.

Despite evidence that effective mental health treatment exists, most people worldwide remain adamant to seeking appropriate care (Goguen et al., 2016).

A study by Hugo et al. (2003) for instance found that most participants in the study conceptualized mental disorders (such as depression, schizophrenia, substance abuse or panic disorder) as being related to stress, or lack of self-control rather than as psychiatric disorders. These authors also found that most participants advocated 'talking the problem over' as the treatment of choice for these disorders, rather than seeking professional medical help. the patters of responses in Hugo et al. (2003)'s study suggests that MI stigma and misinformation regarding the causes of mental disorders still exist, constituting further barriers to effective care delivery and help-seeking attitudes thereof. Jorm (2012) believes that the promotion of mental health requires amongst other things, the provision of mental health literacy which will broaden the understanding of MI and its demands. This echoes the need for education programmes that inform the public about the aetiologies of mental disorders and about the value of seeking appropriate care.

The MHC sector is an area that is faced with various conflicts and misunderstandings regarding the causes, and consequences of mental disorders. This is due to the fact that mental health and MI are viewed in vastly diverse perspectives in different cultures, which influence the treatment options that patients and their care-givers chose to embrace (Saraceno et al., 2009).

Despite growing evidence of improvements in mental health services, as observed in this study, a significant number of people affected by mental ill-health remain reluctant to seeking professional help, especially in low-resource contexts (Goguen et al., 2016). This highlights the need for evidence-based research, which uncovers the treatment preferences of populations as well as the social determinants of mental ill-health, in order to adapt interventions based on needs-evidence.

CHAPTER SIX: CONCLUSION

This chapter is an overall summation of this study. It provides a brief summary of the methodological and theoretical aspects of this study, as well as a discussion of the limitations of this study, and its contributions to the field of MHC.

This study aimed to investigate how balanced care has been researched and reported over the past thirteen years, and if the trends in MHC provision in the past thirteen years are responding to the increasing burden of mental disorders across contexts. This study explored the trends in mental treatment strategies and particularly the trends in balanced care researched and reported in the *AJCP*, *AJP*, *CMHJ*, *SAJPs* and *SAJP* between 2004 and 2016. Moreover, this study compared the trends in MHC strategies that emerged in low, middle, and high-income contexts as well as the South African context to the types of treatment suggested by the WHO-HEN (2003), in order to analyse the efforts that have been made in different contexts to address the gap in MHC.

This study found that MHC research in the past thirteen years and within the *AJCP*, *AJP*, *CMHJ*, *SAJPs* and *SAJP* was mostly empirical in nature, suggesting a focus on observed and measured phenomena, and production of knowledge that is based on patients' experiences of treatment rather than theory. There was also a diversity of research approaches reported in the dataset, suggesting that there is a balance in the type of mental health knowledge that was produced between 2004 and 2016 in the five journals, from approaches that emphasised the homogeneity of treatment experience and those that valued the uniqueness of each patient's experience, to those that provided the mechanisms for determining cause and effect of treatment, and for researching continuous improvement of mental health treatment.

It was also found that most research in the dataset used large samples of adult participants, most of whom had different levels of education with a considerable number who only studied up to secondary school. Most of these participants suffered from schizophrenia, substance use disorders, serious mental disorders, depression, psychotic disorders and bipolar disorders among others. It was also reported that the majority of the participants had difficulties accessing treatment services, were homeless or experienced harm, social exclusion and further negative life events. These facts raised questions about the human rights of patients affected by

mental disorders, and the strategies that are needed to reduce social injustice and stigma toward persons affected by MI, and to improve their quality of life.

The high prevalence of public mental health theories observed in the dataset reveal that efforts have been made in the past thirteen years to reduce risks for MI and enhance protective factors for mental health, as well as to promote the respect of patients and value their human rights, culture, and beliefs. There was however dearth of educational and vocational services destined to educate and empower the affected populations and their communities, in order to reduce the stigmatisation of patients with mental disorders. Finally, the types of balanced care reported across contexts were analysed, and it was observed that balanced care in South Africa and in high income contexts were generally in accordance with the core-components of the WHO-HEN (2003) recommendations, suggesting that MHC provision in these contexts is evolving toward integration of services. The evidence of culturally tailored interventions in high-income and the South African contexts confirmed this argument further. The types of treatment observed in middle- and low-income contexts were also suggestive of evolving efforts to improve the provision of mental health services in these contexts, although there was deficiency of evidence supporting the development of integrated mental health services. It was thus suggested that future studies investigate the effectiveness and accessibility of services across contexts, particularly in low and middle-income contexts as these were not effectively represented in this study.

6.1. Limitations of the Study

This study used published work within five journals over a thirteen year period to investigate the trends in MHC locally (in South Africa) and internationally. While the goals of this study have been achieved, it should be pointed that the selection of the above mentioned journals as data source may have conspicuously excluded studies that were published in other sources, which could have been equally significant for this study. This therefore limits this study's validity to make claims that are generalisable to all mental health research conducted within the same time frame. This however does not compromise this study's relevance to the field of MHC, since the subject of importance was to investigate the state of MHC following the WHO-HEN (2003) recommendations.

Another limitation of this study was the skewed distribution of the data, since high income contexts were the most represented, followed by the SA context, while middle and low income contexts were marginally represented. Although this limited this study's confidence in drawing general conclusions regarding the types of mental care in low and middle income contexts, the use of a more qualitative lens allowed for the results to be engaged with, and for research questions to be answered effectively.

The use of qualitative and quantitative methods also raises further concerns that need to be highlighted. Firstly, the coding aspect of the qualitative methods raises concerns regarding the subjectivity of the researcher. To counter this limitation, the coding categories used in this study were checked and approved by the supervisor before the qualitative coding process was initiated. Moreover, this study made use of pre-established coding criteria, such as those used by Graham (2014), and Graham and Ismail (2011), further enhancing the legitimacy of the coding process. The use of both inductive and deductive coding strategies further validated the capturing of all interesting features of the dataset that were relevant to this study.

Quantitative methods, when used on their own, are said to limit an in-depth engagement with the data. However, by combining the complementary aspects of both qualitative and quantitative approaches, mixed methods designs minimize the limitations of each approach, thus strengthening their contribution. Therefore using mixed methods was appropriate for this study, and minimized the limitations of qualitative and quantitative methods.

6.1. Significance of this Study

Examining trends over time has the potential to emphasise the changes within the content of a field, which may be suggestive of the level of commitment of the field to a particular domain of knowledge (Loo et al., 1998). Throughout the years, researchers, policy makers and service providers have called attention to the need for efficacy studies of mental health services (Newman, Howard, Windle & Hohmann, 1994). Therefore, to respond to the WHO (2001) call for the need of studies that look at prevention of MI and promotion of positive mental health, this study investigated the effectiveness of MI treatment provision in the past thirteen years, following the WHO –HEN (2003) treatment suggestions. As discussed above, the WHO-HEN (2003), based on extensive research and consideration of different countries' resources, suggested that the priorities and policy goals in low income countries be mainly focused on

establishing and improving MHC delivery within primary care settings, using specialists as a backup; that medium-resource countries seek to provide outpatient treatment centres, community-based MHC, acute inpatient care, occupational and long-term community-based residential care. Additionally, this report suggested that high-resource countries, in addition to such measures taken in low and middle income countries, should provide specialised ambulatory clinics and community mental health teams, long-term community residential care together with vocational rehabilitation, as well as assertive community treatment and alternatives to acute inpatient care. This study shows that these suggestions have been fairly applied in high income countries, and in the South African context. This study also observed the absence of integrated mental health services in middle- and low-income contexts. While this reveals that the gap in mental health treatment provision is still persistent in low and middle income countries, this study highlights the methodological factors that could have caused this pattern of results. Future studies should thus investigate the integrations of MHC in larger datasets from low and middle income contexts, as well as their effectiveness in addressing MI. The fact that low- and middle-income contexts were underrepresented limited comparative inferences to be made between the types of treatment reported across all contexts. However, it would be naïve to assume that a uniform type of balanced care model would fit in all contexts, given the huge differences in available resources across low, middle and high income contexts. Different types of balanced care were reported in high-income versus the South African contexts, and this study provided suggestions for future research on balanced care provision across contexts. The provision of traditional or culturally-tailored MHC in high-income and the South African contexts reveal, as discussed earlier, the progress to break the boundary of irreconcilability between Western psychiatry and traditional medicine. Future studies should thus investigate the extent to which traditional services are integrated within psychiatric care, and the applicability and effectiveness of these integrated services in different contexts.

6.2. Future of MHC Research

Researchers interested in MHC have generated a body of work that examines a variety of mental health treatment strategies. This study has also provided a comprehensive description of the state of MHC across contexts, as well as an elaborated discussion of the types of treatment that are more valued, and whether or not they respond to the increasing burden of mental

disorders. It is essential that future studies of this kind undertake to produce results that monitor the state of MHC provision, in order to specify the components of care provision that need to be strengthened, and to identify aspects of care that need to be integrated for effective MHC provision. Since public MHC has been suggested to be a more effective approach for MHC provision, future studies should examine the relationship between the suggested public health strategies (such those suggested by the WHO-HEN, 2003) and their outcomes in promoting mental health and preventing mental ill-health.

6.3. Concluding Comments

This chapter has provided an overview of the implications of this study for mental health research. Discussions around the patterns in mental health research and the trends of mental health treatment that were observed in the dataset were highlighted, as well as discussions around the methodological trends. Considerations of participant characteristics and the life challenges they experience were engaged with in order to comment on the issues of discrimination and stigmatization that individuals with mental disorders experience, and to highlight the types of services that are needed to address these issues. The field of MHC is dedicated to improving the treatment conditions as well as the quality of life of individuals affected by mental ill-health. It is therefore necessary that studies constantly assess if this field's dedication to these objectives are maintained through the years, and if research is being conducted to find continuous and effective strategies to address the burden of MI worldwide.

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Appendix A. Data Coding Sheet

Variable Name	Variable Label	Value Label
ID	Full identification code of journal article	(Abbreviated name, year, volume, page numbers)
Year	Year of publication of journal article	1= 2004 2=2005 3= 2006 4= 2007 5= 2008 6= 2009 7= 2010 8= 2011 9= 2012 10= 2013 11= 2014 12= 2015 13= 2016
Volume	Volume of journal article	
Page	Page numbers of journal article	
Type	Type of article	1= empirical 2=Review article (literature review, systematic review) 3= methodological 4=case study 5= theoretical 6= other
Approach	Methodological approach (empirical articles only)	1= positivist 2=interpretive 3=critical 4= mixed methods 5= applied method (unspecified) 5.1= community needs analysis 5.2= policy analysis/System change 5.3= program evaluation/comparative effectiveness research 5.4= participatory action

		research(participation of care givers in conducting research and evaluation) 6= other 98= not applicable
Primary method	Primary method of data collection (empirical articles only)	1= experimental 2= quasi-experimental 3= survey/questionnaire 4= test/scale/inventory 5= archival 6= qualitative (interviews, focus groups) 7= multi-method (includes more than one type of primary method) 8= other (observations, video footage, telephonic recordings) 98= not applicable
Context	Context in which the research was conducted	1= International (mixture of different international countries) 1.1= high income countries 1.2= middle income countries 1.3= low income countries 2= South Africa 3= multiple contexts (more than one context) 4= unspecified 98= not applicable.
Setting 1 **Setting 2** **Setting 3**	Setting of data collection (empirical studies only)	1= outpatient psychiatric clinic 2= community mental health centre 3= general community 4= community-based organization/NGO (outpatient care) 5= private practice 6= welfare facility/residential care centre (old age home, shelter, children's home) 7= participant's home 8= prison/correctional centre/police station, court 9= workplace 10= rural settings 11= unspecified 12= religious/ spiritual settings 13= other (e.g. social network, conference, electronic databases) 14= rehabilitation centre

		15= camp 16= university 17= school\crèche 18= primary care centre (PCC) 19= inpatient psychiatric ward 20= none 98= not applicable
Age	Age category of participants (empirical articles only)	1= early childhood (approximately 0-5 years) 2=middle childhood (approximately 6-12 years) 3= adolescent (approximately 13-17 years) 4=adult (approximately 18-64 years) 5= elderly (65 years+) 6= mixed age category (more than one main age category) 7= unspecified 98= not applicable
Sample size	Sample size category (empirical articles only)	1= 1-10 2= 11-30 3= 31-100 4= 101-500 5=>500 6= unspecified 98= not applicable
Level of education	Level of education of participants (empirical articles only)	1= preschool 2= primary school 3= secondary school 4= tertiary education 5= postgraduate 6= mixed level of education 7= unspecified 8= no formal schooling 98= not applicable
Gender	Gender of the participants(empirical articles only)	1= female only 2= male only 3= mixed (male and female) 4= other (LGBTI) 5= unspecified 98= not applicable

Employment status	Employment status of participants(empirical articles only)	1= unemployed only (adults) 2= employed only (adults) 3= mixed employment status (adults) 4= university/ college student 5= child/scholar 6= retired 7= unspecified 8= other (not listed here) 98= not applicable
Marginal 1 **Marginal 2** **Marginal 3**	Marginalized group(empirical articles only)	1= race 2= gender/ Sexual orientation 3=psychological condition 4= SES 5= disability (physical, social) 6= geographical location (locations that are secluded and deprived of health care facilities) 7= other (political affiliation) 8= HIV/AIDS 9= unspecified 10= migration status/refugee 11= minority (racial, ethnic) 12= criminal history 13= age 20= none 98= not applicable
Life challenges	Types of challenges that determine participants' quality of life(empirical articles only)	1= homeless 2= orphaned 3= scarce treatment resources/access to facilities 4= Limited social capital 5= at risk population 6= socially excluded 7= unspecified 8= other 9= negative life events (war, natural disaster, lost a significant one) 20= none 98= not applicable
Type of MI 1 **Type of MI 2**	Type of MI participants were diagnosed with	1= Schizophrenia 2= bipolar disorders 3= depression

Type of MI3		4= substance use disorder 5= anxiety 6= other (attachment disorders 7= more than 3 of these 8= psychotic conditions (unspecified) 9= unspecified 10= mood disorders unspecified 11= serious mental illness (unspecified) 12=PTSD 13= behavioural problems 20= none
Theoretical framework 1 **Theoretical framework 2** **Theoretical framework 3**	Type of mental health theory used	1= treatment program evaluation 2= development of new treatment programs 3= promotion and prevention 4= public health 5= empowerment 6= traditional/clinical/individual-based therapies 7= unspecified 8= sense of community 9= other(trends in service use, needs analysis) 10= social action/community integration 11= Recovery/quality of life 20= none
Type of treatment	Type of treatment participants received	1= clinical 2= community-based 3= correctional/incarceration/prison mental health services 4= spiritual/religious 5= no formal care 6= mixed/balanced treatment 7= other/ not specified 8= other (telephonic mental health care, Psychiatry of the elderly, restraints) 9= community-based traditional/cultural 20= none 98= not applicable
Community-based treatment	Type of community-based treatment investigated	1= assertive community treatment 2= rehabilitation (educational and psychosocial) 3= social/peer/family/support groups 4=acute and intensive home care

		5= other (, citizenship programs, art, community surveillance, prevention programs, strengths-based intervention, psychoeducation, Therapeutic education care, decision support interventions, humour-related interventions) 6= housing 7= not specified 8= transitional services 9= traditional/indigenous/ culturally-tailored interventions 10= wraparound and diversion services 11= recovery residences. 12= (peer administered) psychosocial interventions. 13= vocational services 14=community outpatients care 15= residential inpatient services 16= crisis intervention 17= cessation treatment 18= psychoeducation 19= intensive case management 20= none
Clinical/ psychiatric care	Type of clinical care investigated	1= electroconvulsive therapy 2= pharmacotherapy 3= behaviour therapy (CBT, Cognitive Remediation, Dialectical Behaviour Therapy 4=Psychiatric outpatient care 5= psychiatric in-patient care 7= biomedical/psychiatric services unspecified 8= individual/psychotherapy 10= Other (Tele-psychiatry/Electronic psychotherapeutic interventions, measurement-based care) 11= mobile psychiatry/ psychiatric outreach teams 20= none
Balanced care	Type of balanced care valued	1= outpatient + social/peer/family/support groups 2= inpatient+ assertive community treatment 3= rehabilitation+ pharmacotherapy+

		outpatient care 4= Psychosocial treatment: CBT + social supportive services 5= CBT + other 6= system of care 7=, evidence-based psychotherapy 8= Case management, psychiatric care, ACT and housing 9= alternative medicine: indigenous plus conventional biomedical therapeutic approaches. 10= psychiatric treatment plus vocational services 11= CBT plus psychosocial rehabilitation interventions 12= pharmacotherapy and interpersonal/psychosocial interventions 13= Practice-based/Telemedicine-based collaborative care 14= CBT plus vocational/employment service 15= pharmacotherapy and residential inpatient services 16= pharmacotherapy, clinical outpatient, community inpatient care and psycho-education. 17= outpatient psychiatric care, intensive case management and assertive community care 18= assertive community treatment and physical care 19= psychiatric services in PCC (Primary mental health care) 20= psychiatric care + spiritual/traditional practices 21= pharmacotherapy and community outpatient care 22= rehabilitation (educational and psychosocial) plus psychiatric inpatient care 23= Dialectical Behaviour Therapy + ACT 24= integrated dual diagnosis treatment (IDDT) 25= CBT + ACT 26= CBT + psychoeducation 30= none

MI labelling	Label used to refer to individuals suffering from mental conditions (in the title and abstracts particularly)	1= person-first language (e.g. individuals with MI) 2= condition-first language (e.g. mentally ill individuals) 3= unspecified

Appendix B. Country Income Groups

