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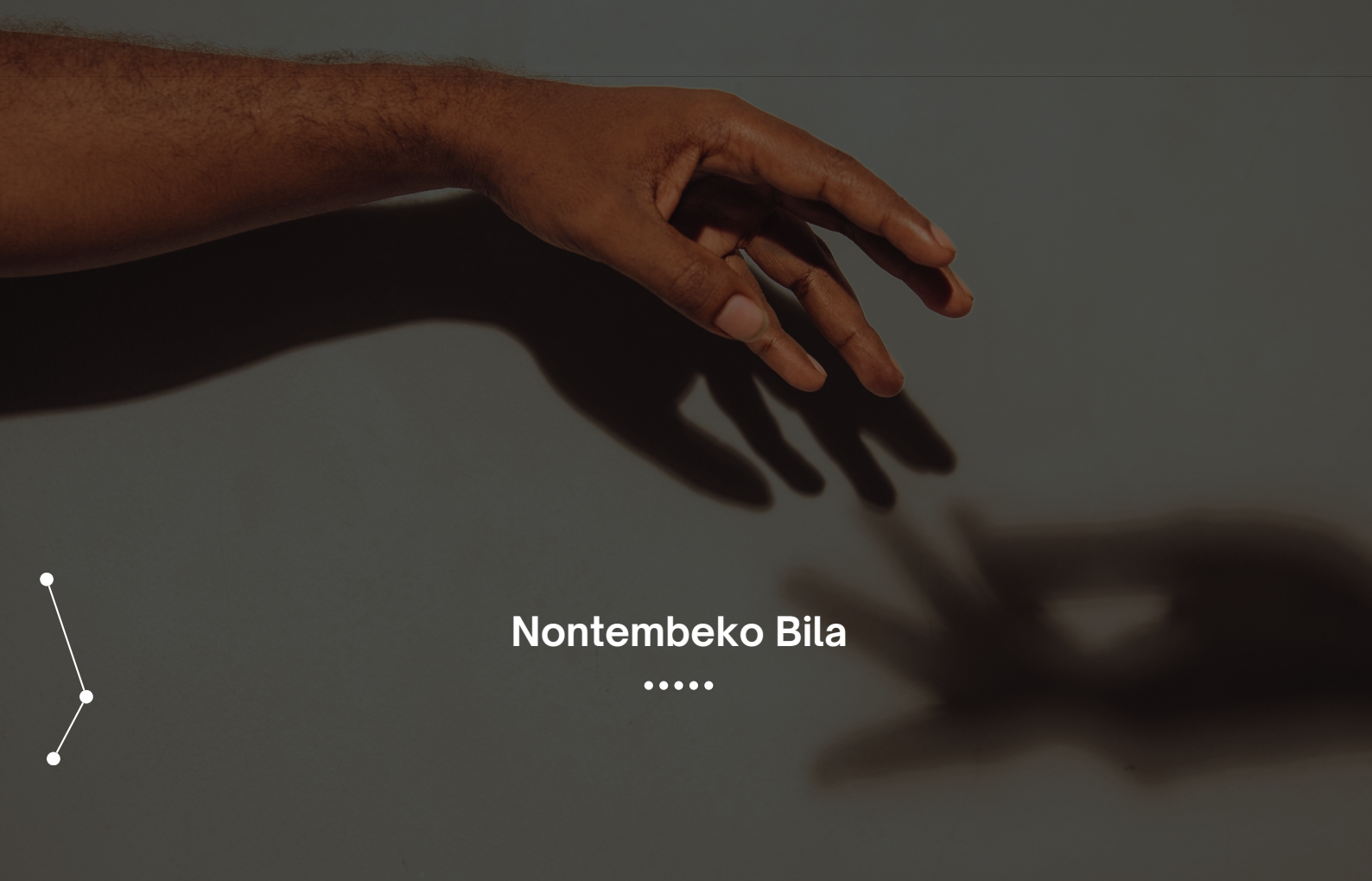
SOCIAL WORK PRACTICE

in Mental Health and Advancing Recovery-Oriented Approach in a South African Context



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ESI Press

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https://esipress.up.ac.za

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Typography & design: Micaela Cagnazzo

Printed and bound in 2025

First published by ESI Press 2025
ISBN: 978-1-0370-8883-4(print)
ISBN: 978-1-0370-8884-1(e-book)

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By
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Acknowledgements

This book, Social Work Practice in Mental Health and Advancing Recovery-Oriented Practice in a South African Context, represents a significant scholarly evolution from its inception as a doctoral study conducted in 2017 in the Limpopo Province. While rooted in empirical research, the work has since transcended its original scope to encompass a broader framework for professional practice. The conceptual foundations and practical insights presented herein are drawn from developing and implementing a tailored programme designed to support social workers operating within hospitals, mental health institutions, and the Department of Social Development. To date, there is a notable paucity of literature addressing the interface between social work and recovery-oriented mental health practice in South Africa. I sincerely hope that this volume will serve as a valuable resource for students, practitioners, policymakers, and scholars and will contribute meaningfully to embedding the social work perspective within global discourses on recovery-oriented mental health care.

I greatly appreciate Dr Heather Thuynsma's and Ms Amy Ashworth's unwavering support and guidance at ESI Press. I am equally indebted to Prof Antoinette Lombard, Prof Charlene Carbonatto, the Department of Social Work, and the University of Pretoria for providing an intellectually nurturing environment conducive to completing this work.

My heartfelt gratitude is extended to all the participants and respondents who generously contributed their time, perspectives, and lived experiences to the original study, namely the social workers, managers, caregivers, and Mental Health Care Users (MHCUs). Their voices form the cornerstone of this text.

Special thanks are due to the anonymous peer reviewers who engaged in the double-blind review process. Their rigorous and insightful commentary significantly enriched the scholarly quality of this manuscript.

On a personal note, I extend profound thanks to my husband, Dr Solly Bila, and our children—Vangi, Sibusiso, Khulu, Shela, Siya, and Bonga—whose encouragement, patience, and steadfast belief in the value of this work have been a constant source of strength. To Vutomi Maluleke, I am especially grateful for your dedicated care and support while writing this book.

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Abbreviations

AASW	Australian Association of Social Workers
ABCD	Asset-Based Community-Driven Development
ACE	Adverse Childhood Experiences
ACT	Assertive Community Treatment
ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immunodeficiency Syndrome
APA	American Psychological Association
ASD	Autism Spectrum Disorder
ASSA	Academy of Science of South Africa
API	Africa Polling Institute
BD	Bipolar Disorder
BFT	Behavioural Family Therapy
BPSS	Biopsychosocial-Spiritual approach
CBT	Cognitive Behavioural Therapy
CHE	Council for Higher Education
CIP	Crisis Intervention Partners
CMD	Common Mental Disorders
CMHT	Community Mental Health Teams
CMHS	Community Mental Health Services
CMI	Chronic Mental Illness
CPA	Care Programme Approach
CRM	Collaborative Recovery Model
CRPD	United Nations Convention on the Rights of Persons with Disabilities
CSW	Clinical Social Work
CSWE	Council on Social Work Education
DMHP	District Mental Health Program
DSD	Department of Social Development
DSM	Diagnostic and Statistical Manual of Mental Disorders
EAC	East African Community
EBP	Evidence-Based Practice
EST	Ecological Systems Theory
FB	Friendship Bench
HIV	Human Immunodeficiency Virus
HWSETA	Health and Welfare Sector Education and Training Authority
IASSW	International Association of Schools of Social Work
ICD	International Classification of Diseases
IFSW	International Federation of Social Workers
IMR	Infant Mortality Rate
IMR	Illness Management and Recovery
IPS	Individual Placement and Support
ISDM	Integrated Service Delivery Model

LHW	Lady Health Workers
LMIC	Low- To Middle-Income Countries
MAC	Ministerial Advisory Committee
MCHU	Mental Health Care Users
MDG	Millennium Development Goals
MDT	Multi-Disciplinary Teams
MHCA	Mental Health Care Act
MHCP	Mental Healthcare Practitioner
MHPF	National Mental Health Policy Framework and Strategic Plan
MHRB	Mental Health Review Boards
MOOSE	Model of Occupational Self-efficacy
NAMI	National Alliance on Mental Illness
NASW	National Association of Social Workers
NCS	National Core Standards
NDD	Neuro-Developmental Disorders
NDOH	National Department of Health
NDP	National Development Plan
NDRP	National Disability Rights Policy
NGO	Non-Governmental Organisation
NHS	National Health Services
NHI	National Health Insurance
NICE	National Institute for Health and Care Excellence
NIMH	National Institute of Mental Health
NIMHANS	National Institute of Mental Health and Neuro-Sciences
NMHP	National Mental Health Program
OECD	Organisation for Economic Co-operation and Development
PBSW	Professional Board for Social Work
PCC	Person-Centred Care
PD	Psychosocial Disability
PHC	Primary Health Care
PIE	Person-in-Environment
PMBMHS	Pietermaritzburg Mental Health Society
PST	Problem-Solving Therapy
PTSD	Post-Traumatic Stress Disorder
PWD	People with Disabilities
RAI	Rapid Assessment Instrument
SACSSP	South African Council for Social Service Professions
SADAG	South African Depression and Anxiety Group
SADC	Southern African Development Community
SAHRC	South African Human Rights Commission
SASH	South African Stress and Health
SAMHSA	Substance Abuse and Mental Health Services Administration
SDG	Sustainable Development Goals

SDH	Social Determinants of Health
SEM	Socio-Ecological Model of Mental Health
SES	socio-economic status
THP	Traditional Health Practitioners
UN	United Nations
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNPF	United Nations Population Fund
USAID	US Agency for International Development
WCA	West and Central Africa
WHO	World Health Organisation
WMH	World Mental Health

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Chapter 1
Introduction

The recovery movement, particularly in mental health, is centred around the belief that individuals can lead meaningful lives despite their mental health conditions. It emphasises personal empowerment, social inclusion and holistic well-being rather than merely managing symptoms. This movement is often referred to as recovery-oriented practice in social work, where the focus is on supporting individuals to regain control over their lives through person-centred interventions. Social work has made significant contributions to the recovery movement by advocating for service-user empowerment, integrating community-based approaches, and addressing social determinants that impact mental health recovery.

The emergence of the recovery movement signifies a pivotal shift in mental health policy and practice, rooted in the perspectives of individuals grappling with mental disorders. This movement fundamentally acknowledges the entitlement of these individuals to active participation within mainstream society and centres on two fundamental principles: the potential for individuals with mental disorders to maintain productive lives amid symptoms and the realistic prospect of recovery for many. The evolution of the recovery concept originated from the dissatisfaction of individuals with mental disorders regarding the care they received, ultimately propelling calls for the reorientation of services and systems to champion this approach, Historically and currently, the social work profession has been a major provider of mental health services through many of the professional services provided to individuals with mental disorders (Mental Health Care Users). It is a profession with strong theoretical and historical ties to mental health recovery-oriented frameworks and shares the same essential values, ethics and practice perspectives. It further promotes social change, problem-solving in human relationships and the empowerment and liberation of people leading to their well-being. On the other hand, the practice of recovery-oriented mental health refers to the application of sets of capabilities that support people to recognise and take responsibility for their recovery, assisting them in defining their goals, wishes and aspirations.

A relativist ontological position is taken in this book since the social reality of recovery and recovery-oriented mental health is regarded as consisting of subjective experiences and not objective facts. Social reality is linked to how people position themselves in relation to it. It is important to fully comprehend how people with mental disorders are treated in society. In many instances, they are marginalised and stigmatised. Moreover, epistemology is closely linked to and determined by the ontological position taken in this book. The epistemological position is interpretivist, focussing on the details of the situation, the reality behind these details, subjective meanings and motivating actions.

A book of this nature will guide mental health practitioners as to how recovery-oriented mental health is implemented in the South African context and thus improve the services provided to mental health care users (MHCUs).

This book comes at a critical time, addressing a topical subject of social work and recovery-oriented mental health practice from a South African perspective. The book transcends being a doctoral study conducted in 2017 in Limpopo Province. The presentation and discussions are based on the programme that was developed for social workers working at hospitals, mental health institutions and the Department of Social Development. Currently, there are no books covering social work and recovery-oriented mental health practice in a South African context. The book consists of twelve chapters. Chapter One provides an introduction and Chapter Two provides a brief historical development of social work in mental health care. Chapter Three considers theories of social work in mental health care, while Chapter Four examines mental health and its related policies. Chapter Five concerns identifying mental disorders, their perceived impact on MHCUs and their caregivers, the coping strategies of caregivers, interventions in assisting MHCUs and their caregivers and the importance of recovery for families. Chapter Six then looks at the current legislative framework under which social workers carry out their various responsibilities. Chapter Seven addresses social work practice in mental health care and Chapter Eight examines intervention methods employed by social workers in mental health care. Chapter Nine focuses on recovery of SAMHCUs, Chapter Ten on recovery-oriented mental health practice and Chapter Eleven on the implementation of recovery-oriented mental health practice. Finally, Chapter Twelve concerns recovery-oriented mental health practice within a South African context.

Chapter 2
Foundations of social work in mental health care

Introduction

Social workers have a crucial part to play in improving mental health services and mental health outcomes for citizens (Allen 2014). Allen (2014) further asserts that social workers bring a distinctive social and rights-based perspective to their work. Social workers also manage some of the most challenging and complex risks for individuals and society and take decisions with and on behalf of people within complicated legal frameworks, balancing and protecting the rights of different parties (Bila 2019). In this regard, a developmental approach has been adopted in South Africa (SA) (Department of Social Development [DSD] 2013). This response to the South African history was based on endemic inequality and human rights violations due to the apartheid system in place prior to 1994. Social work services have therefore been based on the notions of social transformation, human emancipation, reconciliation and healing and the reconstruction and development of society (DSD 2013).

It should be noted that, historically, social work has often been associated with psychiatric social work. Today, this is more broadly referred to as social work in mental health. However, there are many facets of social work practice, including group work, community social work, and even international social work. Not all caseworkers are psychiatric social workers. Two social workers working at Weskoppies Mental Health Facility (Mrs Singh-Beerajh and Dr Van der Walt) were consulted, who stated that in the South African context, social work in mental health is the appropriate terminology. Moreover, authors such as Olckers (2013) and Ornella (2014) also use the same phrase. However, when discussing social work in a global or international setting, it will be referred to here as psychiatric social work. Of note, psychiatric hospitals are referred to as mental health institutions or facilities, whilst psychiatric patients are referred to as mental health care users, as stipulated by the Mental Health Act No. 17 of 2002 (Department of Health [South Africa] 2002). Therefore, the latter terminology will be used consistently in further discussion. For this chapter, the global definition of social work has been adapted from the International Federation of Social Workers (IFSW) and the International Association of Schools of Social Work (IASSW) as follows:

> *Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversity are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address*

life challenges and enhance well-being. (IFSW and IASSW 2022: 2)

Developmental social work supports the commitment of the social work profession to social justice and human rights and the eradication of poverty and inequality (Lombard and Wairire 2010). Hence, the subsequent discussion will focus on the brief historical development of social work in mental health care or psychiatric social work globally.

Historical development of psychiatric social work

The discussion will be based on the global and national historical development of social work in mental health care. This historical context will afford social workers access to knowledge of social work and recovery-oriented mental health practice.

Early psychiatric social work: Britain, Ireland and the United States of America (USA)

Britain and Ireland were the first to recognise the role of medical social workers, initially known as almoners, in extending clinical care (Mohinuddin 2019; Gosling 2017). In Ireland, the profession began with Dr Ella Webb in 1918 at the Adelaide Hospital and Winifred Alcock, who trained as an almoner (Mohinuddin 2019). The Institute of Almoners was formed in 1945 and renamed the Institute of Medical Social Workers in 1964, contributing to the British Association of Social Workers in 1970. By 1974, medical social workers transitioned from the National Health Services (NHS) to local authority Social Services Departments, becoming known as hospital social workers (Gosling 2017).

In the USA, psychiatrists focused on patients' social environments, with Julia Lathrop, a key reformer, advocating for the training of professional social workers (Rajalingam 2019; Sands 2001). Appointed by President Taft in 1893, Lathrop significantly impacted civil service reform and juvenile court movements, serving as President of the National Conference for Social Work from 1918 to 1919 (Britannica 2022; Sands 2001).

The Massachusetts General Hospital established a social service department in 1905, with Dr Richard Clarke Cabot creating the medical social worker position, which aided in controlling syphilis and tuberculosis outbreaks (Mohinuddin 2019). Psychiatric social work began in 1907 at the same hospital and gained prominence with the establishment of the Boston Psychopathic Hospital's social service department in 1913, led by Dr Ernest Sutherland and Dr Mary C. Jarret (Rajalingam 2019). They emphasised the importance of social investigations in understanding mental disorders (Sands 2001).

Grob (1983) noted that before 1920, psychiatric social work emphasised understanding social environments to comprehend individual behaviour, focussing on aiding distressed individuals through supportive services. By

1920, significant changes in the specialty were underway, although detailed descriptions of early practices remain scarce (Stuart 1997).

After World War I, psychiatric social work thrived, while the Home Service programme declined and was eventually abandoned. Psychiatric social workers primarily assisted psychiatrists (Black 1991) but faced challenges as their role was subordinated to psychiatry, leading to instability in their professional identity (Black 1991). By the 1920s, they sought a psychological understanding of patients and aimed to provide direct treatment. However, the blurring of roles between psychiatrists and psychiatric social workers hindered their professional status, resulting in their marginalisation (Grob 1983).

In 1934, the American Association of Medical Social Workers, led by Harriet Bartlett, defined medical social work as a specific type of social casework that addresses the link between disease and social maladjustment. Bartlett emphasised the social worker's role in overcoming barriers to health, highlighting the need for integrating psychological concepts and understanding the interplay between personality and social environments (Bartlett 1934).

During the early 20th century, psychiatry and psychoanalysis evolved rapidly in the United States, introducing competition for psychiatric social work from psychologists and other professionals (Gehlert and Browne 2012). This competition was set against a backdrop of broader socio-historical issues like race, class, and access to care, influencing mental health practices. Despite being marginalised, the social work profession is experiencing a resurgence with a focus on recovery-oriented mental health practices (Grob 1983; Gehlert and Browne 2012).

History of social work in mental health in Africa – English-speaking countries

Social work in Africa has colonial origins, heavily influenced by British systems, which primarily served colonial interests while neglecting local cultural heritage (Hollingsworth and Phillips 2016; Kreitzer 2012; Makofane and Shirindi 2018). The profession's historical evolution in Africa is closely tied to the global emergence of social work and the enduring impacts of colonialism, imperialism, and Western development initiatives (Twikirize, Spitzer and Wairire 2014). The remnants of colonial governance, economic systems, and social welfare structures still influence contemporary social work practices (Midgley 1981). Furthermore, colonial ideologies perpetuated the notion that Western methodologies were superior, which continues to shape social work in Africa (Midgley 1981).

Eastern African Perspective

The East African Community (EAC), consisting of Burundi, Kenya, Rwanda, Tanzania, Uganda, and South Sudan, faces numerous social challenges such as poverty, exclusion, and governance issues (Twikirize and Spitzer 2019). The

emergence of social work in this region can be categorised into two phases: the establishment of basic social welfare services during colonial rule and the development of formal social work education post-independence (Spitzer 2019). Notably, Uganda's Nsamisi Training Institute, established in 1952, and Kenya's social work diploma programme initiated in 1962, marked significant milestones in social work training (Spitzer 2019; Wairire 2014). Despite the presence of social work education, the region grapples with a shortage of qualified professionals and poor working conditions (Butterfield and Abye 2013; Spitzer 2019). The absence of legal protections for the title 'social worker' and the lack of regulatory bodies further complicate the profession's legitimacy in EAC countries (Twikirize and Spitzer 2019).

Western and Central Africa Perspective

Historically, West and Central Africa (WCA) have been overlooked in discussions regarding the social welfare workforce (Davis 2009). Research from the 1970s and 1980s highlighted this gap, with a minimal focus on the social work education landscape in Francophone countries (Council on Social Work Education 2010). Currently, only a small fraction of the African members of the International Federation of Social Workers (IFSW) hail from WCA (IFSW 2014). Social work training in this region varies significantly, with Nigeria leading in educational opportunities due to its large population (Council on Social Work Education 2011; Kreitzer 2012). However, unclear job descriptions and legal frameworks hinder the profession's growth, affecting social workers' motivation and public understanding of their roles (Kreitzer 2012; Krueger, Guy and Vimala 2013). Inadequate funding for social work systems further exacerbates these challenges (Krueger et al 2013).

Southern Africa Perspective

The Southern African Development Community (SADC) consists of 16 member states, each with unique histories, socio-economic challenges, and approaches to social work (SADC 2019). The development of social work in these countries has been influenced by factors such as colonial legacies, cultural practices, economic conditions, and recent initiatives aimed at professionalisation and education (Twikirize and Spitzer 2019).

Social work in Angola has evolved in the context of post-colonial reconstruction and the long-lasting effects of civil war (Twikirize and Spitzer 2019). Following years of conflict, the Angolan government recognised the need for social services to support vulnerable populations. Efforts have been made to establish social work education but challenges remain, including a lack of resources and trained professionals. The government's collaboration with international organisations has been essential in developing community-based social services (Kreitzer 2019).

In Botswana, social work has developed a solid foundation, particularly after

independence in 1966. The University of Botswana offers a Bachelor of Social Work degree, reflecting a commitment to professionalisation (Jongman 2015). Social workers in Botswana are actively engaged in addressing issues related to poverty, gender-based violence, and HIV/AIDS, highlighting the importance of culturally relevant approaches (Mookodi 2004, Mpofu 2010). Furthermore, the government has established policies promoting social welfare, which contribute to the growth of the profession (Botswana National Association of Social Workers 2001, 2012; Brill 2001).

Social work in the Comoros is still emerging, with limited formal education and professional recognition. Efforts to develop social services have been hampered by economic challenges and a lack of trained personnel (Abderemane 2019). However, there is growing awareness of the need for social support systems, especially in areas like child protection and family welfare. Initiatives to train local community workers are underway, aiming to create a foundation for social work practice (Mohamed et al 2021).

In the Democratic Republic of Congo, social work has been influenced by ongoing conflict, economic instability, and health crises. While the country has made some progress in establishing social work education, challenges such as insufficient infrastructure and a lack of trained professionals remain (Ngamamba et al 2024). Social workers in the DRC are often involved in humanitarian efforts, addressing issues like displacement, health, and poverty (IFSW 2024). International organisations have played a crucial role in developing community-based programmes that integrate social work principles (US Agency for International Development [USAID] 2024).

Eswatini's social work framework has evolved to address contemporary social issues, including the HIV/AIDS epidemic and poverty (Dlamini 2020). The University of Eswatini provides a Bachelor of Social Work programme that focuses on community development and advocacy. Social workers in Eswatini are also involved in promoting social justice and human rights, with the government increasingly recognising the importance of social work in addressing social challenges (University of Swaziland 2017).

Lesotho's social work profession has been shaped by its colonial history and the integration of traditional practices (Jhpiego 2013). The government has recognised the need for social welfare services, leading to the establishment of social work programmes at the National University of Lesotho (Dhemba and Marumo 2016). Social workers engage in various areas, including child welfare, community development, and mental health support. Efforts to professionalise social work have been bolstered by partnerships with international agencies focused on capacity building (Jhpiego 2013).

Madagascar's social work profession is still emerging, with a focus on addressing social issues such as poverty and health (De Berry 2023). Efforts are being made to develop formal training and improve social welfare services, with international organisations playing a crucial role in supporting capacity-building initiatives (Parker, Maynard and Gordon 2023).

Malawi has seen significant growth in social work education and practice, particularly in response to HIV/AIDS and poverty (Ng'ong'ola 2004). The University of Malawi offers a Bachelor of Social Work programme, which aims

to equip students with the necessary skills to address pressing social issues. Social workers in Malawi play a crucial role in community-based interventions, emphasising empowerment and participation (Republic of Malawi 2010).

Mauritius has developed a comprehensive social work framework, with education and training programmes available at various levels (Gopaul, Saupin and Ramsamy 2021). The social work profession addresses issues of inequality, mental health, and social justice, supported by government policies and community initiatives. Social workers in Mauritius often engage in advocacy efforts aimed at improving the welfare of marginalised groups, reflecting a commitment to social change (Rambaree 2013).

Mozambique's social work sector has evolved from a focus on post-war reconstruction to addressing contemporary social issues, including poverty and health (Ottmann and Brito 2023). The establishment of social work programmes in universities has been crucial in professionalising the field. Social workers engage in community development projects, emphasising the importance of local knowledge and participation (Ottoman and Brito 2023).

Namibia has a well-defined social work education system, with programmes offered at various institutions (Gibson et al. 2022). Social workers in Namibia play a critical role in community development and advocacy, reflecting a commitment to empowering vulnerable populations (Kamwanyah et al 2021).

In the Seychelles, social work is developing, with an emphasis on family welfare and mental health (Ministry of Health and Social Affairs Seychelles 2005). However, the country faces challenges related to resource allocation and professional recognition. The government is working to strengthen social services and provide training opportunities for social workers (Orock and Navratil 2024).

The history of South African social work is deeply influenced by colonisation and imperialism, with early practices characterised by paternalism and welfare policies favouring Whites (Patel 2005a). Initially, social welfare focused on White orphans, with the first orphanage established by the Dutch Reformed Church in 1814. Similar to Europe, social work in South Africa was initially tied to class structures and individualism, often attributing poverty to personal failings rather than social contexts (Ferguson 2008; Lavalette and Ferguson 2007). South Africa has a robust social work education system, with numerous universities offering undergraduate and postgraduate programmes. The profession is essential in addressing historical injustices, social issues, and mental health challenges, emphasising community-based approaches (Patel V. 2015). In 1994, post-apartheid reforms led to a united Department of Welfare focussing on historically disadvantaged communities (Gray 2000). New welfare policies emphasised accessibility and stakeholder participation, influenced by international standards and the need to address past inequities (Naidoo 2004). However, social work's response to poverty and basic needs was inadequate, highlighting the need for a developmental approach to welfare (Naidoo 2004).

The White Paper of Social Welfare (DSD 1997) proposed harmonising social and economic policies, advocating for social investments to enhance human capabilities and economic development. Despite calls for a reorientation towards developmental social work, defining this approach remains contested

among scholars and practitioners (Gray and Lombard 2008).

In Tanzania, social work has developed from colonial roots, with educational programmes now established to support the profession (Burke and Ngonyani 2004). Social workers are actively involved in addressing child protection, poverty alleviation, and health services, with an emphasis on community engagement and participatory approaches (Tanzania Association of Social Workers 2017). The Tanzanian government recognises the importance of social work in national development and has established policies to support the profession.

Zambia's social work sector is evolving, particularly in response to poverty and health challenges (Silavwe 1995). The University of Zambia offers social work programmes focussing on community development and empowerment. Social workers in Zambia engage in various areas, including child protection, gender equality, and health promotion, with increasing recognition of the profession's role in national development (University of Zambia 2024).

The development of social work in Zimbabwe is rooted in its pre-colonial, colonial, and post-colonial history (Nhapi 2021). Pre-colonial Zimbabwe had well-developed Indigenous systems for addressing social issues, such as kinship care, the King's Granary *(Zunde ra Mambo/Isiphala seNkosi)*, and work parties *(nhimbe)*, which promoted communal support (Mupedziswa and Mushunje 2021; Muridzo, Mukurazhizha and Simbine 2022). However, colonisation disrupted these systems, replacing them with capitalist structures that exacerbated social inequalities (Dhemba and Nhapi 2020). During the colonial period, social work developed to manage issues like crime and juvenile delinquency, mainly benefitting the White population, with racial disparities in social work services and training (Masuka 2015; Chogugudza 2009). The post-colonial era saw the decentralisation of services, the legislation of social work, and the call for a decolonised and Africanised practice to better align with human rights and social justice (Tusasiirwe 2022). Zimbabwe has a well-established social work education system, with several universities offering training (Chogugudza 2009). The profession addresses a range of social issues, including poverty and health, with a strong focus on community development and social justice. The government has recognised the importance of social work in promoting human rights and has implemented policies to support the profession (Ministry of Labour and Social Services 2011).

Clinical social work: A South African perspective

Clinical social work (CSW) in South Africa has a long history, with the first postgraduate programmes offered in 1977 (van Breda and Addinall 2020). The establishment of CSW academic qualifications in South Africa precedes the beginning of the process for professional statutory recognition by about 30 years. Already in 1977, the then School of Social Work at University of Cape Town initiated a postgraduate diploma in psychiatric social work, which by 1980 was developed into a master's in CSW (Isaacs 2019). Around the same time, the University of the Witwatersrand also developed a now-defunct

postgraduate diploma in psychiatric social work. The ripple effects of South Africa's long history of colonisation and apartheid, which formally ended only 30 years ago, continue to negatively impact the lives of most South Africans. Consequently, social work focuses on developmental and macro interventions aimed at addressing these structural issues and on the provision of statutory services to vulnerable children (Patel V. 2015). Clinical social workers typically see themselves as making an important contribution towards addressing the structural legacy of colonialism and apartheid through the provision of high-quality, affordable clinical services to people who are unable to access clinical psychological services (van Breda and Addinall 2020).

Until recently, many social workers who had completed a CSW master's degree, as well as social workers who had undergone other forms of CSW training and practice experience, could and did freely refer to themselves as 'CSWs' and included this designation on their professional marketing materials (van Breda and Addinall 2020). This was possible because no professional association or legislation existed to regulate who could use this professional designation. The process for establishing the statutory recognition of the specialisation in CSW began in June 2008 (van Breda and Addinall 2020). This is when the South African Council for Social Service Professions (SACSSP), the statutory regulatory body for the profession of social work and other social service professions in South Africa and its Professional Board for Social Work (PBSW), first published their criteria and guidelines for the establishment of specialities in social work (SACSSP 2008a). In their criteria and guidelines document, the SACSSP defined a 'speciality in social work as a particular field of practice in social work in which specific activities take place for which additional specialised and in-depth knowledge, skills and expertise on the specific field of practice are required and which could be regarded as the domain of the Social Work profession' (SACSSP 2008b: 1).

In 2009, the PBSW arranged a workshop with academics and other stakeholders interested in the proposed specialisation in CSW. A key point of debate was the proposal from some sectors that Social Work in Health be incorporated into CSW, under the proposed specialisation of 'Clinical Social Work in Health Care'. Ultimately it was agreed to keep these separate and the formal decision was taken that CSW met the SACSSP guidelines and criteria for specialisation in social work and that the PBSW would formally begin the process of developing the regulations for the specialisation in CSW. During 2015 and 2016, extensive work was done to firm up the CSW regulations. On October 21, 2016, the Minister for Social Development called for comments on the regulations relating to the specialisation in CSW (Republic of South Africa [RSA] 2016). On September 1, 2017, the regulations related to the registration of a specialisation in clinical social work were signed by the Minister and published in Government Gazette No. 41082 (RSA 2017). CSW was finally formally and statutorily recognised as a specialisation in social work. During 2018 and 2019, the documents to formalise the criteria for the assessment of applications for registration of a speciality in CSW by social workers were developed, finalised and adopted by the PBSW (van Breda and Addinall 2020). As van Breda and Addinall (2020) alluded to Social Work in Health Care as a speciality, the book

will allude briefly to this speciality.

Social work in healthcare: A South African perspective

The South African context requires a range of responses to address its vulnerable populations' urgent needs. Social work in health care responds to people's diverse and complex needs once they encounter any healthcare setting (Ashcroft 2014; Auslander 2001; Browne 2006; Dhooper 2012). This interface with health care settings places people in direct contact with social workers regarding disease and its impact, simultaneously allowing them to address other needs. Social work in health care fulfils the imperative role of addressing any social determinants of health (SDH) to enable compliance and adherence to treatment (Bywaters and Ungar 2010; Moniz 2010). This implies that social work in health care is valued for counselling and addressing the SDH.

Concurrently with the political transformation of South Africa, important health reforms were mandated (Petersen and Pretorius 2022). The political restructuring of healthcare settings was imperative to address inequalities and mandate equity and accessibility to healthcare facilities in South Africa (Benatar 1997, 2004; Benatar, Sullivan and Brown 2017; Dennill, King and Swanepoel 2000; Kautzky and Tollman 2008; Rispel and Moorman 2010; Venturino 2013). The White Paper for Social Welfare (Republic of South Africa [RSA] 1997a) was issued simultaneously with the White Paper for the Transformation of the Health System (RSA 1997b). As a framework for the health care system, the White Paper for the Transformation of the Health System (RSA 1997b) identified areas and processes of transformation. These included reorganising the health sector, identifying focus areas for essential health services (for example. mother and child health) and clarifying the role of medical doctors and other professionals who form part of the health care system. Further health care reform was directed at improving government assistance, emphasising the re-engineering of primary health care, implementing the National Health Insurance (NHI), performance management and quality assurance (Benatar 1997; Benatar et al. 2017; Bradshaw 2008; Oliver et al. 2011; Venturino 2013). Ruff, Mzimba, Hendrie and Broomberg, (2011) and Venturino (2013) maintain that successful healthcare reform hinged on addressing the country's economic disparities.

The history of social work practice and social work in health care has been well described and recorded in the literature. Auslander (2001), Borst (2010), Dhooper (2012), Ruth and Marshall (2017), Segal, Gerdes and Steiner (2018) and Skidmore, Thackeray and Farley (1994) have given accounts of the establishment of social work in health care as well as the diverse application of this profession in health care, albeit shaped by the demands of the multi-disciplicary teams (MDTs) and charity work. Internationally and in South Africa, social work in health care started as charitable or voluntary work (Carbonatto 2019). Social work in health care in South Africa, however, had to contend with segregation in service provision until the early 1990s in line with the country's political development. From this point onwards, social work in health care transformed into a specialist field, encompassing health promotion and prevention as well

as a range of psychosocial strategies to aid patients in various ways (Carbonatto 2019; South African Council for Social Service Professions [SACSSP] 2008b). It should be noted that the registration of social work in healthcare as a speciality is in the pipeline with the South African Council for Social Service Professions (SACSSP). On the 2nd of February 2018 the then Minister of Social Development Bathabile Dlamini called for comments on the regulations of specialisation in social work in healthcare.

Chapter 3
Theories of social work in mental health care

Introduction

Payne (2014) argues that social work theory succeeds best when it contains all three elements of theory, model and perspective. Theory, model and perspective are all important in understanding the role and significance of social work theory (Teater 2015). In a strictly scientific sense, theory refers to a coherent description of a process of inference which provides an explanation for observed phenomena or makes predictions about those phenomena (West and Brown 2013). Theories attempt to explain why, when and how certain behaviours may or may not occur and indicate the main sources of influence to change the targeted behaviour (Michie et al. 2014). A theory used in social work must, in other words, provide an integration of acquired knowledge about the relevant mechanisms of action and conditions for mental health and social change. The belief in the application of theory as an effective way of building knowledge in social work can be traced back to the writings of Ernest Greenwood, who regarded a 'systematic body of knowledge a significant attribute of the profession' (Greenwood 1957: 45).

Beckett and Horner (2016: 238) describe social work theory as 'a practice guided by a set of ideas or principles, which are sufficiently coherent to be made explicit in a form which is open to challenge'. Payne (2014) argues that theory offers a framework for social professionals and helps them to be accountable and self-disciplined. Yet to this day, there is neither a universal definition of 'theoretical underpinning' nor an articulation of criteria for proper theory use in social work methods. Considering this, one can argue that a social work method has a strong theoretical underpinning when it meets the following requirements: (1) the method presents a coherent and explicit vision of what should lead to behavioural and social change; (2) this vision is supported by relevant theoretical notions from the literature; and (3) the theories are incorporated into the method in such a way that they logically connect to problem definitions, programme goals and target groups. A theory explains or predicts situations and provides a rationale as to the course of action that is needed to alleviate presenting problems (Teater 2015).

A model is an organised set of guidelines and procedures, which is based on research and practice experience, and which can offer a solution to problems (Compton and Galaway 1994). A model is therefore the operationalisation of theory and practice. A model is a structured and organised description of what generally happens in a particular type of situation (Teater 2015). A perspective is basically how we look at things or our point of view. Furthermore, different people have different perspectives. When we use different perspectives, we might see the same scene or objects in different ways (Payne 2014). A

perspective is a particular value base or point of view that informs how one sees the world. A method is the course of action taken to alleviate or diminish the presenting problem (the method is often used interchangeably with intervention, practice, or approach). The choice of method is based on the theories that have been used to explain the current situation (Teater 2015). Theories are critical in social work in mental health care therefore, as they help social workers to assess presenting problems of mental health care users (MCHUs). They also assist in understanding the users' pressing needs and subsequently, social workers can develop and predict interventions and later evaluate the outcomes of the interventions. The theories explained here are the following: ecological systems theory, the socio-ecological system and the biopsychosocial-spiritual model.

Ecological systems theory

Bronfenbrenner's ecological paradigm was first introduced in the 1970s (Bronfenbrenner 1994). Bronfenbrenner (1994) and Turner (2005) argue that it is critical to gain a full understanding of human development and how growth happens and that it is essential to focus on the ecological system in its entirety. Furthermore, Lee and Greene (2009) believe that the interface between an individual and the environment sometimes yields unfavourable life conditions. To Bronfenbrenner, people are active role players in their development and the way they view their environment is often vital in understanding their environmental settings (Rogers 2013). Härkönen (2007: 1) asserts that 'Bronfenbrenner did not create his theory out of nothing. He has transformed Kurt Lewin's human behaviour formula to suit straight development description needs.'

In the ecological systems theory, the social worker not only works with the individual but also intervenes within the family, culture and social factors that are negatively impacting the individual's functioning (Bila 2019). Bronfenbrenner (1994: 39-43) identified 'the ecological system as composed of five socially organised subsystems that support and guide human growth'. These systems include Microsystems, Mesosystems, Exosystems, Macrosystems and Chronosystems. Wakefield (2013) asserts that social work has adopted these systems into three broad practice categories consisting of micro, meso and macro levels of intervention. However, Jeno (2014) states that the ecological model focuses on interventions that occur not only with individuals but also within the context of their environments that are interdependent upon one another. Furthermore, Wakefield (2013) asserts that the social worker not only works with the individual but also intervenes with the family, culture and social factors that impair the individual's functioning. The main aim of applying the ecological systems theory in practice is to improve the fit between people and their environment by alleviating life stressors, increasing people's personal and social resources to enable them to use more and better coping strategies and influencing environmental forces so that they respond to people's needs (Tong and Shidong An 2024).

Social work has sought innovative ways to conceptualise the relationship between the individual and the environment (Gray and Webber 2013). These authors further state that the ecological systems theory is relevant to social work as it provides a comprehensive, multi-disciplinary and holistic framework within which the complex and interrelated elements of peoples' lives can be connected and understood. The theory embodies meaningful attempts to integrate the psychological and sociological dimensions of social work practice and supports a conceptual shift from a static to a dynamic view of the environment (Gray and Webber 2013).

Living with a mental health condition is associated with stigma and discrimination and certain environmental factors do not facilitate the recovery process. Therefore, this theory has proved to be very useful as it facilitates an understanding of how people living with mental disorders are perceived and treated and how a recovery-oriented mental health practice can be applied to facilitate a perfect fit for mental health care users within their environment. Furthermore, rural areas and urban areas have different landscapes of mental health services and environmental factors would consequently affect MHCUs differently. The image below illustrates the five integrated systems.

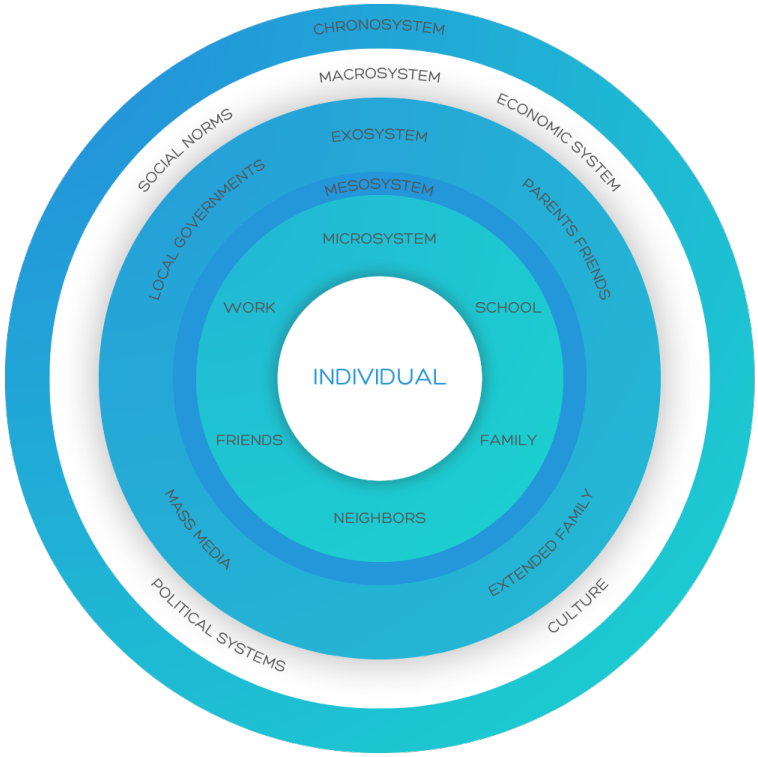

Figure 3.1: The five integrated systems of the ecological model

Socio-ecological Model of Mental Health

The Socio-Ecological Model of Mental Health (SEM) is a theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviours and for identifying behavioural and organisational influence points and intercessors for health promotion within organisations (Singh et al. 2021). Based on ecological systems theory (EST), the SEM was first introduced by Urie Bronfenbrenner, who posited that human development is shaped by several systems or contexts (Bronfenbrenner 1979, 1986). McLaren and Hawe (2005: 9) define the SEM as 'a conceptual framework designed to draw attention to individual and environmental determinants of behaviour'. An SEM offers a way to simultaneously emphasise both individual and contextual systems and the interdependent relations between these two systems and thus offers a variety of concepts for organising and evaluating mental health interventions (Stokols 1996). Lakhan and Ekúndayò (2013) assert that SEM can contribute significantly to the treatment and prevention of depression both at the secondary and tertiary levels. It also can be used as an important framework for spreading awareness among the masses (Lakhan and Ekúndayò 2013). They further state that SEM may be a useful approach in treating and rehabilitating individuals with depression in the community (Lakhan 2013). Additionally, this may require some degree of community sensitisation, empowerment and mental health advocacy (Lakhan and Ekúndayò 2013). The SEM was created to help shift the narrative about mental health and mental illness from an individual issue to include the social and environmental responsibility of others (Biglan et al. 2012). The model also helps to shift the mental health narrative from one focused on illness to mental well-being or flourishing (Keyes 2013). The context that the SEM provides assists in considering the range of strategies available to promote healthy development and mental well-being. The table below depicts the levels of SEM and its application in practice.

Table 3.1: Levels of SEM and application in practice

Socio-Ecological Model Level	Intervention Activities	Intervention Targeted
Intrapersonal	Education/training/skills enhancement of target population.	• Knowledge of intervention participants • Perception/attitudes of affected populations • Stages of change/behavioural intentions • Self-efficacy
Intrapersonal	Education/training/skills enhancement of people who interact with the target population (for example, family members, friends, teachers and co-workers). Modifications to home/family Environments.	• Perception/attitudes of social networks • The behaviour of social networks, including the provision of social support • The makeup of social networks
Institution	Education/training/skills enhancement of the institution members beyond the target population and immediate contacts, including institutional leaders. Modifications to institutional environments, policies or services.	• Perception/attitudes of institution leaders • Institutional culture • Institutional policies • Institutional physical environment • Institutional capacity
Community	Education/training/skills enhancement of the general community beyond the target population and immediate contacts, including community leaders. Modifications to institutional environments, policies or services.	• Delivery of community services • Community physical environment • Community capacity
Policy	Education/training/skills enhancement of the general community beyond the target population and immediate contacts specific to policy change Creation or modification of public policies.	• Capacity for policy advocacy • Social norms • Perception/attitudes of policymakers • Public policy (creation or enforcement)

Adapted from Golden and Earp (2012)

The table above depicts how the socio-ecological model of mental health can be applied in practice. To be effective, the Socio-Ecological Model takes into consideration the individual and their affiliations to people, organisations and their community at large. There are five stages to this model: Individual, Interpersonal, Organisational, Community and Public Policy. The adoption of the SEM will help to better understand the landscape of mental health in a

South African context. Therefore, improving mental health services quality and accessibility will ensure effectiveness in meeting the needs of people with mental and psychosocial disabilities which, in turn, increases their potential to live fulfilling and productive lives.

Lakhan and Ekúndayò (2013) comment that the socio-ecological model can contribute significantly to the treatment and prevention of depression both at secondary and tertiary levels. It also can be used as an important framework for spreading awareness among the masses. Therefore, the authors state that this model may be a useful approach to treating and rehabilitating individuals with depression in the community. This may require some degree of community sensitisation, empowerment and mental health advocacy.

Singh et al. (2019) assert that various social and ecological factors (poverty, economic burden, low socio-economic status, poor social support, stigma and discrimination, social change, education and climate change) are associated with mental health:

Poverty: A systematic review of the epidemiological literature on common mental disorders and poverty in low and middle-income countries found that of the 115 studies reviewed, over 70 per cent reported positive associations between poverty and common mental disorders (Lund et al. 2010). Multiple studies in India concluded that poverty is an important risk factor for common mental health disorders. Systematic reviews showed that around 79 per cent of studies revealed positive associations between poverty and common mental disorders (Patel et al. 2006; Brinda et al. 2016). Depression and emotional distress categorised as somatic symptoms are strongly associated with poverty (Mohindra, Haddad and Narayana 2008; Raguram et al. 1996). Poverty and mental health are linked in an intricately negative vicious cycle. Persons with lower socio-economic groups are more vulnerable to mental health problems because of the inability to afford for mental health services and well-being services (Ministry of Health and Family Welfare, Government of India 2014).

Economic burden: In some studies, a relationship between economic burden and mental health has been found. A population study in England, Wales and Scotland found there is a greater likelihood that people more in debt will develop some form of mental disorder, even after adjustment for income and other socio-demographic variables (Jenkins et al. 2008). Indian studies have shown that poor economic burden is independently associated with common mental disorders (Shidhaye and Patel 2010; Kuruvilla and Jacob 2007).

Low socio-economic status: A systematic review of the literature found that the prevalence of depressed mood or anxiety was 2.5 times higher among young people aged 10 to 15 years with low socio-economic status, than among youths with high socio-economic status (Lemstra et al. 2008). A longitudinal Indian study on 5703 individuals showed that poor socio-economic conditions are associated independently with common mental disorders and increase the chances of relapses (Shidhaye and Patel 2010).

Poor social support: A longitudinal global study on individuals from Australia and India revealed a high level of depression, post-traumatic stress and suicidal ideation because of poor social support (Cheng et al. 2014).

Stigma and discrimination: Stigma and discrimination related to mental

health status also have effects on mental health outcomes and disparities in health care, education and employment outcomes (Hatzenbuehler, Phelan and Link 2013). Delays in accessing mental health care due to stigma and discrimination (Clement et al. 2015) or experiences of stigma and discrimination within the health care system may reduce the quality of care that individuals receive (Thornicroft, Rose and Kassam 2007).

Social change: Researchers in India conducted a community-based study in a rural area, related to mental disorders in rural areas. Twenty years after a similar study was conducted in the same areas and by comparing both studies it was found that overall rates of mental disorders had changed. The rates of depression had increased from 4.9 per cent to 7.3 per cent (Nandi et al. 2000). The World Health Organization commented that rapid social changes such as the experience of insecurity and hopelessness, the risks of violence and physical ill-health may make the poor vulnerable to common mental disorders (World Health Organization [WHO] 2010).

Education: Studies have highlighted that Illiteracy or poor education is a risk factor for common mental disorders. The relationship between low educational level and mental disorders may be a confusing association so it is explained by considering several pathways, these include malnutrition, which impairs intellectual development, leading to poor educational performance, and poor psychosocial development (Araya et al. 2001; Patel and Kleinman 2003)

Climate change: Adverse effects of climate change affect mental health through direct and indirect pathways, leading to serious mental health problems, possibly including increased suicide mortality (Bowen et al. 2012; Page and Howard 2010). Mental health encompasses emotional, psychological, behavioural and social well-being and is associated with the normal stress of life and function within the community. Mental illness, on the other hand, adversely affects one's thinking, feelings and/or behaviours (Bowen et al. 2012). As a result, it can lead to difficulties in functioning. Climate change can cause and intensify stress and anxiety, adversely affecting mental health (Page and Howard 2010). For example, frequent temperature changes can lead to depression, anger and even violence. Targeted populations that are prone to developing mental health issues due to climate change are children, the elderly and women (Bowen et al. 2012; Page and Howard 2010).

The socio-ecological systems approach paves the way for taking into regard varying levels of environmental influences that impact and interact with an individual's feelings, behaviour and overall functioning. It justifies the viewpoint that to understand the individual and his problem/s, his/her social context, environment, family factors and socio-ecological perspective must be taken into consideration. It also advocates that intervention should be made at every level to strengthen resilience and remove or reduce negative features associated with an individual's social functioning. The model also highlights the interdisciplinary collaborative approach to address diverse problems within the society. It thus provides a matrix for determining and directing strategies that can together comprise a consistent, coherent response with cumulative force to effect positive change in the settings of concern. The promotion of positive mental health in the workplace is also an integral part of the socio-ecological model.

Life skills training and awareness programmes on common mental disorders (like depression, anxiety, stress reduction, alcohol and tobacco use) can strengthen the individual and society.

The socio-ecological model also advocates creating opportunities for better care, employment, educational and income-generation activities for persons with mental disorders. Legal, social and economic protection is also an important aspect of mental health. People should be aware of their rights, service delivery systems, the Right to Information Act and self-help groups for persons with mental disorders. Identifying risks and protective factors of common mental disorders by the agencies can be very helpful. A comprehensive understanding of the rehabilitation needs of the mentally ill at the district and state levels along with a longitudinal follow-up of affected individuals can be beneficial initiatives.

Biopsychosocial-Spiritual Model

The Biopsychosocial-Spiritual (BPSS) approach is a theoretical framework developed by Engel (1977, 1980) and adapted by Wright et al. (1996) to promote a holistic conceptualisation of illness and health. According to Engel (1980), a patient's experience is the result of the intersection of biological, psychological and social factors operating on multiple levels of the system (that is, societal-national level, cultural-subcultural level, community and family levels and the individual level). Wright et al. (1996) highlighted spirituality giving way to the Biopsychosocial-Spiritual approach. King (2000) describes the spiritual role in determining one's mental health status. To date, although this biopsychosocial model is helpful in the therapy of mental health issues, Saad et al. (2017) state that most researchers still argue that biopsychosocial models need to be expanded by involving spiritual dimensions. This is also supported by Taukeni (2019) who stated that one of the criticisms of the biopsychosocial model is that this model lacks a comprehensive dimension which is the spiritual dimension. Since the 1990s, this spiritual dimension has been integrated into various practices, with compelling evidence other barriers that weaken mental health services. Thus, in such a context, the complexity of and resistance to decentralisation of mental health services, challenges to implementation of mental health care in primary care settings, insufficient number of trained mental health providers and the frequent scarcity of public-health perspectives in mental health leadership are among the foremost predictors of poor utilisation of mental health services (Abdelgadir 2012; Mojtabai et al. 2010; Molodynski, Cusack and Nixon 2017).

The 1994 genocide against the Tutsi in Rwanda killed more than a million people in only a short time (Barrow 2016), affecting nearly all Rwandans and its effects remain as one of the factors behind a higher rate of mental disorders. Although the government of Rwanda has made efforts to combat mental disorders associated with this massacre through availing financial and human resources for providing appropriate mental healthcare services, the provision of efficient and effective mental services remain a challenge (Berckmoes et al.

2017; Negash et al. 2020). Studies later found a remarkable improvement in the provision of mental health services due to an increase in financial and human resources and an increase in the quality of the services provided (Mutuyimana et al. 2019). Evidently, the main challenges faced by staff in caring for service users with mental disorders included the lack of compliance to medical prescriptions, service users not respecting the appointments, difficulties related to families not supporting their patients, high costs of medications, poor affordability, stigmatisation and difficulties related to families not collaborating with service users' caregivers (Muhorakeye and Biracyaza 2021), highlighted by Shweder and Much (1994). Their research underscores the incorporation of spiritual frameworks into mental health paradigms, particularly in non-Western countries (Shweder and Much 1994).

Koenig (2018) observed that patients or clients with robust religious beliefs, whose spiritual needs are adequately addressed, often set and achieve more successful goals for self-improvement. Conversely, those lacking in these spiritual dimensions may face greater challenges. Koenig (2018) contends that performing a spiritual assessment to identify and address these deficiencies, followed by referrals to a trained health team, can markedly improve healthcare outcomes. Through their study, Kusnato, Agustian and Hilmanto (2018) proved that mental health teams that apply biopsychosocial models and involve the spiritual dimension in promoting health and self-management treatment can achieve good responses and positively impact MHCUs. Apart from that, Trout et al. (2018) also suggested that biopsychosocial and spiritual models should be applied to smoking cessation interventions among hospital patients. The figure below depicts the biopsychosocial spiritual perspective.

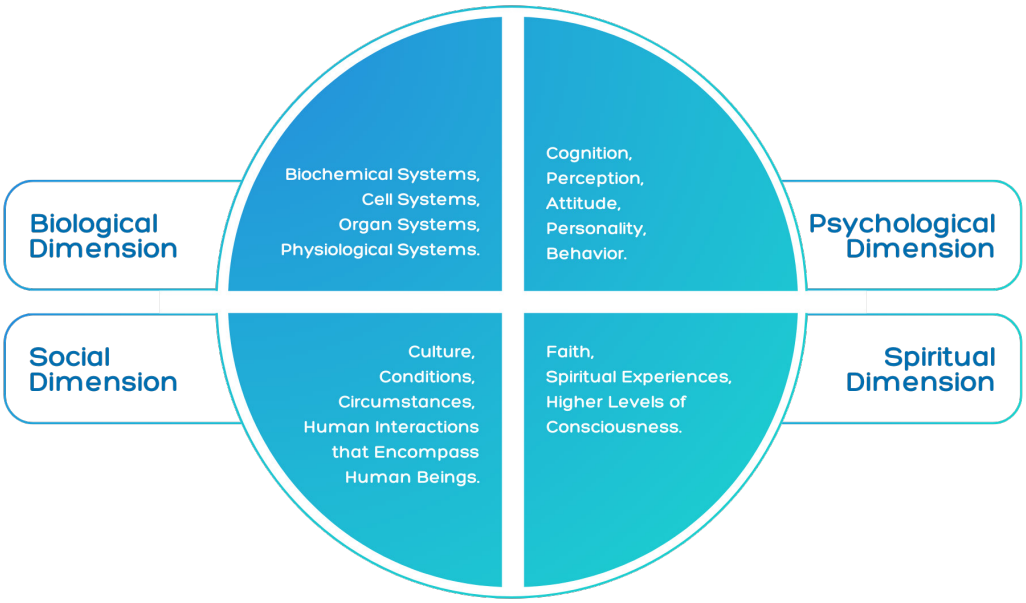

Figure 3.2: University of Nevada, Reno, Biopsychosocial-spiritual model (n.d.)

According to this model, everyone has a spiritual history. For many persons, this spiritual history unfolds within the context of an explicit religious tradition.

Regardless of how it has unfolded, however, this spiritual history helps shape who each patient is as a whole person and when life-threatening illness strikes, it strikes each person in his or her totality (Ramsey 1970). This totality includes not simply the biological, psychological and social aspects of the person (Engel 1992), but the spiritual aspects of the whole person as well (King 2000; McKee and Chappel 1992). This biopsychosocial-spiritual model is not a 'dualism' in which a 'soul' accidentally inhabits a body (Sulmasy 2002: 24). Rather, in this model, the biological, the psychological, the social and the spiritual are only distinct dimensions of the person and no one aspect can be disaggregated from the whole. Each aspect can be affected differently by a person's history and illness and each aspect can interact with and affect other aspects of the person (Sulmasy 2002).

The social work profession is unique among healthcare disciplines in its emphasis on assessing and treating the MHCU from a person-in-environment perspective, meaning that social workers conceptualise the client and his or her physical and mental health needs as existing within a social context. The social worker not only looks at psychological or physical needs but also assesses how the client is affected by his or her environment and how the client's spirituality influences his or her overall sense of well-being. Spirituality can be defined as one's religious beliefs and practices as well as one's sense of purpose and meaning in life. As the term indicates, a biopsychosocial-spiritual assessment evaluates the MHCU in four domains: biological, psychological, social and spiritual (Lacks and Lamson 2018: 707). The assessment is both the process of gathering information about these domains and their interconnectedness and a written document that is used to determine treatment goals and objectives for the MHCU.

Biopsychosocial-spiritual assessment is a holistic approach to understanding the client's experiences, including his or her physical and mental health (Khalid and Naz 2020).

The biopsychosocial-spiritual assessment is the primary means used by the sociarker to evaluate an MHCU's treatment needs. Oxhandler and Giardina (2017) concur that assessment consists of a variety of activities and processes used to gather information about an MHCU's current circumstances, needs, risk and protective factors and the environmental context within which these elements exist. These elements are organised into a written document which is used to determine treatment goals and objectives (Oxhandler and Giardina 2017). In mental health settings, the biopsychosocial-spiritual assessment is also used to help determine the mental health diagnosis for the MHCU (Norris, Clark and Shipley 2016). While the specifics of each assessment will vary based on the MHCU's age and challenges, a biopsychosocial-spiritual assessment will always include information from all four domains (San Antonio et al. 2014).

For social workers working in a mental health setting, a biopsychosocial-spiritual assessment will include the identification of a DSM-5 diagnosis, as well as supporting information on how the client meets the diagnostic criteria. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the standard classification of mental disorders used by mental health professionals (American Psychological Association [APA] 2013). Currently in its fifth edition (DSM-5), the

DSM is sometimes referred to as psychiatry's bible (APA 2013). The DSM applies to a wide array of contexts (APA 2013). Clinicians and researchers of different orientations such as biological, psychodynamic, cognitive, behavioural, interpersonal and family/systems use the DSM (Clarke et al. 2013). The DSM-5 was designed for utilisation in inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice and primary care settings (Clarke et al. 2013).

The DSM is commonly referenced by social workers, particularly by clinical social workers practising in the field of mental health (Olckers 2013). DSM diagnoses help social workers and other mental health professionals understand clients, guiding their interventions from an evidence-based perspective (Olckers 2013). Diagnosis helps professionals with goal setting, treatment planning and determining a client's prognosis and having a common jargon for diagnoses also facilitates research (Barsky 2015). Despite the widespread use of the DSM, social workers should be cognisant of the ethical issues that may arise in the context of using this diagnostic tool (Barsky 2016).

The social work value of 'respect for the dignity and worth of all people' (in the National Association of Social Workers (NASW) 2024c; see Chapter Seven) can be translated into ethical guidelines such as being nonjudgmental and building on client strengths. Diagnosing a mental disorder, however, is essentially an exercise in judging clients and focussing on their pathologies or weaknesses (Olckers 2013). So, does this mean that using the DSM to diagnose clients runs contrary to social work ethics (Barsky 2016)? Although some professionals might argue that DSM diagnoses violate the principles of non-judgmentalism and strengths-based practice, others might argue that such diagnoses are ethically justifiable under the principle of beneficence, doing well. As noted earlier, providing diagnoses serves clients by providing a framework for selecting appropriate, effective interventions (Barsky 2016).

Thus, in terms of respect, social workers who use diagnoses should avoid language that reduces the person to a diagnosis – for example, 'He is a borderline personality,' or 'She is a schizophrenic.' Rather, they should use language that separates the person from the problem – for example, 'He is a person with borderline personality disorder,' or 'She is coping with schizophrenia' (Barsky 2016). Social workers should also ensure that they provide holistic assessments, not just focussing on problems or psychopathologies. A holistic assessment highlights client strengths and considers clients in the context of their social environments, including their family, friends, co-workers, neighbours, and other social support systems. A holistic assessment includes psychological functioning and problems but also includes social functioning, spirituality, physical health, and coping abilities (Barsky 2016).

The advantages of using DSM as stipulated by Olckers (2013) include:

i. The use of the DSM system will lead to improved treatment of individuals. Social workers in the mental health field are responsible for making diagnostic decisions and formulating their treatment plans according to the

diagnosis.

ii. Social workers must be able to communicate with their colleagues to maintain a position as members of a multi-disciplinary treatment team.

iii. The DSM system can serve as a comprehensive educational tool for teaching about psychopathology and mental disorders.

iv. Social workers will be enabled to conceptualise clients' problems.

v. Social workers will establish their professional status by utilising the DSM system.

Torrey (2009 in Olckers 2013: 69) refers to the International Statistical Classification of Diseases and Related Health Problems, 10th edition, as ICD-10. ICD codes are alphanumeric designations given to every diagnosis, description of symptoms and cause of death attributed to human beings. The World Health Organization (WHO) develops, monitors and copyrights these classifications. The ICD-10 coding provides for each mental health disorder (Kaplan et al. 1994). Therefore, social workers in the mental health field should be equipped with knowledge of how to interpret these diagnostic tools.

The focus of treatment efforts should be established and written into the MHCU's treatment plan. The roles and tasks of a social worker, the MHCU, the family and other significant collaterals who will be involved in the treatment process should be included. Social workers should conduct a comprehensive biopsychosocial-spiritual assessment, integrating the core principles of social work practice. These encompass the pivotal aspects of respecting human rights, preserving human dignity, advocating for social justice, and upholding professional conduct. These principles are explicitly outlined in the International Federation of Social Workers (IFSW) Global Social Work Statement of Ethical Principles (2018) and the SACSSP code of ethics (2005). Integrating these foundational principles is integral to the effective execution of the biopsychosocial-spiritual assessment.

Medical model

The medical model is the dominant model within medical organisations regarding mental health (Huda 2021). The medical model is used by medical professionals to diagnose and treat mental ill health on the pretext that all mental health issues are generic or chemical imbalances and that those illnesses can be treated with medication or medical treatments (Deacon 2013). The medical model approaches mental health disorders akin to physical illnesses, a comparison that, to some extent, may not always be feasible or applicable.

If someone has a bad heart or lungs for example, then medication can in all probability heal their issues but if someone has a bad mind then medication can perhaps help them in the short term, but will the medication fix or cure them

in the long term (Huda 2021)? While drugs can provide quick fixes, there are significant concerns about potential side effects and the long-term damage they may cause to the body. Obviously, with other non-medical models, this would not be the case (Huda 2021). The medical model's perspective would presume that social, cultural and environmental issues that are present in an individual's life are a result of the medical condition rather than part of it (UK Essays 2015).

Traditionally, the hospital social worker takes on numerous roles within the medical model. It is common for the role of the social worker to shift depending on the medical facility (Tadic et al. 2020). Their role could differ in community-based teaching hospitals, non-profit medical facilities, university-affiliated hospitals and county hospitals, as each setting takes on its own culture and model of practice (Tadic et al. 2020). The interpretation of the social worker's role also fluctuates depending on the type of medical setting and available financial funding within each institution (Gilbelman 2003). Gregorian's (2005) research exploring the multifaceted role of the medical social worker found that there are numerous roles one can hold and within a multitude of medical settings. There are many hospitals in which the social worker holds the responsibility of discharge planning, including collaboration with community mental health agencies, as well as assisting patients and families with community resources while on inpatient units and thereafter hospitalisation. Yet, in other medical facilities, discharge planning is assigned to the hospital's nursing staff and clinical care coordinators and the social work departments are primarily focused on the psychosocial concerns and needs of the patients and families. Today, many medical institutions include social workers as part of the medical team and consider social workers to be the primary providers of emotional support to patients and families (Gregorian 2005). It is also evident in most medical facilities that social workers regularly hold multiple roles with various responsibilities, including but not limited to: patient and family counselling, community referrals, discharge planning, interdisciplinary team consultation, collaboration and treatment planning, psychosocial assessments, child abuse assessments, grief counselling, crisis intervention, medical team meetings and seminars, new diagnosis meetings and multi-purpose family conferences (Gregorian 2005). These roles can vary depending on the medical setting, available funding and primary patient unit within the hospital (Gregorian 2005).

Medical social workers are involved in various responsibilities and make multiple contributions to the medical model, which helps social work departments around the country maintain importance and necessity within the hospital setting. However, the various roles can also create confusion and differing opinions on the skill set of the medical social worker. The more misinterpreted this role is, the less likely social workers will be able to serve their patients and families best and most effectively within the hospital. Social work departments within hospital settings must remain valuable to the medical model within their respective institutions. However, Cowles (2000) states that because of the financial demands on many hospital facilities, social service departments are often the first to downsize and receive cost cuts. For social work services and practices to be used most effectively, the medical model should incorporate the skills and immeasurable importance of the hospital social worker, ensuring that

patients receive the necessary referrals from the medical team and are afforded appropriate time for psychological care (Cowles 2000).

As seen in Mizrahi and Abramson's (2000: 18) study on the perceived role of the social worker from a physician's standpoint, researchers suggested that most physicians were 'less likely to perceive patient problems related to the hospital environment or accessing community resources ... many physicians have only a limited grasp of the complexities of social work intervention in these arenas.' Furthermore, most physicians did not interpret the clinical social worker as proficient in delivering psychological counselling services for patients and families (Mizrahi and Abramson 2000).

Zigmond (1976) asserts that the medical model does not lend itself to understanding factors that are outside of measurable and quantifiable data such as the importance of psychological and social stressors on the individual. Traditionally, the mental health arena is highly influenced by the medical model where severe mental disorders are considered chronic with irreversible neuropathological brain changes and processing deficits. Mental health recovery seems like an impossible dream (Jeno 2014). Many health systems have traditionally adopted a medical view of mental disorders based on diagnostic categories such as schizophrenia, bipolar disorder and personality disorders. The emphasis has been on looking for pathologies or symptoms in people with mental illnesses based on the diagnostic criteria for mental disorders (Xie 2013). The Diagnostic and Statistical Manual of Mental Disorders (DSM) is an evolving document that serves the many mental health care disciplines as the primary reference guide for classifying mental disorders (Pilecki, Clegg and McKay 2011). While the successive framers of the DSM-5 have attempted to base it on scientific evidence, political and economic factors have also shaped the conceptualisation of mental illness. These economic and institutional forces have reinforced the DSM's use of a medical model in understanding psychopathology (Pilecki et al. 2011). As healthcare providers paint a gloomy picture of MHCUs, MHCUs also view themselves in a negative light (Xie 2013). They often realise that they are different from others. They may isolate themselves, which per se, affects their self-esteem (Xie 2013). In MHCUs with low self-esteem, a compromised quality of life (QoL) and poor psychosocial functioning are often observed (Brekke, Kohrt and Green 2001). MHCUs with such negative self-appraisals perform badly in the community and are more likely to relapse (Wright 2000), thus impeding their recovery.

Therefore, instead of employing the traditional medical model, which emphasises pathology and focuses on problems and failures in people with mental illnesses, the adoption of recovery-oriented models will be appropriate. Hence, a strengths-based perspective is more appropriate when working with people with mental disorders.

Strengths-based perspective

The World Health Organization (WHO) 2001, states that mental illnesses rank first in terms of causing disability as compared to other diseases. In 1979, the term 'salutogenesis' was coined by Aaron Antonovsky, a professor of medical sociology, to go beyond looking at disease to focus on factors that support human health and well-being (Antonovsky 1979). The strengths-based approach does this by focussing attention on individuals' attributes that promote health, instead of focussing on symptoms and pathologies that induce sickness (Xie 2013). The strengths-based perspective is a dramatic departure from conventional social work practice (Saleebey 2006). Social work, as is the case in other helping professions, has not been immune to the difficulties caused by mental disease and disorder-based thinking. Social work has constructed much of its theory and practices around the supposition that MHCUs are mentally ill because they have deficits, problems, pathologies, and diseases and that they are in some way flawed or weak (Miley, O'Melia and DuBois 2011). This orientation arises from a past mired in the conviction among social workers that all MHCUs are morally defective, poor, despised and deviant (Saleebey 2006: 2). In the past few years, there has been an increasing interest in developing a strengths-based perspective to practice case management with a variety of MHCU groups such as the elderly, youth in trouble, people with addictions, people with chronic mental illness and even communities and schools (Saleebey 2006). In addition, rapidly developing literature, enquiry (research) and practice methods in a variety of fields bear a striking similarity to a strengths-based perspective (Saleebey 2006). These methods are developmental resilience, healing and wellness, solution-focused therapy, an asset-based community and narrative and story therapy (Saleebey 2006).

The strengths-based approach aligns itself with the notion of mental health recovery by focussing on a person's ability, helping them develop the confidence to embark on the journey of recovery and aiding them to progress towards mental health recovery. Attention is placed on people's abilities rather than their shortcomings, symptoms, or difficulties. Mental health issues are seen as a normal part of human life (Shanley and Jubb-Shanley 2007). MHCUs' positive attributes, including assets, aspirations and interests are elicited and cultivated. Gable and Haidt (2005) assert that an understanding of strengths can help to prevent or lessen the damage of disease, stress and disorder. It has been suggested that people have strengths within themselves that can contribute to recovery. Personal factors could aid the recovery process (Deegan 2003). Strengths have been linked to the prediction of positive outcomes. Mental health care approaches in the community setting have moved in the direction towards encouraging people to cultivate their interests, identify and build their strengths to advance change at a macro level in communities (Davidson et al. 2006).

Recovery-oriented mental health practice can instil dignity in MHCUs. If the playing fields are levelled and MCHUs are supported and their strengths are tapped, they can lead a fulfilling life. This is underscored by Saleebey (2006),

who asserts that the process of recovery from serious and persistent mental illness is currently at a promising stage; few areas of enquiry in the field have drawn as much interest and enthusiasm among consumers and professionals alike. The strengths-based perspective is predicated on the central premise that all people should have access to social resources. Therefore, professional services guided by a strengths model, principles and practices are ideally positioned to advance the process of recovery. Professionals often serve as a bridge for MHCUs to advance the process of recovery.

Afrocentric/African perspective

The Afrocentric paradigm has its origin in the academic work of African American academics in response to the needs and issues of African people and people of African descent around the world (Graham 1999). The paradigm is particularistic in that its focus is the liberation of African people but is also universalistic in that it is grounded in the spiritual and moral development of the world (Graham 1999). While the term Afrocentric paradigm is used here, identical terms are found in literature including African-centred, Afrocentricity and Afrocentricity and Africology. The foundation of the paradigm is that for any study or work with African people or people of African descent, the African must be at the centre of the study as the subject and the paradigm is informed by African history, cultural values and worldview (Graham 1999). There are many interpretations of African values but in the paradigm, those that underpin an African-centred worldview are: the interconnectedness of all things and beings; the spiritual nature of human beings; collective/individual identity and the collective/inclusive nature of family structure; oneness of mind, body and spirit and the value of interpersonal relationships (Graham 1999).

Molife Kete Asante is the founder and principal theorist of Afrocentricity (Turner 2002). As argued by Asante (2006), Afrocentricity as a theoretical perspective and philosophy sought to convey the profound need for African people to be re-located historically, economically, socially, politically and philosophically from holding up the margins of the American and European world. This, according to Asante (2006: 647) would ensure that Africans free their minds and shift from being decentred to being centred on African cultural heritage. This would indeed, enable Africans to develop and promote their heritage and contribute to the world of knowledge. Afrocentricists contend that humans cannot divest themselves of culture (Asante 2006). He further asserts that Afrocentricity as a movement becomes the key to the proper education of children and the essence of an African cultural revival and indeed survival. According to Asante (2006), several key characteristics set apart and distinguish Afrocentrism as a unique paradigm from Eurocentrism. Firstly, contrary to the Eurocentric racial views that elevated the European experience and downgraded others, Afrocentrism had no racial or ethnic consciousness and no hierarchy. It does not claim to occupy all spaces and times. Secondly, Afrocentrism as a pluralist philosophy was characterised by respect for all cultural centres (Asante 2006: 649). Thirdly, while data takes precedence over the context in

the Eurocentric world, cultural context and location take precedence over data in the Afrocentric world. Fourthly, culture is the main driver in the orientation to centredness. Lastly, the individualism, nuclear family and competition found in the Eurocentric paradigm are countered by collectivism, communalism, cooperation and an extended family system in the African context demonstrated through *Ubuntu* (group consciousness and cohesion).

In the African-centred worldview, there is no separation of body, mind and spirit as they are regarded as having equal value and are interrelated. There is also an emphasis on the concept of balance and harmony to maintain psychological, social and physical well-being. The harmonious balance of body, mind and spirit leads to the attainment of optimum health and a harmonious existence based on peace with oneself and the external environment (Graham 1999; Schiele 2000).

The interconnectedness of human beings means that people are perceived as an integral part of nature and living in harmony with the environment helps them to become at one with all reality (Graham 1999). The interconnectedness has a spiritual dimension as it links all human beings spiritually across time and space (Graham 1999; Schiele 1997). This also links with the African concept of kwimenya (self-knowledge), an idea that suggests individual as well as a collective rediscovery and re-connection to traditional cultural roots (Maathai 2009; Mungai 2012). Cultural self-knowledge links one to others within that culture and the connection with others assists in spiritual development, well-being and transformation from an individualist focus to being part of a collective that is humanity (Graham 1999).

The collective identity emphasises our similarities as human beings rather than our individual differences. People who see themselves as connected in a collective are also likely to care for other individuals whom they perceive as part of their collective self. Spirituality is regarded as the key to understanding the interconnectedness of all human beings and other elements in the universe and the foundation of the concept of a collective identity (Schiele 1997). Individual uniqueness is still valued but it is also believed that harm to the individual is harm to the collective and vice versa. Mbiti (1970: 141) expresses this well with the expression *'ndim ngenxa yokuba sinjalo nangenxa yokuba sinjalo ngoko ndinjalo'* 'I am because we are and because we are, therefore, I am.' The Western approach tends to put emphasis on individual autonomy and rights, while traditional African societies tend to put more emphasis on family and community welfare.

It Is clear, therefore, that social work has its roots in Western theories and discourses, but these are not always compatible with cultural values of non-Western people especially those who have in the past been victims of Western imperialism (Mungai 2015). Afrocentric social work embraces the African worldview to be relevant to the needs of the African people. Furthermore, Thabede (2014) asserts that an Afrocentric viewpoint stems from the cultural values of people of African descent globally. This perspective harmonises with the core principles of social work, which emphasise universal values like human justice and compassion. Consequently, it remains consistent with the foundational ethos of social work, as highlighted by Graham (1999) and Schiele

(1997).

There are thus differences in the particular focus and a commonality in the universal core values. The distinguishing feature of Afrocentric social work is that the African person is placed at the centre to promote empowerment, growth, transformation and development (Graham 1999). The goals of Afrocentric social work are identified by Schiele (1997) as optimal thinking, fighting against political, economic and cultural oppression; building on community strength; engendering effective professional relationship and mutuality within the professional relationships. Afrocentric social work aims to assist in transforming people from suboptimal thinking to optimal thinking which implies holistic thinking. Optimal thinking seeks answers to problems and conflicts that bedevil our world and calls for a way of thinking that guides us from conflict to cooperation. A holistic approach views differences as interdependent rather than sources of conflict and, therefore, leads to better ways of working together for the satisfaction of all, despite the differences (Schiele 1997). Marginalisation is a reality for Africans and people of African descent through the long history of colonisation and racial discrimination (Mungai 2015). Overcoming marginalisation is, therefore, a major objective of Afrocentric social work, as well as ensuring that all cultural groups are treated equally in all respects.

Afrocentric social work promotes engaged social relationships that break down the boundaries of the helper and the helped which, in mainstream social work, would be regarded as professional heresy or de-professionalisation. Schiele (1997) argues that emotional connection leads to a more trusting and authentic helping relationship and transformation.

Accommodating other alternative worldviews would enrich, not threaten social work. To enrich social work and make the profession relevant in different parts of the world, a process of indigenisation should be recognised. Therefore, recovery-oriented mental health practice needs to be implemented within the context of the geographical area. For this practice to be relevant in a South African context it should recognise the importance of the Afrocentric perspective. It is appropriate then to discuss the *ubuntu* (humanity) perspective.

Ubuntu (humanity) perspective

Ubuntu, a philosophical concept that frames a particular world view and in turn structures behavioural expressions of humanity, has the potential to inform social scientists' understanding of broader aspects of the human experience including mental health (Engelbrecht and Kasiram 2012). *Ubuntu* is a Nguni Bantu term meaning 'humanity'. It is sometimes translated as 'I am because we are' (also 'I am because you are'), *'Ndim ngenxa yokuba sinjalo' (kwaye 'ndinguye ngenxa yokuba unjalo')*, or 'humanity towards others' *(umuntu ngumuntu ngabantu)* (Chasi 2021). In Xhosa, the latter term is used but is often used in a more philosophical sense to mean 'the belief in a universal bond of sharing that connects all humanity' (Mboti 2014; Battle 2007). *Ubuntu* is defined as 'an ancient African worldview, based on the primary values of intense humanness, caring, sharing, respect, compassion and associate values, ensuring happy and

qualitative human community life in the spirit of the family' (Fox 2010: 122).

Ubuntuism is an African philosophical framework that is characterised by the interconnectedness of all things and beings; the spiritual nature of people; their collective/individual identity and the collective/inclusive nature of family structure; oneness of mind, body and spirit; and the value of interpersonal relationships (Mungai 2015 as cited in Zvomuya 2020). The philosophy is known in different languages in Africa including *bomoto* (Congo); *gimuntu* (Angola); umunthu (Malawi); *vumutu* (Mozambique); *vumuntu, vhutu* (South Africa); *humhunu/ubuthosi* (Zimbabwe); *bumuntu* (Tanzania); and *umuntu* (Uganda) to mention but a few (Mupedziswa et al. 2019). Ubuntu is rooted in the sayings, *'Ndingumntu kuba unguye, ndinguye ngenxa yokuba ndabelana kwaye ndithatha inxaxheba' kwaye 'ndingenxa yabanye.'* 'I am a person because you are, I am because I share and participate' and 'I am because of others.' There has been a broad consensus among scholars that Ubuntu is an African philosophy expressing humanness in the values of compassion, solidarity, harmony, consensus, hospitality, sympathy and sharing among others (Mupedziswa et al. 2019).

The African construct of *ubuntu* has garnered increasing recognition in academic literature over the past years, arguably as part of a broader move towards foregrounding African constructions of the world and unravelling the legacy of colonialism (Ndlovu-Gatsheni 2018). *Ubuntu* has been taken up by a wide range of disciplines, including philosophy (Metz 2014), theology (Shutte 2001), nursing (Marston 2015), psychology (Mkabela 2015), leadership (Ndlovu 2016), literary studies (Stuit 2016) and anthropology (Mawere and van Stam 2016). It appears that *ubuntu* has a paradigmatic numinosity that appeals not only to African scholars but also to scholars across the world.

In social work, however, while *ubuntu* is a well-known concept (Twikirize and Spitzer 2019), there has been little work on articulating what *Ubuntu* means for this discipline. Mupedziswa et al. (2019: 21) are among the few to explicitly endeavour to make Ubuntu central to social work. The authors aim to explore its 'potential as a philosophical framework for social work practice in Africa'. *Ubuntu* is regarded by these and other authors (Mugumbate and Nyanguru 2013; Sekudu 2019) as consonant with the values and ideals of social work, notably 'human solidarity, empathy and human dignity' (Mupedziswa et al. 2019: 29). *Ubuntu* is regarded as a key concept in the broader context of indigenisation, Africanisation, or decolonisation of social work in Africa (Osei-Hwedie 2014).

Ubuntu's emphasis on human relationships and the notion that a person is only a person through these relationships with other people resonates with the ecological or person-in-environment (PIE) perspective in social work (Weiss-Gal 2008; Mbedzi 2019). The PIE has long been argued to be central to and even definitive of social work as a distinct discipline and profession (Strean 1979). However, ubuntu in social work goes further than most Western understandings of PIE, in that PIE tends to still focus on the individual (in their social context), while ubuntu focuses on the relationships (van Breda 2019). It has much in common with the African maxims, 'It takes a village to raise a child' (Mugumbate and Chereni 2019: 28) and 'your neighbour's child is your own [child]'

(Mugumbate and Nyanguru 2013: 86). *Ubuntu* thus decentres the individual as the prime unit of analysis and centres rather the relationships between people. van Breda (2019: 8) emphasises this when he writes, 'Relationship-centred resilience aligns well with African *Ubuntu* values, which emphasise social connections as the crucible of personhood.' *Ubuntu* is also associated with the core social work value of social justice, which refers to 'an ideal condition in which all members of a society have the same basic rights, protection, opportunities, obligations and social benefits ... [and] is also about ensuring that resources are equitably distributed' (Patel L. 2015: 147).

Agreeing with Wilson (2019) in relation to mental health, the ubuntu perspective has the following principles: connectedness, competence and consciousness. It is proposed that the term connectedness be used as a fundamental principle or theme of mental health for all individuals. More so, corresponding with Wilson (2019), connectedness refers to an individual's attitude and need to form social bonds; it serves as a psychological construct of belonging, whilst competency is a general repertoire of skills required for effective human functioning. Social competence is the relationship skills, flexibility and the ability to navigate between primary culture and dominant culture (cultural competence) (Wilson 2019). Consciousness – the state of awareness of internal and external activities – at its basic level features the interplay between perception and conception. Perceptual consciousness is the process of attaining awareness or understanding as experienced through the senses, revealing one's conscious understanding (Wilson 2019).

In the African context, individual identity is inherently interconnected with communal bonds. In the Xhosa language, a proverbial expression exists: *'awungekhe ube yinkomo edla yodwa'*, which translates to 'You can never be a cow that grazes alone'. This adage encapsulates a profound truth about the significance of social cohesion and interdependence. It is within this cultural framework that the essence of the book finds resonance, as it firmly grounds one of its foundational principles in this communal perspective.

Chapter 4
Mental health and its contextual dimensions: an overview

Introduction

Pre-pandemic, in 2019 an estimated 970 million people in the world were living with a mental disorder, 82 per cent of whom were in low- to middle-income countries (LMICs) (Kaur et al. 2022). Between 2000 and 2019, an estimated 25 per cent more people were living with mental disorders, but since the world's population has grown at approximately the same rate the (point) prevalence of mental disorders has remained steady, at around 13 per cent (World Health Organization [WHO] 2022). The international health community had already been advocating for mental health action for decades. But the WHO (2001) report marked a watershed moment in global awareness of mental health's importance, the prevalence and impact of mental health conditions and the need for a public health approach. Through its ten recommendations, the report provided one of the earliest and clearest global frameworks for action on mental health. It called on countries to provide treatment in primary care; make psychotropic medicines available; provide care in the community; educate the public; involve communities, families and consumers; establish national policies, programmes and legislation; develop human resources; link with other sectors; monitor community mental health; and support more research (WHO 2022).

Despite this progress, for most countries and communities, mental health conditions continue to exact a heavy toll on people's lives, while mental health systems and services remain ill-equipped to meet people's needs (WHO 2022). Nearly a billion people around the world live with a diagnosable mental disorder (WHO 2022). Most people with mental health conditions do not have access to effective care because services and supports are not available, lack capacity, cannot be accessed or are unaffordable; or because widespread stigma stops people from seeking help. Different belief systems, languages and idiomatic expressions around mental health across cultures influence whether, how and where people seek help. They also influence whether people recognise problems or experiences – their own and those of others – as concerning mental health (WHO 2022). The chapter will focus on the prevalence of mental health globally, in Africa and South Africa, human rights, social justice and mental health, social determinants of mental and legislative and policy mandates.

Mental health in a global context

In 2019, one in every eight people, or 970 million people around the world

were living with a mental disorder, with anxiety and depressive disorders the most common (Charlson et al. 2019). In 2020, the number of people living with anxiety and depressive disorders rose significantly because of the COVID-19 pandemic. Initial estimates show a 26 per cent and 28 per cent increase respectively for anxiety and major depressive disorders in just one year (WHO 2022). While effective prevention and treatment options exist, most people with mental disorders do not have access to effective care. Many people also experience stigma, discrimination and violations of human rights (WHO 2021). In the first year of the COVID-19 pandemic, the global prevalence of anxiety and depression increased by a massive 25 per cent, according to a scientific brief released by the World Health Organization (2022).

Concerns about potential increases in mental health conditions have already prompted 90 per cent of countries surveyed to include mental health and psychosocial support in their COVID-19 response plans, but major gaps and concerns remain (Ransing et al. 2020). The COVID-19 pandemic has posed a serious threat to global mental health. Multiple lines of evidence suggest that there is a varying yet considerable increase in mental health issues among the general population and vulnerable groups (Charlson et al. 2019). The aftermath is obscure and speculative from a social, economic, individual and public mental health perspective. Recently published studies supported the existence of an emotional epidemic curve, describing a high probability of an increase in the burden of mental health issues in the post-pandemic era (Ransing et al. 2020). Furthermore, previous major public health emergencies showed that more than half of the population developed mental health problems and required mental health intervention (Moitra et al. 2022). There is, therefore, an urgent need to reorganise existing mental health services to address the current unmet needs for mental health and to prepare for future challenges in the post-pandemic era in terms of prevention and management.

The existing evidence and published literature on past epidemics indicate a pattern where mental health concerns surfaced post-peak of the pandemic, particularly affecting vulnerable populations and individuals with risk factors (Vadivel et al. 2021; Esterwood et al. 2020; Reinz et al. 2023; Santomauro et al. 2021; Janiri et al. 2021; Pierce et al. 2021).

Box 1

Mental health issues, vulnerable populations and risk factors

1. Mental health issues: include grief reactions, substance use disorders, anxiety, sleep disorders, depression, suicides, post-traumatic stress disorders, and panic disorders.

2. New mental health issues arising from COVID-19-induced stress, fear, and loneliness might lead to persistent neuropsychiatric symptoms or disorders such as acute ischemic stroke, headaches, dizziness, ataxia, delirium, and seizures, which could be attributed

to cytokine storms triggered by the COVID-19 infection.

3. Relapse of pre-existing mental illness: due to reduced access to therapeutic resources, disruption of therapies, service provision and social support.

4. Suicides: due to neuropsychiatric manifestations and the socio-economic impact of COVID-19

5. Other issues: COVID-19-related stigma, discrimination and hate crimes.

6. Vulnerable population: children and adolescents; elderly; unemployed and homeless persons; COVID-19 survivors; healthcare workers (HCWs); those with pre-existing psychiatric disorders; grass-roots workers; pregnant women; people with disabilities and chronic diseases; migrants; refugees; lesbian, gay, bisexual, transgender and queer (LGBTQ) community; racial and ethnic minorities.

7. The prevalence of suicide is also noteworthy in this context.

8. Risk factors: the death of either parent, caregivers or loved ones, misinformation, loss of peer support because of closure of school or workplace, academic loss, medical comorbidities, uncertainties, stigma, prolonged isolation, social rejection, work stress, burn-out, being in direct contact with active cases and facing economic burdens.

Adapted from Vadivel et al. (2021)

If all the issues in Box 1 are unattended, there will be a surge in mental health issues that may remain untreated or undiagnosed due to interrupted mental health services and other challenges for mental health services in the post-COVID-19 pandemic era. Therefore, addressing emergent challenges with appropriate interventions could be challenging in many countries, particularly in low-resource settings (Sher 2020). Thus, efforts should be taken towards the prevention of mental health issues on a large scale and the organisation of services for early identification of mental health issues (Sher 2020). The approaches to mental healthcare prevention and treatment after the COVID-19 crisis can be classified as universal, selective, or indicated (Sher 2004, 2020).

The universal approach is a population-wide intervention that helps reduce the overall burden of mental health issues (stress, anxiety and fear) through prevention; therefore, it is imperative to have a universal approach for each country (Box 2) (Vadivel et al. 2021).

Box 2

- Focus of universal approach in the post-pandemic era
- Promoting mental health wellness and reducing distress through adequate sleep, healthy diet and exercise, mindfulness based programmes (for example, yoga) and awareness about mental health issues.
- Using traditional and social media for mental health awareness campaigns and to encourage individuals to seek help with responsible, transparent and timely media reporting.
- Establishing community support for those at risk and encouraging them to stay connected and maintain relationships.
- Establishing primary screening services for common mental health issues such as anxiety, depression and suicidal thoughts.
- Establishing national suicide prevention helplines or other helplines.
- Integrating basic mental health services into primary care for early identification of COVID-19-related mental health issues.
- Developing self-help resources and promoting healthy coping strategies.
- Ensuring financial support for people through governmental and non-governmental organisations (for example, loans and credit).

Adapted from Vadivel et al. (2021)

The selective approach is used for an individual having the risk factors for developing mental health issues (Vadivel et al. 2021). Adiukwu et al. (2020) are thus of the view that a screening toolkit or guidelines should be developed to identify people who are at risk. The indicated approach is designed for individuals having signs and symptoms of mental health issues (Vadivel et al. 2021). The authors are of the view that the indicated approach ought to be guided by well-defined guidelines before the intervention as some people with mental health issues might not seek help because of fear of COVID-19 infection, stigma and poor motivation. It is therefore important to identify these individuals through a network of hospitals and community health workers (Vadivel et al. 2021).

Globally, COVID-19 has affected the mental health of many people, and

some measures should be in place to address the aftermaths of COVID-19. Post-COVID-19 measures should be devised. The strategies suggested in Box 2, focussing on the post-pandemic era, could be applicable in the South African context.

Mental health in an African context

Mental disorders continue to increase and these disorders remain poorly understood especially in developing countries (Wittchen, Mühlig and Beesdo 2003; Wainberg et al. 2017; Alloh et al. 2018). Preceding studies found that mental disorders are less prioritised in most developing countries in terms of policies, health services and research, and only 36 per cent of people with mental disorders are covered in developing countries, whereas more than 92 per cent of people are provided mental health services in developed countries (Abdelgadir 2012; Glderisi et al. 2010). In some countries, mental health services and resources are available, but they are not accessed, possibly due to different factors such as stigma, poverty and discrimination toward patients with mental health conditions (WHO 2019). This discrepancy may affect access to mental health services and may worsen the mental health disorders of the service users (Abdelgadir 2012; Thyloth and Singh 2016; WHO 2001, 2019). Recent studies obviously indicated multiple barriers to the use and utilisation of mental health services in developing countries where three-quarters of the service users with mental disorders do not have access to mental health services (Ali and Agyapong 2020; Thyloth and Singh 2016). They revealed that the treatment gap for mental health in developing countries is higher than in developed countries (Wainberg et al. 2017; WHO 2002).

Prior studies indicated that the major barriers to mental healthcare access comprise limited availability and affordability of mental healthcare services, insufficient mental healthcare strategies, lack of education about mental disorders, negative attitudes toward mentally disordered patients, and stigma (Ayele et al. 2011; Saxena et al. 2007). Moreover, preceding studies documented that the barriers to the utilisation of mental health services included shame and stigma of being diagnosed with mental disorders, sociocultural influences, social marginalisation for persons with mental disorders, less prioritisation of mental healthcare services, scarcity of human and financial resources, physical and psychosocial violence experienced by patients with mental disorders, the difficulty of access to geographical areas where the patients reside and difficulty in charging poorly organised services (Abdelgadir 2012; Atilola 2015; Glderisi et al. 2010; Jacob and Patel 2014; Vigo, Thornicroft and Atun 2018; WHO 2002). Studies in sub-Saharan African countries revealed that barriers such as scarcity of financial means, poor awareness of mental disorders, poor knowledge of mental health services, poor quality of services, negative beliefs about healthcare provision and sociocultural and physical barriers hinder the utilisation of mental health services (Henderson, Evans-Lacko and Thornicroft 2013; Jack-Ide and Uys 2013; Mugisha et al. 2019; Tumbwene, Outwater and Liu 2015). Studies in Kenya established that service users with mental disorders mistrust the healthcare

providers, experience barriers like stigma related to their mental disorder, experience sociocultural misunderstandings, resist therapies and experience barriers to medical infrastructures, resulting in their difficulty in accessing and utilising mental health services (Musyimi et al. 2017).

Earlier studies in Uganda, Kenya and Tanzania discovered that the other important factors that hamper the adherence to mental health interventions include poor accessibility of clinical guidelines to provide mental health services and obstructions, due to a limited number of trained mental healthcare providers (Atilola 2015; Henderson et al. 2013; Mugisha et al. 2019). Another challenge is that several service users seek mental health support interventions from traditional healers and faith healers, instead of accessing mental health interventions from trained mental health providers in medical or psychiatric settings (Barrow 2016). Research carried out in Ethiopia revealed that the main impediments to non-adherence to mental health care involve service users refusing to seek mental health services because of thinking that they would get better later and that they also want to solve their mental problems without seeking health care from mental health providers, lack of medical infrastructures, negative attitudes of healthcare providers toward mentally ill patients and preference to get alternative forms of mental health services (Negash et al. 2020; Wakida et al. 2018). Mental disorders thus affect hundreds of millions of people and if left untreated, create enormous suffering, disability and economic loss (Ambikile and Iseselo 2017).

In some health facilities in Rwanda, there is an insufficient number of mental health professionals and service users have inadequate access to mental healthcare (Mutabaruka et al. 2012) This may result in a negative reception of mental health care (Munyandamutsa et al. 2012; Mutabaruka et al. 2012). Furthermore, access to mental health services in Rwanda remains low, regardless of the efforts the government of Rwanda has made to attenuate the high prevalence of mental disorders (Wakida et al. 2018; Mukamana et al. 2019). Recently, mental health services in Africa have suffered from many challenges (Nicholas, Joshua and Elizabeth 2022). The situation has not shown any sign of change in recent years, especially considering the COVID-19 pandemic (Nicholas et al. 2022). Lack of resources and commitment from public stakeholders continue to hinder the development of mental health care in most African nations, where specialised psychiatric care is primarily provided in urban-situated mental institutions (Nicholas et al. 2022). Even though many African nations have policies to address mental health problems, these policies are often weak and outdated to combat the present challenges. It therefore becomes challenging to pinpoint areas of need, organise the efforts and decide on the course of legislation (Nicholas et al. 2022).

In essence, issues related to mental health continue to be neglected across Africa. For instance, a poll on mental health conducted by the Africa Polling Institute (API) and EpiAFRIC in Nigeria, the most populous nation in Africa, reveals a poor awareness of mental health, with most respondents unaware that they have mental health illnesses (Abdulmalik et al. 2019). Most of service users often seek spiritual interventions because mental health disorders are frequently linked to cultural and ancestral roots (Abdulmalik et al. 2019). Government

support for mental health initiatives continues to be pitifully inadequate (Abdulmalik et al. 2019). Failure to collaborate and address this health crisis has enormous adverse effects on human potential and unnecessary suffering for the African population (Nicholas et al. 2022). Nicholas et al. 2022 further assert that the current look at Africa's mental health is gloomy and despite attempts to improve this, the situation has not changed.

Africa has 1.4 mental health workers per 100 000 people, a low figure besides the global average of nine workers per 100 000 people (World Health Organization [WHO] 2015). Also, there has been a very small number of practising psychiatrists. Additionally, the global annual rate of visits to outpatient mental health facilities is 1051 per 100 000 people, but when examining Africa, it is only about 14 per 100 000 (WHO 2016). In Sierra Leone, it is estimated that 98 per cent of people lack access to mental health care (Yoder, Tol and Reis 2016). The demand for mental health treatments in Africa has increased recently and Africa's population increased by 49 per cent over the previous two decades (United Nations Development Programme [UNDP] 2018).

Mental health care remains on the periphery, whilst there are numerous efforts to improve it. Various policies and acts have been devised but the lack of implementation of these policies is alarming. Moreover, mental disorders will be on the rise based on the continent's socio-economic difficulties. Therefore, Africa requires robust mental health care on all fronts. The scientific community and other relevant public parties must intensify their efforts to prepare for this impending calamity.

Mental health in the South African context

Mental health has largely been treated as a peripheral and insignificant part of the health sector (Burns 2011; October 2019; Pillay 2019). This has been to the detriment of those who live with mental disorders, undermining and limiting access and quality of mental health care services (Nguse and Wassenaar 2021). This is reflected in the paucity of investment and limited government contribution to mental health (Docrat, Lund and Chisholm 2019; October 2019). The South African government may be applauded for the legislative and policy direction it has taken in prioritising access to mental health care. Legislation and policies such as the Mental Health Care Act of 2002 and the National Mental Health Policy Framework and Strategic Plan 2023-2030 and National Health Insurance (NHI) are evidence of such direction (Republic of South Africa [RSA] 2002; Department of Health [South Africa] 2023; Republic of South Africa [RSA] 2019); however, a gap exists between policy development and implementation. The lack of a sustainable funding model for mental health perpetuates the lack of mental health services, as there is no clear source of funding for the implementation of the policies and plans (Nguse and Wassenaar 2021).

Furthermore, while South Africa, compared to other African countries, has shown some improvements in the legislation and provision of mental health care services, the ratio of physical/biological to psychiatric/psychological health care remains unbalanced (Marais and Petersen 2015; Petersen et al. 2017). Burns

(2011) notes this gap between physical and mental health services and refers to it as a violation of human rights. Indeed, the treatment of mental health in South Africa is a case for violation of human rights and disregard for the lives of those who live with mental illnesses. It borders on ableism and a lack of empathy for MHCUs (Nguse and Wassenaar 2021). Marais et al. (2020) state that the inadequacy and paucity of mental health care services may reflect (1) the exclusion of mental health practitioners and MHCUs from the consultative process leading to the development of policies; and (2) limitations in the implementation of experiential knowledge-informed policies.

Nevertheless, the mental health care service gap in South Africa has been well documented in other policy proposals and academic research (Burns 2011; October 2019; Pillay 2019; Pillay and Barnes 2020; South African Human Rights Commission [SAHRC] 2019; World Health Organization [WHO] 2007). Numerous examples of how mental disorders have been neglected by the health system demonstrate the magnitude and severity of the state of mental health care in South Africa. The abhorrent Life Esidimeni incident tragically illustrates the neglect of mental health services in South Africa (Dhai 2017; Makgoba 2017; Pillay 2019; SAHRC 2019). October (2019) reported that 144 mental health care users (MHCUs) died in this incident, nine had not been found by 2019, four years after the negligent movement and 'treatment', of MHCUs, referred from a state facility to unregistered and unsuitable nongovernmental facilities. The Life Esidimeni incident was an avoidable tragedy but was consistent with the way mental health had been and remains to be treated as a peripheral and insignificant element of public health care. The question that remains is what lessons have been learned from the incident? What measures and developments have been put in place to prevent the repetition of such a brutal and inhumane incident? What have the government and the legal system done about those who were found to have been responsible for the approval of the transfer of patients to unregistered and unequipped NGOs and the other irregularities contained in the Makgoba (2017) report?

The release of the South African Human Rights Commission's report on the status of mental health services on 28 March 2019 should cause all of us to pause and reflect on what needs to be done to provide quality rights-based mental health services for the people of South Africa. The South African Human Rights Commission (SAHRC) (2019) asserts that mental health overall is a neglected area, and this sub-field is especially under-prioritised, with the result that violations of the rights of this group are perpetrated regularly in the form of cruel, degrading and inhumane treatment that places them at risk for abuse.

The first nationally representative survey of the prevalence of mental health conditions among adults was conducted between 2003 and 2004, with a particular focus on common mental disorders (CMDs), including depression, anxiety and substance use disorders (SAHRC 2019). The South African Stress and Health (SASH) study was conducted as part of the WHO's World Mental Health Survey Initiative (Herman et al. 2009). The study refers to relatively high prevalence rates of mental health conditions, finding that the lifetime prevalence for any mental health condition in South Africa was 30.3 per cent.

Anxiety disorders were the most prevalent form of the disorder, while substance abuse and mood disorders were the next most prevalent conditions in South Africa (Herman et al. 2009). The study also noted differences in prevalence across provinces, noting that the Western Cape and the Free State had a significantly higher prevalence of mental health conditions than other parts of the country, while the Eastern Cape and the Northern Cape had prevalence figures that were significantly lower than the rest of the country (Herman et al. 2009). It is however notable that the General Household Survey of 2017 indicated that the Eastern Cape had the highest prevalence of mental disorders followed by Gauteng and KwaZulu-Natal (SAHRC 2019).

A blog on the South African College of Applied Psychology (2018) website entitled 'The shocking state of mental health in South Africa in 2018' noted the following:

- One in six South Africans suffer from anxiety, depression, or substance-use disorders
- 40 per cent of South Africans with HIV suffer from a mental disorder
- 41 per cent of pregnant women are depressed
- If motor vehicle crashes and crime are considered, about 60 per cent of South Africans could be suffering from post-traumatic stress
- Only 27 per cent of South Africans with severe mental disorders receive treatment

This bleak picture is not only found in academic journals. In 2014, the Sunday Times published a report titled 'South Africa's sick state of mental health' in which the authors note that one-third of South Africans suffer from mental illness, with only 25 per cent able to receive treatment. This bleak picture was further exacerbated by the Life Esidimeni tragedy as previously mentioned in this section. While there is an imperative to deinstitutionalise psychiatric patients and provide community-based mental health services, this needs to be done with care and by ensuring that non-governmental organisations (to whom patient care is entrusted) have the capacity to provide quality care (Nguse and Wassenaar 2021). There are both local and global lessons to be learned from this tragedy (Durojaye and Agaba 2018; Freeman 2018; Pillay 2017). It can be deduced that the lessons that should be learnt are as follows: adherence to ethics is paramount, involvement of MHCUs and their families in decision-making is of utmost importance, as is the role of mental health review boards and accountability. Clearly, the situation of mental health in South Africa is troubling and urgent action is needed. This lack of access to, as well as the quality of mental health services, is not unique to South Africa, but is a worldwide phenomenon and is found in almost all countries. This means that a global movement is urgently needed.

Prior studies in South Africa identified various structural issues as being linked to poor mental health. For example, Khumalo, Temane and Wissing (2012) found that those who live in rural areas, the poorly educated and the unemployed had poorer psychological well-being. Similarly, the SASH report noted that stress and trauma levels were high due to racial discrimination,

inequality, economic challenges, as well as interpersonal violence (Jack et al. 2014). These studies illustrate the complex context in which mental health and mental disorders must be considered in South Africa. Purely focussing on the treatment of psychological conditions or psychiatric illnesses without an equal focus on prevention will not be sufficient. Despite these studies, mental health and mental disorders do not appear to be a priority either in South Africa or in the rest of the world, as noted by Patel et al. (2018). In a four-country study, including South Africa, Bird et al. (2011) suggest that there are three categories of reasons for this: not having the data to convince policymakers that it is a priority, not being able to articulate what needs to be done to strengthen mental health services and not being able to mobilise support for a response. So, what needs to be done? Both the Patel et al. (2007) study and the South African Human Rights Commission Report (South African Human Rights Commission 2019) include a host of recommendations. Patel et al. (2007) note that the Sustainable Development Goals to be reached by 2030 provide a backdrop to thinking about mental health. These include:

- Target 3.4: reduce by a third premature mortality from non-communicable diseases and promote mental health and well-being (indicator: suicide mortality rate)
- Target 3.5: strengthen prevention and treatment of substance abuse (indicators: coverage of treatment interventions for substance use disorders; harmful use of alcohol)
- Target 3.8: implement universal health coverage (indicator: number of people covered by health insurance and a public health system)

The report of the South African Human Rights Commission (2019), like the Lancet Commission report, locates their findings and recommendations within a human rights context. Given the stigma and abuses to which people with mental health challenges are often subjected, this is both correct and imperative. The Department of Health (South Africa) adopted a human rights lens in developing the Mental Health Care Act as well as in the drafting of the National Mental Health Policy Framework and Strategic Plan, 2023-2030 (Department of Health [South Africa] 2002; Republic of South Africa [RSA] 2023). However, as the Commission reported, there were significant challenges in the implementation of both the Act and the Strategic Plan. The Commission found that there was insufficient funding for mental health services, shortages of human resources to provide mental health services, inadequate collaboration and joint planning across government departments and inadequate management of mental health service provision (South African Human Rights Commission 2019). The recommendations therefore apply across government departments and include time frames for implementation. As expected, the bulk of the recommendations were directed at the National Department of Health (NDOH) as well as the Provincial Departments of Health.

During the launch of the Commission report, the Commission's chair emphasized that its recommendations carried the same authority as those of the Public Protector. They were directives to the government, with the Commission

committed to monitoring their implementation. Many of the findings listed in the Commission's report are already known to the NDOH because of an audit of mental health services in South Africa conducted in response to the findings of the health ombud (Makgoba 2017). The NDOH has already begun to respond to many of the findings. However, the Report should provide a further impetus to the government to fast-track change in the mental health system. What has the NDOH already done or initiated? A team of researchers was commissioned to calculate how much is currently spent on the provision of mental health services in the public sector. More than R7.8 billion was spent on both in-patient and out-patient mental health services in the 2016/2017 financial year or 4.6 per cent of the total spend in the public health sector (Docrat et al. 2019). Of this, 14 per cent was spent on outpatient services and 86 per cent on in-patient services. Only 8 per cent was spent on primary mental health care, while 44 per cent was spent on psychiatric hospital services and the remainder or 48 per cent was spent on services provided in general hospitals.

In South Africa, the pandemic occurred against a backdrop of serious unmet human rights needs among people with psychosocial disabilities (SAHRC 2017; United Nations Committee on the Rights of Persons with Disabilities [UNCRPD] 2018) and a suicide rate exceeding 2.5 times the global average (23.5 compared with nine per 100 000 population) (WHO 2019). Pre-pandemic mental health services were characterised by a treatment gap of 91 per cent, high readmission rates, poorly resourced community-based and primary care and neglect of children and adolescents (Docrat et al. 2019; Nguse and Wassenaar 2021). Furthermore, pre-service mental health care training of all primary health care staff cadres is inadequate for the population's mental health care needs (Academy of Science of South Africa [ASSA] 2021). This Ministerial Advisory Committee (MAC) on COVID-19 advisory provides evidence-informed recommendations to address the mental health impact of COVID-19 on all who live in South Africa, with a focus on building back better to prepare for future pandemics and other healthcare crises (Department of Health [South Africa] 2022).

The Department of Health (South Africa) (2022) developed a Build Back Better strategy. The COVID-19 pandemic occurred against a well-documented backdrop of a pre-existing significant treatment gap in mental health care services in South Africa (Department of Health [South Africa] 2022). The mental health system is insufficient to service or withstand the pressures of the pandemic. There is an urgent need for investment in system strengthening to provide the resilience needed, not only for post-pandemic recovery, but also to prevent and respond to future challenges (Department of Health [South Africa] 2022). Therefore, the MAC on COVID-19 recommends that:

- The mental healthcare system be scaled up, according to the National Mental Health Policy and the Framework and Strategic Plan 2012-2020, the WHO Optimal Mix of Services (WHO 2007) and the WHO Mental Health Action Plan 2013-2030.
- The investment case for mental health commissioned by the National Department of Health and drafted by the Alan J Flisher Centre for Public

Mental Health should be fast-tracked and adopted.
- Mental health should be more expressly represented and actioned at the COVID-19 MAC in parallel with infection prevention and treatment strategies.
- In addition, the new MAC for Mental Health should be urgently appointed under Section 71 of the Mental Health Care Act No.17 of 2002.
- Greater emphasis be given to community-oriented mental health services that strengthen resilience and self-care in addition to quality decentralised treatment and care to build back better to promote greater resilience in future pandemics and healthcare crises (Petersen et al. 2016, 2019).
- Mental health policies in acute and prolonged public health emergencies should be accompanied by detailed implementation guidance, especially regarding the integration of mental health into general health services.
- Rigorous research needs to be conducted that monitors the long-term mental health impacts of COVID-19, including 'long COVID' in priority groups over the next 2-3 years, including HCWs, mental health users, children and adolescents and those living in poverty. Such research should also drive evidence-based prevention and care strategies for these and other priority groups (Adebiyi et al. 2022).

Practically, this means that the design of the National Health Insurance system should incorporate the package of mental health services including a focus on prevention and wellness at each level of care. Moreover, the package should be fully funded with the right mix of health providers equipped to provide the best possible quality of care. Equally, as noted by the Lancet Report, we need to deal with the social determinants of mental disorder with an intersectoral focus on reducing levels of poverty and inequity, increasing gender equity, improving access to employment and educational opportunities and decreasing levels of interpersonal violence. The social determinants of mental health will be discussed in detail later in the chapter.

Human rights, social justice and social activism

Mental health and well-being cannot be defined by the absence of a mental health condition but must be defined instead by the social, psychosocial, political, economic and physical environment that enables individuals and populations to live a life of dignity, with full enjoyment of their rights and in the equitable pursuit of their potential (Puras 2019). Human rights are not only entitlements that have a legal and ethical force but also 'fundamental pillars of justice and civilization' (Mann, Bradley and Sahakian 2016: 263). The Equality and Human Rights Commission (2019: 1) defines 'human rights as the basic rights and freedoms that belong to every person in the world, from birth until death. They apply regardless of where you are from, what you believe or how you choose to live your life. They can never be taken away, although they can sometimes be restricted.'

On 30 March 2007, South Africa became a signatory to the United Nations

Convention on the Rights of Persons with Disabilities (CRPD) (Burns 2011). The CRPD sets out a framework for a rights-based approach to disability and in doing so 'calls for changes that go beyond quality of care to include both legal and services reforms' and 'demands that we develop policies and take actions to end discrimination in the overall society that has a direct effect on the health and well-being of the people with psychosocial disabilities' (Yamin and Rosenthal 2005). The CRPD articulates several guiding principles crucial for promoting the dignity and rights of individuals with disabilities (Burns 2011). These principles include respect for inherent dignity and individual autonomy, ensuring non-discrimination and full participation in society, and recognising the diversity of human experience, including the acceptance of persons with disabilities. Furthermore, the CRPD emphasises equality of opportunity, accessibility, and gender equality, while also highlighting the evolving capacities of children with disabilities and their right to maintain their identities. Additionally, the CRPD outlines essential rights related to legal recognition and access to justice, public awareness initiatives to combat prejudice and protection from abuse and violence. It underscores the rights to independent living, freedom of expression, privacy, equal education and employment opportunities, along with access to health services, habilitation, rehabilitation, and a suitable standard of living, all of which are fundamental to enhancing the quality of life for persons with disabilities (Burns 2011).

How could this framework inform South Africans' response to the inequities and discrimination present in society and mental health care, with respect to mental disorders? Specifically, if the South African government takes these principles and rights and applies them to the South African context, what actions could be required to transform that society so that persons with mental disabilities experience full equality, an end to discrimination and full recognition of their personhood? An action plan at national as well as local levels includes:

a. The development of a strong advocacy movement, led by persons with mental disabilities.
b. Legislative reform to abolish discrimination, outlaw abuse and exploitation and protect personal freedom, dignity and autonomy.
c. Legislative reform to enforce equality of opportunity, access and participation in all aspects of life.
d. Inclusion of mental disability on the agenda of development programmes.
e. Mental health and social services reform with equitable funding for resources, infrastructure and programmes development.
f. Removal of barriers to access to health services encountered by persons with mental disabilities.
g. Removal of barriers to access to social, family-related, accommodation, educational, occupational and recreational opportunities and full participation for persons with mental disabilities.
h. Service systems reform to move away from institutional care toward providing treatment, care, rehabilitation and reintegration within the community.

If South Africa wants to achieve human rights for people with mental disorders, there should be a strong formation of advocacy movements that are led by the people with mental disorders; stigma and discrimination might thus be minimised. Furthermore, the South African government has enacted the Mental Health Act which is geared at ensuring that the human rights of the MHCUs are adhered to, however, the challenge then is when this act is not implemented optimally. Therefore, inclusive programmes aimed at achieving the human rights of MHCUs as well as development targets, poverty alleviation and addressing inequality are worth being advocated for. 1

Social work and human rights

Human rights, social justice and social activism dominated the practice of progressive social workers within the apartheid state and under conditions of extreme political conflict (Turton and Van Breda 2019). The social work profession, through historical and empirical evidence, is convinced that the achievement of human rights for all people is a fundamental prerequisite for a caring world and the survival of humans (United Nations 1994). It is only through the recognition and implementation of the basic concept of the inherent dignity and worth of each person that a secure and stable world can be achieved (United Nations 1994). Consequently, social workers believe that the attainment of basic human rights requires positive action by individuals, communities, nations and international groups, as well as a clear duty not to inhibit those rights (United Nations 1994). Moreover, the International Federation of Social Workers (IFSW) (2008) states that human rights and social justice should be practiced with an understanding that all people have an equal right to enjoy the social conditions that underpin human health and to access services and other resources to promote mental health and deal with disorders.

Ife (2016) asserts that framing the social work profession has a dire consequence in the way social work is defined and practiced and internationally, social work has a long history of concern for human rights. Arguments have been raised about whether social work is a human rights profession or indeed whether social work should locate itself within a human rights profession (Ife 2001, Murdach 2011). This was not a debatable issue in the context of progressive social work in South Africa. Apartheid in all its manifestations was recognised as a crime against humanity because of the systematic attack against a civilian population (Slye 1999). Every human right that one could envisage in every sphere of life was violated through a systematic attack on the disenfranchised population. One could argue that social workers who supported and entrenched apartheid laws and policies were indeed culpable of violating Black people's human rights, whether by choice or inadvertently. Patel (as cited in Schmid and Sacco 2012: 293) notes that 'social workers were complicit with discrimination, though such collusion was mostly not deliberate'.

Social workers have a substantial task in educating communities about mental disorders. Hence, the lack of knowledge about mental disorders, their

causes, symptoms and recovery-oriented treatment options result in common but erroneous beliefs that they are caused by the individuals themselves or by supernatural forces, possession by evil spirits, or punishment by God (Lauber and Rossler 2007). This is just a drop in the ocean, there are many other issues regarding the causation of mental disorders. Therefore, the misinterpretations often lead to the philosophy that mental disorders are untreatable and that affected people are not valued as members of their communities or entitled to resources allocated to provide social work services or support (Funk, Drew and Knapp 2012). Equally, Kakuma (2010) asserts that people living with mental disorders are abandoned for long periods in poorly resourced, unhygienic, abusive institutions. The WHO (2005) highlights that people with mental disorders experience human rights violations in their daily lives in the community, with responsibilities handed to guardians who make decisions about place of residence, movements, personal and financial affairs and medical treatment. In many countries, people with mental disorders are denied rights of citizenship and participation, such as the right to vote.

For example, people under guardianship are denied the right to vote in many countries, as is the case in the Republic of Hungary (Funk et al. 2012). Participation means not only the right to vote and to stand for election, but to participate in the conduct of public life effectively and fully (Drew et al. 2011). Participation allows for the creation of an active civil society, able to give a voice to the poor and marginalised and drive national reform (Funk et al. 2006). The South African Constitution protects the right to vote for every citizen (Republic of South Africa [RSA] 1996). The Electoral Act (No. 73 of 1998) limits registration on the voter's roll based on being declared of 'unsound mind' or 'mentally disordered' by the high court or detention under the Mental Health Care Act (No. 17 of 2002) (Republic of South Africa [RSA] 1998; Department of Health [South Africa] 2002). There is limited information regarding voting knowledge and subsequent voting-related decisions amongst South African involuntary MHCUs.

In a series of studies, Bhugra, Pathare, Joshi, et al. (2016), Bhugra, Pathare, Gosavi, et al. (2016), Bhugra, Pathare, Nardodkar, et al. (2016) and Nardodkar et al. (2016) examined the laws of 193 countries. This group was interested in looking at the personal, economic and political rights of people with mental disorders. They looked at four areas of rights: to inherit property or to make a will, the right to marry, the right to employment and the right to vote of individuals with mental illnesses. All 193 countries were signatories of the United Nations Charter on Rights of Persons with Disability, but the number of rights given to people with psychiatric disorders was often very low. There is an exhaustive list of how the human rights of the MHCUs are infringed and just one example of voting has been singled out here. Therefore, positioning social work as a social justice and human rights profession also means that engaging with questions of human rights extends beyond the application of specific laws to a more holistic human rights orientation. The subject of human rights and social work therefore covers a large and complex area (Harms-Smith et al. 2019).

Social justice and mental health

On the face of it, social justice and mental health are strange bedfellows (Sheppard 2002). Social justice is concerned, as its name would suggest, with the 'social'. Its focus is on the distribution of material goods between different groups (Sheppard 2002). Mental health, or at least mental ill health, some conventional wisdom might suggest, is an individual issue. The state of mental ill health resides within the individual and the proper focus of treatment is on the person with the mental illness (Pilgrim and Rogers 1999). However, some views from the anti-psychiatric movement, which suggest that mental ill-health is less a property of the individual than of groups that create rules whose transgression is labeled as mental illness (Sheppard 2002), tend to have less currency among the most influential circles than in the past.

Social justice is the virtue that guides people in creating those organisations called institutions. When justly organised, social institutions offer people access to what is good for them, both individually and in their association with others (Guala 2016). Thus, social justice requires that everyone to assume personal responsibility in collaborating with others to design and improve institutions (Bhugra, Tribe and Potter 2022). Hence institutions carry with them the responsibility of improving society in a just way (Guala 2016).

Klein and Huang (2010) have described four concepts of difference: disparity, inequity, inequality and burden. Disparity is the quantity that separates a group from a reference point by measuring rates of ill health (Klein and Huang 2010). Inequity is defined as a difference in the allocation of resources, whereas inequality measures the degree of association between differences in rates between groups and the distribution of the population among groups (Klein and Huang 2010). Burden refers to how many people in each population are affected and what their health needs will be (Klein and Huang 2010). The World Health Organization (2021) defines equity as the absence of unfair, avoidable, or remediable differences among groups of people, whether these groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality, for example, sex, gender, religion, race, ethnicity, disability, or sexual orientation. Health equity is achieved when everyone can maximise their full potential for health and well-being (Bhugra et al. 2022). Health and health equity are determined by the conditions in which people are born, grow, live, work, play and age and these are also influenced by biological and genetic factors (Bhugra et al. 2022). Structural determinants, such as political, legal and economic, as well as social institutions (which create processes and norms by which people must abide), tend to become institutionally deviant by hanging onto power and resources for the benefit of few (Bhugra et al. 2022). These structures and institutions also affect people's living conditions by discrimination, stigma, prejudice and stereotyping. A key task for policymakers and advocates is to identify systemic inequity and eliminate it. Some groups are not involved in full representation in such decision-making which makes them peripheral and difficult to engage, thus creating a perpetual negative loop (Bhugra et al. 2022).

As a result, various institutions which are responsible for social justice often unthinkingly both tend and continue to reward specific groups for so long that

the unintentional privileges become rooted, fossilised, taken for granted and discriminatory (Bhugra et al. 2022). Equity offers to address social systems to rebalance them. Social justice brings in equity and takes this notion one step further by changing the system through changing its institutions in a way that these alterations are long-term and sustained (Bhugra et al. 2022). The Centers for Disease Control and Prevention (Centers for Disease Control and Prevention 2007, 2020) also sees equity as offering opportunities for everyone to be as healthy as possible. There is little doubt that the route to achieving equity in health must be through just and equitable approaches. A big challenge in such an approach is to be aware of discrimination and discriminatory practices which can be explicit as well as implicit and can occur at either or both institutional and individual levels. All the right policies at the institutional or national level may be in place, but it is at an individual level where people may choose to accept, work with, or ignore and work against equity and its principles.

During apartheid, the issue of social justice was not evident in social work theory and practice. Social justice violations, such as poverty, unemployment and discrimination, were central to the apartheid state. Taylor (2018) notes that political and social struggles prior to 1994 were focused on the wide-scale transformation of state institutions, policies and legislation to dismantle the apartheid state and create change that would embed constitutional democracy and social justice. It is noteworthy that post-apartheid and with a transformed welfare system in place, social workers still do not act against the continued violation of social justice issues towards most individuals, families and communities. Patel (2008: 78) notes that despite the service delivery model of the state and welfare agencies 'defining itself as a developmental model, its orientation is more accurately described as remedial'. In this way, social workers justify their existence by maintaining the social and economic system that is the cause of all the ills that they ought to confront if they want to live up to the true values of the profession (Turton and Van Breda 2019). Conflict did not disappear after 1994 and is still evident in post-apartheid South Africa, though it has taken on a different character (Turton and Van Breda 2019).

Violence and conflict are represented by ever-increasing poverty, unemployment and homelessness still experienced by the Black majority (Turton and Van Breda 2019). The country grapples with poor service delivery and corruption in the government, leading to periodic civil unrest. Little wonder that social workers have become known as 'office-based', 'paper pushers' with little community engagement and very little impact on the people they ought to serve (LeCroy 2012; Jones 2001).

Social justice is identified by the profession as an organising value and a foundation of social work (Morgaine 2014). The Code of Ethics of the South African Council of Social Service Professionals (SACSSP) (SACSSP n.d.: 1) notes that 'social workers promote social justice and social change with and on behalf of their client systems'. While they do not clearly define social justice, examples provided of social injustices include poverty, unemployment and discrimination and social workers 'generally act with, or on behalf of, vulnerable and disadvantaged individuals, families, groups and communities' (SACSSP n.d.: 6). The Social Work Dictionary (as cited in Patel L. 2015: 147) defines social justice as

'an ideal condition in which all members of a society have the same basic rights, protection, opportunities, obligations and social benefits ... [and] is also about ensuring that resources are equitably distributed.'

Social justice and social work cannot be separated. Social workers use their strong communication and empathy skills to relate to patients undergoing stress and trauma which could be related to social injustices (Austin 2013). They ensure people are treated with respect and promote social justice within schools, hospitals, community centres, nursing homes and more. According to the National Association of Social Workers' Code of Ethics (National Association of Social Workers [NASW] 2022: 1), '(t)he primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed and living in poverty.' The NASW (2022) and the SACSSP (n.d.) list social justice as one of the social work profession's core values, which include:

- Service
- Social justice
- Dignity and worth of the person
- Importance of human relationships
- Integrity
- Competence

Each value is tied to an aspirational ethical principle. For social justice, the ethical principle is 'social workers challenge social injustice.' The NASW Code of Ethics expands upon this principle:

> *Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services and resources; equality of opportunity; and meaningful participation in decision-making for all people (NASW 2022: 1).*

Social workers engage in social justice because they must be attentive to the environmental and societal factors that contribute to people's struggles (Austin 2013).

Social justice entails equal access to liberties, rights and opportunities, as well as care for the least advantaged members of society. Social workers have a gigantic task to see to it that social justice is adhered to. Social workers have a quest to pursue social change on behalf of MHCUs, therefore they must address the social ills that impede the functioning and the mental health of the South African populace.

Social work and social activism

During apartheid, social activism was confined to those social workers who joined organisations such as CSW and South African Black Social Workers Association (Turton and Van Breda 2019). However, Turton and Van Breda (2019) assert that these attempts were made to provide social workers with an alternative vehicle for struggle that combined social work and activism. Both these organisations were small and, in the bigger scheme of things, did not replace the more conservative approach of social workers, who either turned a blind eye to what was happening around them (maybe for fear of state reprisal) or who deliberately upheld the state apparatus and the status quo (Turton and Van Breda 2019). In a call for social work activism, Bent-Goodley (2015) explains that social workers can create space for the voices of the vulnerable and marginalised to be heard. She refers to the role of the social worker as empowering those who feel powerless to find hope and opportunity to create change. Using one's voice creates a sense of hope and optimism that can be infectious in a community. Through the nurturing of hope and power in one's voice, social workers can create individual and social change (Bent-Goodley 2015).

There are many opportunities for social workers to participate in social activism in meaningful ways, such as the support of voter registration efforts (Anderson 2019). Helping to shape public policy is another way to engage, especially since this is an essential component of the social work field. 'We can sit and wonder what will happen, or we can look for opportunities to make things happen' (Anderson 2019: 1). The National Association of Social Workers (NASW) (2022) provides information for social work professionals who would like to better the lives of those in need by supporting public policy and legislation.

Social activism is absolutely critical in assisting MHCUs. Social workers can advocate for the rights of MHCUs as well encouraging that the MHCUs should also advocate for their rights. Advocacy groups can be established and the MHCUs lead these groups therefore social workers should facilitate the social activism as well as collaborate with MHCUs in all the activities geared to promote social activism.

Social determinants of mental health

Social determinants frameworks focus on understanding how the circumstances in which people live and work shape their health outcomes (Alegría et al. 2018). The authors further assert that these circumstances (that is, social determinants) are believed to drive many deep-rooted world health inequalities, such as lower life expectancy, higher rates of child mortality and greater burden of disease among disadvantaged populations (Alegría et al. 2018). More so, social determinants frameworks build upon the concept of the 'social gradient' – that individuals with lower social status have greater health risks and lower life expectancy than those with higher status and that the impact of social position

can accumulate over time (Marmot and Bell 2016). Observed differences in social determinants are thought to develop from an unequal distribution of resources (Marmot et al. 2008); thus, they can be reduced through targeted social and economic policies and programmes. Although less frequently discussed than the converse pathway, mental disorders can also impact social determinants, including homelessness, school dropout, marital instability and economic insecurity (Corrigan, Morris and Michaels 2012; Hjorth, Bilgrav and Frandsen 2016; Ljungqvist et al. 2016). A two-way relationship exists between mental health disorders and social determinants, as poor mental health can aggravate personal choices and affect living conditions that limit opportunities (WHO 2014).

Alegría et al. (2018: 2) assert that as social determinants frameworks have developed, a difference between 'upstream' versus 'downstream' determinants has surfaced. Braveman, Egerter and Williams (2011) accentuate that upstream social determinant (for example, economic opportunities) act as 'fundamental causes' and typically impact health through downstream social determinants (for example, living conditions). They also broaden the concept of social determinants to include 'any nonmedical factors influencing health' (Braveman et al. 2011: 383), thereby including fixed individual characteristics such as gender and race/ethnicity and more malleable factors like educational attainment, occupational status and social support (Braveman et al. 2011). Correspondingly, Fisher and Baum (2010) describe the impact of chronic stress on mental health outcomes through biological pathways. They propose mechanisms by which low socio-economic status impacts mental health for those at the lower end of the social gradient, including stress from navigating everyday circumstances, anxiety about insecure and unpredictable living conditions and perceived lack of control. Likewise, Lund, Stansfeld and Da Silva (2013) maintain that an appreciation of the social factors affecting mental health is significant to recognise the aetiology of different mental health disorders, not only from an individual or genetic perspective but also from a social perspective. Figure 4.1 depicts the conceptualisation of social determinants.

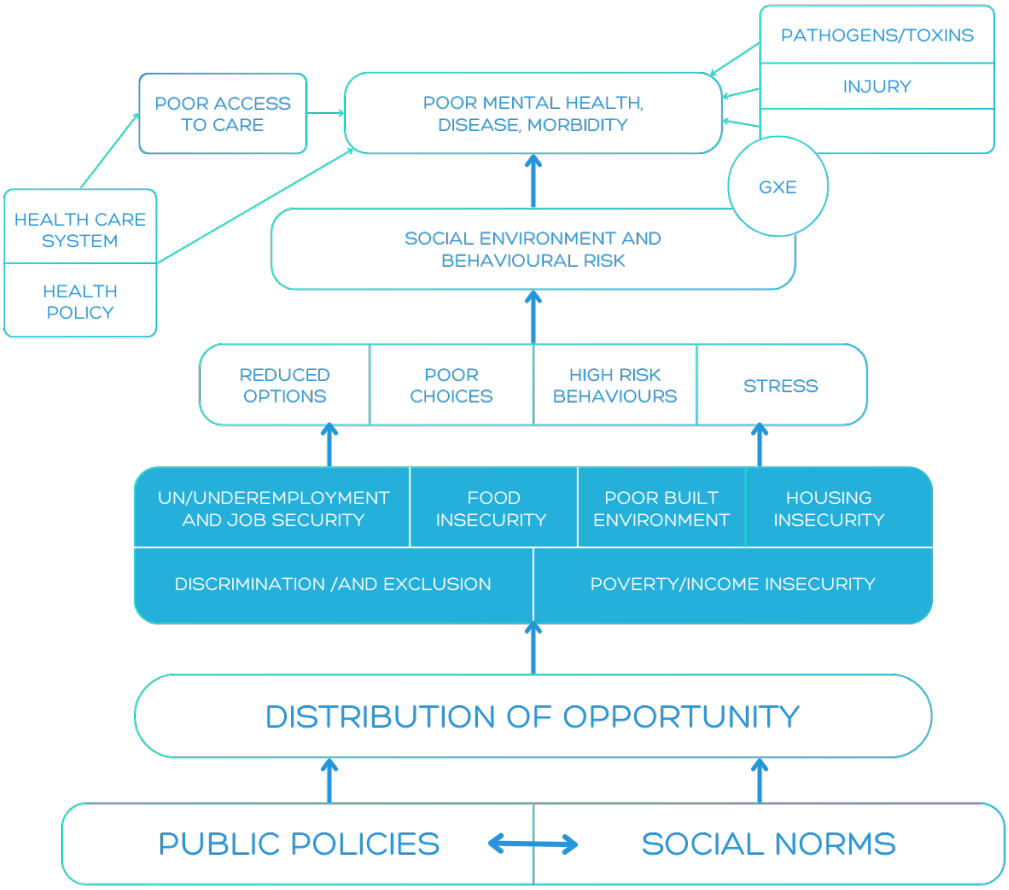

Figure 4.1: Conceptualisation of social determinants of mental health. (Adapted from Compton and Shim 2015)

Figure 4.1 depicts the main 'core' social determinants of mental health as racial discrimination and social exclusion; adverse early life experiences; poor education; unemployment, underemployment and job insecurity; poverty, income inequality and neighbourhood deprivation; poor access to sufficient healthy food; poor housing quality and housing instability; adverse features of the built environment; and poor access to health care (Compton and Shim 2015). These nine core social determinants shown in Figure 4.1 serve as a starting point, partly because they have been recognised for diverse chronic physical health conditions. Yet other social determinants of mental health could be articulated, including inadequate or unequal access to transportation, exposure to violence, conflict and war in childhood or adulthood; mass incarceration and poor relations between law enforcement and communities; environmental air, water, or land pollution; climate change; sexism and other forms of non-ace-based discrimination; and adverse or unsupportive features of the workplace (Schulz and Northridge 2004; Pedersen 2002; Freudenberg, Daniels and Crum 2005; Vlahov, Freudenberg and Proietti 2007; Berry, Bowen and Kjellstrom 2010).

Lund (2023) cautions about the importance of understanding the social determinants of mental health because of these reasons: First, it is essential

to understand the aetiology of mental disorders, not only from a genetic or individual perspective but also from a social perspective. Social factors play a major role in determining the mental health status of individuals, interacting with more proximal genetic factors and individual experiences across the life course. Second, understanding this social aetiology opens opportunities for interventions at a population level. These can target the promotion of mental health and primary and secondary prevention of mental illness, to reduce social and health inequities. Third, with a better understanding of social determinants, population-level interventions that target these determinants can be planned more effectively and efficiently. This is particularly important as tackling social determinants of mental health is likely to require the coordination of a range of social, health, education and justice sectors (Skeen et al. 2010). Fourth, with the large body of international research and policy regarding the millennium development goals (MDGs) and more recently sustainable development goals (SDGs) (Sachs 2012), it is essential to link mental health with international development targets. As some have argued, mental health is crucial, both as a means and an end towards global development and there is substantial and growing evidence regarding these links (Lund et al. 2012; Skeen et al. 2010).

Moreover, a multilevel framework for understanding social determinants of mental disorders can be applied to strategies and interventions to reduce mental disorders and promote mental well-being (Bell, Donkin and Marmot 2013). These areas are important for two reasons: they influence the risk of mental disorders, and they present opportunities for intervening to reduce risk as listed below (WHO 2014):

- Life course: Prenatal, pregnancy and perinatal periods, early childhood, adolescence, working and family building years, older ages all related also to gender.
- Parents, families and households: parenting behaviours/attitudes; material conditions (income, access to resources, food/nutrition, water, sanitation, housing, employment), employment conditions and unemployment, parental physical and mental health, pregnancy and maternal care, social support.
- Community: neighbourhood trust and safety, community-based participation, violence/crime, attributes of the natural and built environment, neighbourhood deprivation.
- Local services: early years care and education provision, schools, youth/adolescent services, health care, social services, clean water and sanitation.
- Country-level factors: poverty reduction, inequality, discrimination, governance, human rights, armed conflict, national policies to promote access to education, employment, health care, housing and services proportionate to need, social protection policies that are universal and proportionate to need.

Life course

The experience and impact of social determinants vary across life and influence people at different ages, genders and stages of life in particular ways (WHO 2014). To tackle mental and physical health, Kieling et al. (2011) emphasise the need for understanding the life course approach as it accounts for inequalities that impact the social determinants throughout life. Moreover, the WHO (2013) proposes actions to tackle health inequality appropriate for different stages of life (Figure 4.2). Strong evidence shows that many mental and physical health conditions emerge in later life but originate in early life (Fryers and Brugha 2013: Shonkoff et al. 2012). Figure 4.2 depicts a life course approach.

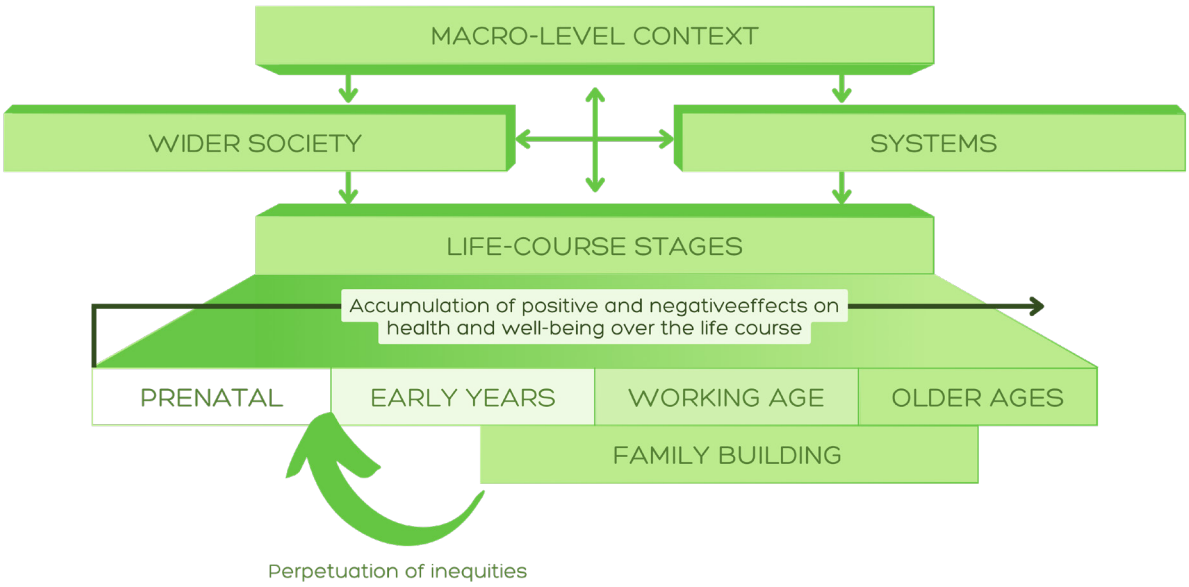

Figure 4.2: A life course approach to tackling inequalities in health. (Adapted from WHO 2004)

Understanding the crucial role played by social determinants in shaping mental health is very significant. Adopting a life-course perspective reveals how these determinants operate across various life stages, influencing vulnerability and exposure to detrimental processes or stressors.

Social arrangements and institutions, like preschools, schools, the labour market and pension systems thus have a significant impact on the opportunities that empower people to choose their own course in life (WHO 2014). These social arrangements and institutions differ enormously, and their structures and impacts are, to a greater or lesser extent, influenced or mitigated by national and transnational policies (WHO 2014). A life-course approach has various components, each of which will be discussed, the first being prenatal experience and mental health.

Pre-natal experience and mental health

The prenatal period has a significant impact on physical, mental and cognitive outcomes in early life and throughout life (WHO 2014). Glover (2014) asserts that several different types of prenatal stress for the mother have been shown to increase the risk of emotional, behavioural and cognitive problems for the child and play a causal role. Moreover, such stress in the mother includes her worry about the outcome of her pregnancy, her exposure to a raised level of daily hassles, a natural or man-made disaster and emotional cruelty, or other forms of domestic abuse by her partner (Glover 2014). Additionally, Graham et al. (2019) state that there is evidence that maternal and foetal cortisol levels are correlated especially in more anxious or depressed mothers. For example, if the mother is anxious or depressed, this can alter the function of the placenta in a way that allows more cortisol to pass through to the foetus. More so, raised maternal cortisol is associated with altered brain function in the child, including higher internalising symptoms in girls via alterations in neonatal amygdala connectivity (Graham et al. 2019). Glover (2014) asserts that possible mediating factors for the effects of early trauma are those associated with the immune system and inflammation. Studies conducted underscored the importance of maternal education for an extensive range of results for children with lower maternal education relating to increased infant mortality, stunting and malnutrition, overweight children, lower scores on vocabulary tests, conduct problems, emotional problems, lower cognitive scores, mental health problems and infections (Bicego and Boerma 1993; Case, Fertig and Paxson 2005; Schady 2011; Gleason et al. 2011).

In a study conducted in South Africa between September 2019 and March 2020, by Brown, Macnaughton and Sprague (2020), based on in-depth interviews with 14 key informants, they found that (1) physical health was prioritised over mental health at the clinic level; (2) there were insufficient numbers of antenatal and mental health providers to ensure minimum essential levels of perinatal mental health services; (3) the implementation of human rights-based mental health policy has been inadequate; (4) the social determinants were absent from the clinic-level approach to mental health; and (5) a lack of context-specific provider training and support has undermined the quality of mental health promotion and care. Therefore, Brown et al. (2020) offer recommendations to address these barriers and improve approaches to perinatal mental health screening and care, guided by the following elements of the right to mental health, namely progressive realisation; availability and accessibility; and acceptability and quality.

The findings of this study are concerning because South Africa's National Mental Health Policy Framework and Strategic Plan (MHPF) 2013-2020 promises the human rights of people living with mental illness will be promoted and protected through the active implementation of the Mental Health Care Act (Department of Health [South Africa] 2002); moreover, the plan was to be realised by 2020. Delivering on this promise in practice has been hindered for many reasons, particularly a lack of funding. Docrat, Lund, and Chisholm

(2019) further support this notion in their investigation of sustainable financing strategies for mental health care in South Africa. Their findings revealed that despite the implementation of the South African MHPF (Department of Health [South Africa] 2013), health budgets and wider transformations within the health sector have failed to materialise the policy's intended outcomes (Docrat, Lund, and Chisholm 2019).

The early years

Experiences during early childhood play a major role in shaping later life (Currie and Rossin-Slater 2014; National Scientific Council on the Developing Child 2007; Shonkoff, Boyce and McEwen 2009). There are three key ways in which the lifelong effects of early experiences impact on the later achievements, health and longevity of individuals, namely:

- Biological embedding is a developmental process whereby prenatal and early childhood experiences affect physiological and neurological development in ways that have long-term consequences (Gluckman, Hanson and Buklijas 2010; Hertzman and Boyce 2010).
- The cumulative effect of adverse experiences during childhood can lead to toxic stress that influences every aspect of health and well-being in childhood and beyond (Brown et al. 2009; Shonkoff et al. 2009; Shonkoff 2012); and
- 'Escalations in risk over time shape children's development so that exposure to adverse experiences at one stage of the life course increases the probability of similar exposures subsequently (Hertzman and Boyce 2010; Repetti, Taylor and Seeman 2002).

Extensive research has been conducted globally on childhood abuse and maltreatment and their effect on health and well-being (Kalmakis and Chandler 2014). However, the concept of adverse childhood experiences (ACEs) as a set of specified exposures was first described in the seminal 'CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study' (Felitti et al. 1998). The ACE study described adverse experiences as 'common, stressful and traumatic exposures affecting the (neuro) development of children' (Manyema and Richter 2019: 1). The ACE hypothesis posits that adverse or stressful childhood experiences such as abuse and neglect, or growing up in a dysfunctional household, create common vulnerability to social, emotional and cognitive impairments that lead to increased risk of poor health behaviour, social adjustment and physical and mental illness (Anda 2007). ACEs are more than child maltreatment and the neglect of a child's needs and incorporate household and environmental influences as well (Kalmakis and Chandler 2014).

The first wave of the study conducted in 1995/1996 included seven adverse events in the definition of ACEs, namely sexual, physical and emotional abuse and household dysfunction (household substance abuse, household mental illness, domestic violence and household member with a history of

imprisonment) (Felitti et al. 1998). The second wave in 1997 updated the list to ten with the addition of emotional and physical neglect and parental divorce or separation (Anda 2007; Dong et al. 2004; Felitti et al. 1998). The latter study also became the basis for expert recommendations to expand the definition of ACEs to include exposures experienced in high-income as well as low- to middle-income countries (LMICs), including the domains of socio-economic status, peer-to-peer and community violence (Anda et al. 2010).

Though not using the ACE definition stated above, studies conducted in South Africa suggest high rates of individual exposure. For example, in a prospective survey of both rural and urban adolescents, 18.3 per cent and 19.5 per cent reported frequent physical and emotional abuse, respectively (Meinck, Cluver and Boyes 2015). According to Jewkes, Dunkle, Nduna and Shai (2010), 54.7 per cent and 56.4 per cent of rural South African women and men experienced emotional abuse respectively, 41.6 per cent and 39.6 per cent, respectively experienced emotional neglect and 39.1 per cent and 16.7 per cent experienced sexual abuse before the age of 18.

A mother's influence on resilience in children and exposure to traumatic, stressful and violent situations in early childhood development has been examined (Gartland et al. 2019). Research suggests that mothers' exposure to domestic violence and depression can influence early childhood coping, adaptation and resilience. Still, the effects of domestic violence on children vary widely (Anderson and Van Ee 2018). Despite witnessing domestic violence, many children have adequate behavioural and emotional functioning (Garland et al. 2019). Factors that are likely to have affective influences on resilient children include the following: positive parental/partner relationships, effective parenting when under stress and family/support networks (Garland et al. 2019). Subsequently, when mothers can model effective coping and convey a sense of security and confidence to their children, there is an increased likelihood of the child being able to function and manage stress better (Anderson and Ee 2018).

The ACE Studies affirm the interrelationship of adverse childhood experiences of abuse, neglect and family dysfunction on adult health and well-being. Social workers can use the study findings to explore how childhood traumatic exposure to violence and other ACEs are linked to medical, mental health and substance abuse conditions throughout the life span. The data, factors and findings gathered from the ACE study can guide social workers and support them in addressing policies and practices that promote early childhood prevention and treatment intervention. The study findings draw attention to improving adult physical, mental health and substance abuse conditions by focussing on primary prevention of childhood physical and sexual abuse; preventing domestic violence, behavioural and substance abuse conditions; and promoting mental health.

Later childhood

There has recently been an increase in mental health issues among children and adolescents around the world (Abraham and Walker-Harding 2022). Mental

health is closely linked to what is termed physical health and is shaped by a child or teen's social, economic and local environment (Abraham and Walker-Harding 2022). Risk factors for many of the common mental disorders such as depression, are heavily associated with social inequalities (Berry, Londoño Tobón and Njoroge 2021). Adolescence is a crucial period for developing social and emotional habits important for mental well-being (WHO 2021). These include adopting healthy sleep patterns; exercising regularly; developing coping, problem-solving and interpersonal skills; and learning to manage emotions (WHO 2021). Protective and supportive environments in the family, at school and in the wider community are important. Multiple factors affect mental health (WHO 2014). The more risk factors adolescents are exposed to, the greater the potential impact on their mental health (WHO 2021). Factors that can contribute to stress during adolescence include exposure to adversity, pressure to conform with peers and exploration of identity (WHO 2021). Media influence and gender norms can exacerbate the disparity between an adolescent's lived reality and their perceptions or aspirations for the future (WHO 2021). Other important determinants include the quality of their home life and relationships with peers. Violence (especially sexual violence and bullying), harsh parenting and severe and socio-economic problems are recognised risks to mental health (WHO 2021).

Living in poverty has also been demonstrated to negatively affect children's focus and memory (Abraham and Walker-Harding 2022). For example, in one study concerning poverty and child health, researchers at Cornell University tracked 341 children for over 15 years. Short-term spatial memory was evaluated by having participants press coloured pads in a specific order to repeat a sequence of sounds and lights (Kelley 2016). Researchers noted that study participants who grew up in poverty were more likely to have decreased short-term spatial memory and were not able to perform this task at the same level as participants from middle-income backgrounds (Kelley 2016; Abraham and Walker-Harding 2022). Researchers also noted that children who live in poverty are at higher risk of experiencing chronic stress which could continue to affect them through adulthood (Kelley 2016; Abraham and Walker-Harding 2022).

In a study conducted among underprivileged children in rural China, researchers reviewed school-based surveys of nearly 1,300 children in grades 4–9 (Li, Wu and Liang 2019). They concluded that poverty had a significant correlation with a subject's mental health. Also, family and peers had a mediating effect on poverty and children's mental health (Li et al. 2019). Research shows that children and teens in low-income families are at higher risk of behavioural and psychological issues. Examples include impulsiveness, attention deficit hyperactivity disorder (ADHD), anxiety, depression and poor self-esteem (American Psychological Association 2009). Children living in poverty also had a greater likelihood of antisocial conduct such as bullying as well as helplessness behaviour, than kids from more affluent backgrounds (American Psychological Association 2009).

The presence of mental disorders in adolescence is a strong predictor for mental health problems in adulthood (Belfer 2008; Charasse-Pouélé and Fournier 2006; Clark et al. 2007; Flisher et al. 2012; Kleintjes et al. 2006) and

may have a direct impact on economic and educational outcomes, as well as crime and suicide (Patel et al. 2007). Adolescents who live in households and attend schools which are socially and economically disadvantaged are at a greater risk of mental disorders through several mechanisms, including increased exposure to violence, food and income insecurity, substance abuse, reduced economic protection and fewer employment or career prospects (Patel et al. 2007). In South Africa, some of these risk factors, such as exposure to violence and poverty are more prevalent (Flisher et al. 2012; Kleintjes et al. 2006). However, little work has been done to assess the association of these experiences with mental disorders, within this context (Flisher et al. 2012).

Education is important in building emotional resilience and affecting a range of later life outcomes that raise the risks of mental disorders – such as employment, income and community participation (WHO 2014). More so, schools are also important as institutions capable of delivering upstream, preventive programmes to young people (WHO 2021). As with infancy and early childhood, children and adolescents from poorer backgrounds are likely to have greater exposure and experience of poor environments and stressful family contexts, there is, therefore, a need for a proportionately greater focus on those most at risk (WHO 2014).

Social work principles of empowering, service-user focused practice, combined with a social model of human growth and development are valuable perspectives and can be combined with a collaborative intervention work in this area of practice. Moreover, a psycho-social model of practice rooted in wider social science theory enables social workers to maintain an anti-discriminatory stance and value community-based solutions to child and adolescent mental health problems.

Working age/adults

Adult mental disorders have impacts beyond the individuals concerned: they also influence children, partners and the wider family, communities, economic development and subsequent generations (WHO 2014). Unemployment and poor-quality employment are particularly strong risk factors for mental disorders and are a particularly significant cause of inequalities in mental disorders, as the risk of unemployment and poor quality employment closely relates to social class and skill levels (WHO 2014). A recent report from the Institute of Health Equity on health impacts of economic downturns, describes evidence suggesting close associations between job loss and symptoms (though not clinical diagnoses) of depression and anxiety (Catalano et al. 2011) and demonstrates that these impacts are particularly clear for the long-term unemployed. Strategies to reduce long-term unemployment will be particularly important in reducing the risk of mental disorders in adults (Marmot 2010).

Poor quality employment, such as employment with no or short-term contracts and jobs with low reward and control at work, have significant harmful impacts on mental health (WHO 2014). Conversely, job security and a sense of control at work are protective of good mental health (Bambra 2010). Employers

therefore have a significant role in potentially reducing or exacerbating mental disorders among working-age populations and should institute better employment practices to ensure a higher reward and control balance at work and better working conditions (Bambra 2010).

The Global Burden of Disease Project indicates there are significant and increasing levels of mental disorders among the global adult population (WHO 2014). Among women, major depression is the leading cause of years lived with disability, while anxiety ranks 6th in this list (WHO 2014). Among men, major depression ranks 2nd, drug use disorders rank 7th, alcohol use disorders rank 8th and anxiety ranks 11th (Murray et al. 2012). An estimated one in four or five young people (aged 12-24) will suffer from a mental disorder in any one year, notwithstanding substantial variations in prevalence between regions (Patel et al. 2007). Many mental disorders are undiagnosed and untreated globally (Ferrari et al. 2013; WHO 2011). At work, risks to mental health, also called psychosocial risks, may be related to job content or work schedule, specific characteristics of the workplace or opportunities for career development among other things (WHO 2022). Moreover, the WHO (2022) outlines the risks to mental health at work:

- under-use of skills or being under-skilled for work;
- excessive workloads or work pace, understaffing;
- long, unsocial, or inflexible hours; lack of control over job design or workload;
- unsafe or poor physical working conditions;
- organisational culture that enables negative behaviours;
- limited support from colleagues or authoritarian supervision;
- violence, harassment or bullying;
- discrimination and exclusion;
- unclear job role;
- under- or over-promotion;
- job insecurity;
- inadequate pay;
- poor investment in career development; and
- conflicting home/work demands.

The primary social determinant of mental health in South Africa is socioeconomic status (Hudson 2005). Lower socio-economic status is associated with a higher risk of developing a mental health disability (Hudson 2005). According to Ardington and Case (2010), significant differences in depression have been noted between populations in South Africa based on their socio-economic status. Higher rates of depression were associated with households where children were often hungry and people were classified as being at the lowest level of the socio-economic ladder (Ardington and Case 2010). On the other hand, an increase in household expenditure and in the number of assets was also negatively correlated with depression to a significant level.

Family building

Along with the economy, polity and education, the family is universally viewed as one of the essential sectors without which no society can function (Ziehl 2003). As the setting for demographic reproduction, the seat of the first integration of individuals into social life and the source of emotional, material and instrumental support for its members (Belsey 2005), the family influences the way society is structured, organised and functions. It is essentially through the family that each generation is replaced by the next; that children are born, socialised and cared for until they attain their independence; and through family that each generation fulfils its care responsibilities to minors, older persons and the sick (Waite 2000). Although dysfunctional families – in which conflict, misbehaviour, neglect, or abuse occur continually or regularly – can foster and legitimise oppression of certain family members, especially women and children, an established body of research evidence from different parts of the world has shown that stable and supportive families are associated with several positive outcomes. These include higher levels of self-esteem; lower levels of antisocial behaviour such as crime, violence and substance abuse; higher levels of work productivity; lower levels of stress; and more self-efficacy to deal with socio-economic hardships (Amoateng et al. 2004). Overall, through its instrumental and affective roles, the family has the potential to enhance the socioeconomic well-being of individuals and society at large. Instrumental roles are concerned with the provision of physical resources such as food, clothing and shelter, while affective roles promote emotional support and encouragement of family members (Peterson and Green 2009).

Moreover, family building and parenting influence children's mental and physical health and a range of other outcomes throughout their lives; in addition, adult mental health can be profoundly affected during family building (WHO 2014). Disruption in family structure can lead to several adverse events, impacting both the mental health of children and their parents and not all disruptions have equal effects (Behere, Basnet and Campbell 2017). More emotional and behavioural problems occur in families disrupted by divorce compared to other types of disruptions, for example, the death of a parent. Certain characteristics have been identified in caregivers as well as the children themselves that serve as risk factors for abuse (Behere et al. 2017). Young age, depression, substance abuse, poverty and history of mothers being separated from their own mothers during childhood serve as risk factors (Oliver, Kuhns and Pomeranz 2006).

Similar risk factors are also seen in male caregivers with an unrelated male partner present at home acting as an additional risk factor. Some 30 per cent of children are expected to be living with an unrelated surrogate father (Oliver et al. 2006). Studies have also found that the presence of a stepparent increases the risk of being abused by a staggering factor of 20–40 times, in contrast to living with single mothers where the risk was about 14 times compared to living in a biologically intact family (Behere et al. 2017; Oliver et al. 2006). Some risk factors have also been identified within the children themselves, such as low

birth weight, physical, mental disabilities, aggression and hyperactivity (Behere et al. 2017). Parents exposed to abuse in their childhood or domestic violence were also more prone to act aggressively toward their own children (Oliver et al. 2006). However, studies have not been able to decipher and document in detail the different forms of abuse experienced by children who come from various types of disturbed family structures.

Supporting transitions to parenthood and providing appropriate access to maternity services are protective factors for both adult and child mental health. Support should continue into adolescence and throughout childhood. Support must also be suitable for the child's developmental stage and the family situation. Parents and children will benefit from initiatives to enhance maternal and postnatal mental health, which will also assist in stopping the intergenerational transmission of disparities. Successful parenting and the decline of mental disorders are also influenced by parental support that increases their employment, income and housing opportunities.

Older people

The world's population is aging rapidly with persons aged 65 or older projected to reach 1.5 billion by 2050 (United Nations Department of Economic and Social Affairs, Population Division 2020). Approximately 20 per cent of them will have mental health conditions such as dementia, depression, anxiety and substance use, often complicated by physical and psychosocial comorbidities (WHO 2017). Implicit and explicit biases that negatively influence their care include the triple jeopardy of ageism, mentalism and ableism (Rabheru and Gillis 2021). Older people's mental health relates both to earlier life experiences and to experiences, conditions and contexts specific to ageing and the post-retirement period (WHO 2014). Experiences of mental and physical health also differ throughout the older age period.

Social determinants may play a role as risk factors for mental health problems (unemployment, poverty, inequalities, stigma and discrimination, poor housing, adverse childhood experiences, violence, abuse, drug and alcohol abuse, poor general health, caring duties), while others may be protective factors (social protection, resilience, social networks, positive community engagement, positive spiritual life, hope, optimism, good general health, good quality family interactions, positive intergenerational relationships) (Allen, Balfour and Bell 2014; Silva, Loureiro and Cardoso 2016). Ageism manifests in various forms throughout the life course and is most impactful in old age. It is the stereotyping, prejudice and discrimination against an individual based on his/her age or the aging process (Iversen, Larsen and Solem 2009). Coined in 1969 by Robert Butler, it primarily denotes ageist attitudes against senior citizens, although it is also rooted in sexism and racism (Iversen et al. 2009). The World Health Organization (WHO) Global Report on Ageism was developed by the High Commissioner for Human Rights, the United Nations (UN) Department of Economic and Social Affairs as well as the United Nations Population Fund (UNPF) (WHO 2021a). Ageism also leads to the concerning social evil of elder

abuse, which is high in institutional settings (Iversen et al. 2009). Based on WHO data, one in six individuals above 60 years of age has experienced some form of abuse in the community settings within the last year (WHO 2021b). Ageism affects not only the older mentally ill adults but also those who care for them. Often it is perceived that caring for older adults with mental health conditions is less prestigious than other positions in the health care system, with the professionals' career, self-esteem and their own mental health being prejudiced (WHO 2021b). Family members of older adults with mental health conditions may also fall victim to stigma and discrimination, with loss of personal projects and resources (including financial ones) (Banerjee et al. 2021).

A meta-analysis of research on older people aged 75 years and above in South Africa revealed the prevalence of depression was 40 per cent (Padayachey, Ramlall and Chipps 2017). The authors also found that females who were single and had poor self-perceived health were meaningfully associated with higher levels of depression. Another South African study revealed that depression rates were 25.2 per cent in urban areas and 27 per cent in rural areas (Bunce et al. 2012). The latter authors also posited that due to the adverse effects resulting from a decline in functioning (social impairment), awareness of decreased health and frequent use of medical facilities, depression was recognised as a problem in the older population. Additionally, Nyirenda et al. (2013) found the prevalence of depression among 50+ year-olds to be 42.5 per cent in South Africa. Being female, receiving a government grant, residing in an urban area and giving care or receiving care were meaningfully associated with any depressive incidence. Respondents with a depressive incident were two to three times more likely to report poor health perceptions.

In another South African study (Welthagen and Els 2012), 18.3 per cent of the population were receiving treatment for depression, 16.7 per cent were doubtful they had depression and 65 per cent did not suffer from depression. In the same study, depression was associated with work engagement, burnout and stress-related well-being. Tomlinson et al. (2009) found a lifetime prevalence of depression of 9.7 per cent and a prevalence of 4.9 per cent 12 months before the interview in a study in South Africa. The prevalence was higher among females and those with lower levels of education. The authors reported that more than 90 per cent of the participants with depression had overall role impairment, suggesting an association between depression and social impairment. In another study in the Netherlands (Saris et al. 2017), patients with comorbid anxiety and depressive disorders showed the most severe social impairments, followed by depressed and anxious patients ($p < .001$).

Older persons should receive the same mental health care as the rest of the population. They desire services that are dependable, accessible and with qualified staff that are sensitive to and aware of diversity. Older persons want to have their health issues managed collaboratively when they arise. This necessitates a welcoming environment. If they need hospital treatment, older persons prefer to be near their families. To do this, innovation is necessary and it may be necessary to adapt to new technology and use it ethically and responsibly while also taking the older person's perspective into account.

Community context

Contemporary analysis into social determinants has often focused on community characteristics such as urbanicity or neighbourhood safety. Residents of rural areas demonstrate higher disorder prevalence than urban residents (Robinson et al. 2017) and population density appears to influence depressive symptoms among gay and bisexual men (Cain et al. 2017). Neighbourhood safety – measured by personal perception and experience – has emerged as an important predictor of mental health outcomes (Chen et al. 2017; Stansfeld et al. 2017). Some prospective studies also explored the impact of context on mental disorders (Silva, Loureiro, and Cardoso 2016). Neighbourhood deprivation was associated with worse mental health (Santiago, Wadsworth and Stump 2011), increased psychiatric medication prescription (Crump et al. 2011) and higher risk of being hospitalised for mental disorder, independent of individual-level sociodemographic characteristics. Hamoudi and Dowd (2014) concluded that housing market volatility may influence the psychological and cognitive health of older adults. Another study by Jokela (2014) provided little support for social causation in neighbourhood health associations and suggested that correlations between neighbourhoods and health may develop via selective residential mobility.

More recently, the concept of social capital has become popular in mental health research, with several studies suggesting that there may be qualities of communities and neighbourhoods that contribute to the aetiology or prevention of common mental illnesses (Almedom 2005), although any causal relationship is likely to be highly context specific (Caughy, O'Campo and Muntaner 2003). Social capital is defined as the resources available to individuals and to society through social relationships, (Kawachi, Subramanian and Almeida-Filho 2002: 647) 'The features of social organisation, such as civic participation, norms of reciprocity and trust in others, that facilitate cooperation for mutual benefit.'

Some of the empirical studies reviewed assessed the association between social capital and mental health. Social capital may affect mental health in different ways, through its 'structural' (connectedness, membership of organisations) or 'cognitive' (trust, sense of belonging and shared values) components. High levels of structural social capital (Brisson, Lopez and Yoder 2014; Lofors and Sundquist 2007; Phongsavan et al. 2006; Sundquist et al. 2014) and high levels of cognitive social capital (Sunquist et al. 2014; Phongsavan et al. 2006) were associated with lower risk of mental health distress or disorder after considering potential individual confounders. People who reported fewer neighbourhood problems had higher levels of mental well-being, independently of individual factors (Gale et al. 2011).

The perception of severe problems in the community (Brisson, Lopez and Yoder 2014; Gary, Stark and LaVeist 2007), exposure to violence and negative life events (Stockdale et al. 2007) and high frequency levels of discrimination (Ajrouch et al. 2010) were associated with higher levels of psychological distress. Perceived neighbourhood satisfaction (Kamimura et al. 2014) and

stress-buffering mechanisms in the neighbourhood (Stockdale et al. 2007) were associated with a lower likelihood of disorders. Higher workplace social capital was associated with lower odds of poor mental health in a study among Chinese employees (Gao et al. 2014). One study of women in Lusaka, Zambia and Durban, South Africa suggested that membership in community groups (in this study, primarily church groups) was associated with better self-rated mental health, although adjustments for individual socio-economic position are not reported (Thomas 2006).

South Africa differs from many other middle-income nations in that it has a distinct historical context, high rates of trauma and violence and a more diverse socio-cultural and economic society. The study of the social determinants of mental health is faced with several difficulties even though this diversity contributes to social situations being variable. The most pertinent components of social networks and social capital may vary throughout communities, the most relevant types of life events may vary between locations and the most relevant mental health measurements may have various meanings in different groups within the South African population. This potential variety emphasises the necessity to comprehend the reliability of these measures and other constructs in South African public mental health research.

Interventions to address the social determinant of mental health

To address social determinants of mental health, varied elements are required for effective responses which include an informed social work educational programme, growth of a transdisciplinary team, well-informed interventions, culturally responsive provision, clinical evidence-based services and relevant policy with actions to minimise inequalities identified in mental health (Alegría et al. 2018). Additionally, Compton and Shim (2015) state that these determinants of mental health include factors that contribute to health and illness which may be addressed by policy formulation and programme implementation, through environmental changes and with both collective and individual verdicts within the society. The determinants of mental health tend to interlink with both physical health and mental health disorders.

Compton and Shim (2015) declare that social determinants of mental health such as discrimination and social prohibition, early negative life experiences, inadequate education, lack of employment, underemployment and work insecurity, income inequality, poverty and neighbourhood, poor housing quality and housing instability, negative built environment features and limited access to healthcare, predispose individuals and populations to poor health. These determinants may have a negative effect on the mental stability of an individual suffering from various disorders (Compton and Shim 2015). Besides, in exploring social determinants of mental health, mental disorders are regarded as highly comorbid conditions and are commonly associated with many mental diseases, such as substance use disorders and chronic health conditions including pulmonary, cardiovascular, cerebrovascular diseases and the severity and needs

of mental health illnesses are often affected by social determinants (Compton and Shim 2015). Moreover, Compton and Shim (2015) assert that it is important to address mental health's social determinants for various reasons:

- First, treatment for some mental disorders remains very limited with moderate effects and outcomes at best because the ability to cure or fully manage mental disorders with medical interventions needs to provide ways for people living with mental illnesses to lead healthy, fulfilling and meaningful lives which involves attention to economic, social and environmental factors.
- Second, even if a highly effective medical treatment for mental health illnesses is discovered, it is known that such disorders are initially caused by complex interactions between biological, social and environmental factors. Therefore, paying attention to the social factors, many of which are emendable through public health and policy, interventions will, arguably, always be necessary for effective preventative measures to address the burden of mental disorders.
- Finally, determinants of mental health primarily pertain to identified inequalities in mental health, therefore the focus should be on issues that emerge from social factors influencing mental health.

According to a World Health Organization review (WHO 2014), the following concepts need to be taken into consideration when addressing social determinants and mental health:

(I) Use a life course approach

A life-course perspective indicates that health at each stage of life is affected by both unique and common factors.

(II) Focus on early intervention to improve health

Programmes, particularly in low- and middle-income countries, that intervene early in a child's life can prevent both acute and long-term mental health issues. This approach also helps children and adolescents to maximise their potential and to thrive.

(III) Address physical health to optimise mental health

More specifically, decreasing inequalities in mental health attainment cannot occur without addressing barriers related to addressing the health of the whole child. Providing comprehensive care for acute and chronic physical illness can help prevent mental health issues.

(IV) Prioritise mental health and ensure mental health equity in all policies

There is a clear need, globally, for mental health to have greater focus

and recognition. This is true in low- and middle-income countries, where lack of resources is notable, but of note, there are also challenges in high-income countries related to access to mental health services, payment structures and stigma.

(V) Implement action at both the local and country-wide level

Finally, reducing inequalities in mental health is a task that must be addressed on a local level, as well as nationally (WHO 2014). Country-level strategies are most likely to have a significant impact on decreasing inequalities (WHO 2014). A wide range of actions at the national level, including alleviating poverty, implementing effective social protection across the life course, reducing discrimination, preventing violent conflict and promoting access to health care, housing and education, can lead to significant benefits in mental health across a population (Berry, Londoño Tobón and Njoroge 2021).

Specific strategies for addressing social determinants

The following are some more specific strategies to consider for addressing poverty, food insecurity, family/neighbourhood and community-related issues, trauma and racism.

Poverty

Poverty may affect a family's ability to provide a safe and healthy environment for their child. Parental employment and access to quality education can play significant roles in support of families and their children (WHO 2014).

Families, neighbourhoods and communities

Schools play a significant role in the development of social, emotional, academic and cognitive ability. Actions to address children and teen mental health disorders within school settings have been implemented successfully in countries across the world (WHO 2014). Of note are school-based interventions in communities affected by violence where the chances of acquiring mental health problems are especially high. Regarding community space, a recent study reviewing the evidence on the effects of green space in urban areas shows that these spaces offer benefits such as psychological relaxation and stress reduction, in addition to decreasing air pollution. Therefore, there is a need for small green spaces close to where people live and larger spaces such as parks, that provide formal recreational facilities (Hedblom, Gunnarsson and Iravani 2019). It is also crucial to ensure safe and healthy surroundings, as the environment has a profound influence on children's growth and development. To provide a healthy environment for children, the WHO recommends improving sanitation, reducing air pollution and building safer environments (Pereira and Diego-Rosel 2017).

Malnutrition and food insecurity

Eliminating food deserts and increasing access to low-cost, healthy foods early on and throughout childhood and adolescence is essential. Promoting breastfeeding is one of the best ways to protect babies. Maternal nutrition is critical and elimination of diets deficient in essential nutrients can support a healthy pregnancy and an infant's physical and mental health. In a recent trial in Nepal, the use of low-dose vitamin A supplements reduced maternal mortality by 44 per cent and was a low-cost strategy for improving paediatric outcomes (Costelo and Osrin 2010).

Studies also show that community-based approaches are needed to strengthen household food security. Community-wide awareness programmes are needed to raise the alert on the importance of health and nutrition. For example, there is a need to ensure a sustainable, adequate intake of iodine by all adolescent girls and women of childbearing age prior to conception to prevent mental retardation and iodine deficiency. This can be accomplished in the long run by using iodised salt and fortified foods such as bread (WHO 2014).

Trauma

It is common for children and teens to be exposed to more than a single traumatic event and children exposed to chronic trauma are especially vulnerable to the impact of additional trauma. When families come to the attention of professionals, the specific trauma needs to be attended to but also essential is gathering a thorough, detailed history of all trauma exposure throughout the life course and the provision of comprehensive psychological support (Abraham and Walker-Harding 2022).

Racism

Finally, reviewing and revising policies that perpetuate institutionalised racism in the systems of healthcare, housing, education and the economy will begin to address the pervasive impact of differential and unequal treatment on the mental health and well-being of children and adolescents worldwide (Institute of Medicine 2001).

Given substantial evidence of the relations between social determinants and mental health outcomes, multilevel interventions intended at eliminating systemic social inequalities – such as access to educational and employment opportunities, healthy food, secure housing and safe neighbourhood and well-being are crucial (WHO 2014). A framework devised by Bell, Donkin and Marmot (2013) integrates the meta-analysis' systems (for example, health, education), societal (for example, social norms) and macro (for example, political, economic) levels. Interventions targeted at improving household and well-being for individuals with mental disorders have demonstrated success in increasing housing stability, community functioning, perceived well-being and quality of life and increased self-esteem (Aubry et al. 2016).

A meta-analysis of interventions targeting employment showed that Individual Placement and Support (IPS) programmes have effectively improved employment rates, as well as individual functioning and well-being (Modini et al. 2016). However, limited funding impedes IPS programme implementation (Drake et al. 2016). Studies investigating the effects of addressing mental health needs before offering housing have not shown promising outcomes (Drake et al. 2016). Social policies targeting housing stability have also been credited with decreasing food insecurity rates (Li, Dachner and Tarasuk 2005). Food insecurity has been associated with poor mental health outcomes (Davison, Gondora and Kaplan 2017; Martinez et al. 2020), however, benefits of national programmes like the Supplemental Nutrition Assistance Programme may be moderated by individual perceptions of government assistance (Bergmans et al. 2018). Other poverty reduction programmes, such as the Earned Income Tax Credit, suggest that such national efforts can decrease depressive symptoms and improve self-esteem among beneficiaries (Boyd-Swan et al. 2016).

Within the current South African context, a focus on social determinants remains high on the health agenda. South Africa exemplifies stark social inequities which translate into a high burden of premature mortality and marked health inequities. For example, estimates of the infant mortality rate (IMR) from the 2011 Census in the predominantly rural Eastern Cape Province is 40.3 per 1 000 live births – double that of the Western Cape with an IMR of 20.4 per 1 000 live births (Massyn et al. 2015). There are also significant differences within provinces. For example, the maternal mortality in facility ratio is 56 per 100 000 live births in urban Cape Town and 371 per 100 000 live births in the rural district of the Central Karoo in the same province (Massyn et al. 2015). Addressing social determinants is a cornerstone in the National Department of Health's Primary Health Care (PHC) Re-engineering Strategy (Naledi, Barron and Schneider 2011).

South Africa has several distal policies that have the potential to promote mental health in children and adolescents (Krieger 2008). The Child Support Grant in South Africa is as important during this life stage as for infants. Up to 8.7 million children, that is, 58 per cent (in a total population of 15 million children) under the age of 14 years received such a grant in 2008 (Spires et al. 2016). South Africa also has foster care grants to assist in the financial provision of orphaned children (Republic of South Africa [RSA] 2003). Further, the National School Nutrition Programme which has been in operation for 13 years, provides meals to school-going children, reaching approximately seven million children (Republic of South Africa [RSA] 2003).

Family strengthening interventions for children and adolescents are equally important. Apartheid left a legacy of fractured Black families because of the migratory labour system. There is also additional disruption to families because of the HIV/AIDS pandemic, with South Africa having an estimated 1 900 000 child orphans due to AIDS in 2009 (Mayosi et al. 2012). In this respect, the Collaborative HIV/AIDS Adolescent Mental Health Programme South Africa (CHAMPSA), which has also recently been adapted to support caregivers of HIV+ children, demonstrated significant improvements in communication and monitoring and control in the parents/caregivers receiving the intervention

(Development Bank of South Africa 2008).

The Department of Health has policy guidelines for health-promoting schools and the Department of Basic Education is in favour of whole school development (Scotti et al. 2017). These authors state that central to the health-promoting whole school approach is an appreciation of contextual influences on risk behaviour and mental health which demands a comprehensive systems intervention. Strengthening health-enabling school policies such as anti-bullying policies, recreational facilities to promote health and well-being, parental and community relationships and the provision of life skills programmes to develop interpersonal skills as well as adolescent-friendly health services are central to this approach (Scotti et al. 2017; United Nations Children's Fund [UNICEF] 1991).

Given that 25 per cent of mental disorders in adulthood begin before the age of eight years and 50 per cent by adolescence, prevention of many adult mental disorders requires interventions earlier in the lifespan (Igumbor et al. 2012). The South African Stress and Health (SASH) study found that low socio-economic status and low educational levels are associated with increased psychological distress (Okop, Mukumbang and Mathole 2016). Recent negative life events and relationship problems were predictors of the 12-month and lifetime prevalence of mental disorders (Mvo, Dick and Steyn 1999). In women, physical partner violence, reported at 19 per cent, was the strongest predictor of any lifetime disorder (Abdool Karim and Baxter 2016). Interpersonal violence is a major public health problem in South Africa, being the second leading cause of disease burden in Disability Adjusted Life Years (DALYs). Further, it is also associated with elevated risk for engaging in high health-risk behaviours such as smoking, alcohol consumption and the use of sedatives and analgesics in women (Abdool Karim and Baxter 2016).

For men, predictors of mental distress include criminal assault, childhood abuse and political detention and torture (Mvo et al. 1999). Further, the SASH study revealed elevated risk for common mental disorders (CMDs) in people who reported discrimination, with chronic non-racial discrimination being a strong predicator (Abdool Karim, Sibeko and Baxter 2010). Distal policy interventions required to address the social determinants of mental disorders in adults in South Africa thus overlap with many existing public health, poverty alleviation and gender equity initiatives as well as actions to reduce discrimination and interpersonal violence. Proximal mental health promotion and prevention programmes for adults that have shown promising outcomes in other LMICs include those that combine building social capital with economic generation initiatives (Scotti et al. 2017). Social capital provides people with access to emotional support and resources for dealing with stressful life events. Economic generation initiatives assist in addressing poverty-related social determinants of poor mental health. The importance of incorporating both strategies into mental health promotion and prevention interventions for adults in South Africa is reinforced by findings from the SASH study that lower levels of social capital as well as lower socio-economic status are independently associated with increased psychological distress in South Africa (Gupta et al. 2008).

In the context of interpersonal violence being of particular concern in South

Africa, an example of an evidence-based programme in South Africa that has the potential to be scaled up is the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) programme (Scotti et al. 2017). This programme addresses intimate partner violence, through skills building and promoting financial independence within the context of strengthening social capital. It targeted deprived women and combined a microfinance intervention with a participatory learning programme that included HIV prevention, communication skills and gender empowerment (Scotti et al. 2017).

The two biggest mental health conditions in later life are dementia and depression (Edwards and Collins 2014). More so, the authors state that unhealthy lifestyles and associated diseases such as hypertension, type II diabetes, hypercholesterolemia, obesity and smoking are risk factors for vascular dementia in later life. In South Africa, these conditions are becoming more prevalent with the diffusion of urban lifestyle risk factors, including tobacco smoking, unhealthy diet and physical inactivity (Chersich and Rees 2008; Kim et al. 2008; Jewkes, Durkie, Nduna and Shai 2010), with cardiovascular disease projected to increase by over 40 per cent in the 35–65-year age group by 2030 (Jewkes, Dunkie, Nduna, Jama and Puren 2010). Risk factors for late life depression, include being disabled, especially having a functional impairment, having a history of prior depression, as well as being socially isolated (Edwards and Collins 2014).

In addition, in South Africa, many older people who take care of their sick children or orphaned grandchildren because of the HIV/AIDS pandemic are also at risk (Scotti et al. 2017). The financial, physical and emotional burden of this caregiving role on older people in relation to bereavement, stigma and discrimination, social isolation and lack of support is becoming increasingly apparent (Gibbs et al. 2012; Leclerc-Madlala 2008). In relation to distal policy level interventions to promote healthy lifestyles, South Africa has some of the most progressive policies in Africa. These include 'sin' taxes on alcohol and tobacco products, health label warnings on these products, as well as restrictions on tobacco and alcohol use in public places and restrictions on tobacco advertising. South Africa also has one of the most generous state pension systems in the developing world, although it rarely serves to promote independent living for the elderly, rather serving to alleviate household poverty, with unintended beneficiaries being children and the unemployed (Edwards and Collins 2014). Proximal mental health promotion for older people remains limited, however. Traditionally, the older person is cared for by their children in African culture. In the context of changing patterns of support, many older people must now take on the burden of caring for the unemployed, sick and/or orphaned children (Scotti et al. 2017).

In relation to promoting mental health in adults and older people, several distal policy level interventions in South Africa should be beneficial, including poverty alleviation, gender equity, social redress policies as well as efforts to promote healthy lifestyles (Scotti et al. 2017). At a proximal level, the need for programmatic mental health promotion and prevention interventions that address interpersonal violence is urgently indicated (Scotti et al. 2017). Programmes that simultaneously promote sustainable livelihoods as well as

promote health enhancing social capital should also be encouraged (Scotti et al. 2017).

This chapter has delved into the intricacies of mental health policy implementation, highlighting the significance of sustainable financing strategies and the impact of social determinants on mental health outcomes. These elements, along with the challenges in actualising policy goals despite their adoption, pave the way for a deeper exploration in the following chapter. In the upcoming chapter, we will delve deeper into the realm of mental disorders, examining how they are defined, their perceived impact on mental health care users and caregivers, and an overview of strategies aimed at alleviating their effects. This exploration will shed light on the complexities of mental health conditions, their implications for both those receiving care and those providing it, and the various approaches employed to mitigate their impact.

Chapter 5
Mental disorders defined, percieved impact on mental health care users and caregivers and overview of alleviating strategies

Introduction

Mental disorders are common diseases affecting people's health (Angermeyer and Dietrich 2006; Jorm 2012). Charlson et al. (2019) assert that it is anticipated that one in 10 people in the world is living with a moderate or severe mental disorder. It is therefore likely that during a lifetime almost everyone will have direct contact with someone who suffers from mental illness. Only a third of the people who suffer from a mental disorder are treated and many of those who remain untreated suffer deep consequences throughout their lives (Bourget and Chenier 2007). One of the major reasons why people fail to get treated is due to lack of knowledge. Corrigan and Watson (2003) established that people do not have sufficient or accurate knowledge of mental disorders. Awareness of mental disorders is vital as it may be a significant determinant of help-seeking behaviour (Bourget and Chenier 2007). Rüsch, Angermeyer and Corrigan (2011) are of the view that there is a need for enhanced knowledge of mental health and mental disorders which will improve people's awareness of where to go for help-seeking and treatment. Enhanced knowledge will also help in reducing stigma at individual, public and institutional levels, this will help with early recognition of mental disorders, developed mental health results and improved the use of mental health facilities (Rüsch et al. 2011).

Mental disorders defined and conceptualised

In all countries, mental health conditions are highly prevalent and about one in eight people in the world live with a mental disorder (World Health Organization [WHO] 2022). The prevalence of different mental disorders varies with sex and age. In both males and females, anxiety disorders and depressive disorders are the most common (WHO 2022). The WHO (2022: 8) defines a mental disorder as 'a syndrome characterised by clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning.' According to some African interpretations, some mental disorders are due to being possessed, such as that of *Amafufunyana*, which is defined as a soul possession that results from

witchcraft (Galvin, Chiwaye and Moolla 2023). According to the Zulu and the Xhosa cultures in South Africa, spirit possession is a result of a mixture of soil and ants taken from a cemetery, allegedly having fed from a corpse; the mixture is said to be positioned in the pathway of the targeted person (Galvin et al. 2023). After walking on this mixture, the person will have symptoms like those of hysteria, throwing themselves on the floor, tearing off their clothes, speaking in a strangely muffled voice that cannot be understood and may harm themselves due to acting violently and may also try to commit suicide (Galvin et al. 2023). *Amafufunyana* is 'described as a hysterical condition characterised by people speaking in a strangely muffled voice in a language that cannot be understood and strange and unpredictable behaviour' (Niehaus et al. 2004: 60).

Another example is *Indiki* which happens because of being possessed by *amadlozi* (ancestors). Ancestors are family members who have passed on and are assumed to live in the spiritual world (Nwoye 2015) but are still active members of the family who protect and give guidance to the family. Nwoye (2015) argues that African epistemology assumes an interconnection between the visible and invisible worlds that influence each other. The bizarre behaviours of an individual with `*Indiki*' are the initial signs that the ancestors have chosen that individual. An individual with *Indiki* starts by having certain dreams at night and due to emotional conflict, he or she loses appetite and becomes thin. Thus, within the Western perspective, the person is manifesting some form of anorexia nervosa (Galvin et al. 2023). In the African culture, the individual with *Indiki* accepts their calling, he or she becomes treated through traditional ceremonies called *Ukuthwasa* to become a *sangoma* (Manyike and Evans 1998). *Ukuthwasa* is a process or a practice that an individual goes through to learn to become a *sangoma*.

Bila and Carbonatto (2022) established in their study how cultural beliefs influenced the help-seeking behaviour in rural communities of South Africa. Therefore, knowledge about mental disorders differs between people, relatives, societies, beliefs and countries. Understanding people's cultural beliefs about mental disorders is important for the application of active methods to provide mental health care (Nieuwsma et al. 2011). Understanding people's cultural and individual conceptions about mental illness is therefore important for the application of effective strategies to provide mental health care. People's views about mental illness affect their willingness and where to go for treatment (Nieuwsma et al. 2011). African communities view a mental disorder as a problem caused by hidden cultural meanings that need interpretation to free the tormented person with the mental disorder. There are diverse ways of understanding mental disorders, as people living in 'Mozambique and Angola believe that mental disorder is directly related to the anger of the spirits of the dead and in southern Mozambique, these spirits are called *Mipfhukwa*' (Honwana 1998: 105). These spirits are thought to belong to people who have been killed irrationally and they did not have a proper funeral. Thus, their souls are said to not be at peace and are spirits of unpleasantness. It is presumed that the spirits can cause trouble and cause mental illness (Honwana 1998). A

ritual is then carried out to remove the spirits, performed to place the spirits in their rightful position in the world of the ancestors (Honwana 1998). 'A study conducted in Uganda revealed that the phrase depression is not culturally appropriate among the population, while an alternative study conducted in Nigeria found that people answered with fear, avoidance and anger to those who were observed to have a mental illness' (Amuyunzu-Nyamongo 2013: 59). One-third of Nigerian respondents perceive drug abuse as the primary cause of mental illness. Following closely, beliefs in divine wrath and the will of God rank as the second most prevalent reasons, trailed by notions of witchcraft or spirit possession (Amuyunzu-Nyamongo 2013: 59).

The COVID-19 pandemic has posed a serious threat to global mental health. Multiple lines of evidence suggest that there is a varying yet considerable increase in mental health issues among the general population and vulnerable groups (Qiu et al. 2020). The aftermath is obscure and speculative from a social, economic, individual and public mental health perspective. Recently published studies supported the existence of an emotional epidemic curve, describing a high probability of an increase in the burden of mental health issues in the post-pandemic era (Ransing et al. 2020; Ren and Guo 2020). Furthermore, previous major public health emergencies showed that more than half of the population developed mental health problems and required mental health intervention (Ren and Guo 2020; Taylor and Asmundson 2020). There is, therefore, an urgent need to reorganise existing mental health services to address the current unmet needs for mental health and to prepare for future challenges in the post-pandemic era in terms of prevention and management. In the post-pandemic era, it may be difficult to identify mental disorders aetiologically related to COVID-19 (for example, anxiety due to cytokine storm) owing to a lack of specific diagnostic or screening tools (Ransing et al. 2020).

COVID-19 has had a significant impact on mental health (Kim, Nyengerai and Mendenhall 2020; Naidu 2020; Pillay and Barnes 2020). Kim et al. (2020) in their recent study of the mental health impact of COVID-19 on South Africans living in Soweto, found that adults who had experienced childhood trauma and other related adversities were at higher risk of developing depressive symptoms precipitated by the perceived risk of contracting COVID-19. In addition, Naidu (2020) states that due to public biological, psychological and social predispositions in South Africa, COVID-19 may lead to mental health presentations such as post-traumatic stress disorder, mood disorders, anxiety disorders, phobias and obsessive-compulsive disorders. A study conducted by the Human Sciences Research Council (2020) reported that 33 per cent of South Africans were depressed, while 45 per cent were fearful and 29 per cent were experiencing loneliness during the first lockdown period. While the provision of and access to essential services, including mental health care, was permitted during the lockdown period, as gazetted by the Government (Lockdown regulations No. 43232, April 2020) (Department of Cooperative Governance and Traditional Affairs [RSA] 2020), some MHCUs were unable to access services due to limitations and risks presented by physical contact and in-person

consultations (Pillay and Barnes 2020).

People will suffer from post-traumatic stress disorder post-pandemic. The country was severely affected by COVID-19. South African citizens suffered great losses, such as losing their loved ones, business closure and the high unemployment rate caused by COVID-19. Therefore, strategies for post-COVID-19 recovery should be devised.

Classification and prevalence of mental disorders

As described above, a mental disorder is characterised as a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour (WHO 2022). It is usually associated with distress or impairment in important areas of functioning and there are many different types of mental disorders. Mental disorders may also be referred to as mental health conditions (WHO 2022). The latter is a broader term covering mental disorders, psychosocial disabilities and (other) mental states associated with significant distress, impairment in functioning, or risk of self-harm (WHO 2022). In 2019, one in every eight people, or 970 million people around the world were living with a mental disorder, with anxiety and depressive disorders the most common (Charlson et al. 2019). In 2020, the number of people living with anxiety and depressive disorders rose significantly because of the COVID-19 pandemic. Initial estimates show a 26 per cent and 28 per cent increase respectively for anxiety and major depressive disorders in just one year (WHO 2022). The Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association [APA] 2013) categorises and defines diseases but is not exhaustive. The APA released the DSM-5-TR, a text revision edition, in 2022. This updated version incorporates changes and updates in mental health practice since 2013, making it the preferred and most current accurate rendition of the DSM-5. There is a growing consensus that the DSM is Western-biased, and many argue that its classifications can be more harmful than helpful to people from the African continent. Scholars emphasise that the DSM's framework is rooted in Western concepts of mental illness, which often fail to account for cultural differences in non-Western regions. Kirmayer and Pedersen (2014) highlight the challenges of applying Western psychiatric models, such as the DSM, globally, and advocate for culturally sensitive approaches that consider local contexts, particularly in Africa. Similarly, Watters (2011) critiques the exportation of Western mental health concepts, pointing to the unintended negative consequences for African cultures. Patel et al. (2023) call for a rethinking of global mental health strategies and policies, particularly the reliance on Western diagnostic systems like the DSM, urging for more culturally inclusive and locally relevant approaches.

A special Sunday Times investigation has uncovered the shocking state of mental health in South Africa (Johnston 2019). One third of all South Africans suffer from mental disorders and 75 per cent of them will go untreated. According to the South African Federation of Mental Health (2021), more than

17 million people in South Africa suffer from depression, substance addiction, anxiety, bipolar disorder and schizophrenia, which make up the top five mental health diagnoses. The first nationally representative survey of the prevalence of mental health conditions among adults was conducted between 2003 and 2004, with a particular focus on common mental disorders (CMDs), including depression, anxiety and substance use disorders (South African Human Rights Commission [SAHRC] 2019). The South African Stress and Health (SASH) study was conducted as part of the WHO's World Mental Health Survey Initiative (Herman et al. 2009). The study refers to 'relatively high' prevalence rates of mental health conditions, finding that the lifetime prevalence for any mental health condition in South Africa was 30.3 per cent. Anxiety disorders were the most prevalent form of 'disorder', while substance abuse and mood disorders were the next most prevalent conditions in South Africa (Herman et al. 2009). The study also noted differences in prevalence across provinces, noting that the Western Cape and the Free State had significantly higher prevalence of mental health conditions than other parts of the country, while the Eastern Cape and the Northern Cape had prevalence figures that were significantly lower than the rest of the country. It is notable, however, that the General Household Survey of 2017 indicated that the Eastern Cape had the highest prevalence of 'mental illness' followed by Gauteng and KwaZulu-Natal (Statistics South Africa [StatsSA] 2017).

Prevalence statistics relating to psychosocial and intellectual disabilities (mental disorders) are often under-estimates (SAHRC 2019). There are several reasons for this, including how the SASH study only focused on CMDs and not severe mental disorders such as schizophrenia and bipolar disorder; the stigma associated with reporting mental health problems; and because of a lack of sufficient skilled personnel to accurately diagnose potential challenges (Vigo et al. 2020). Apart from the SASH study, smaller studies have also demonstrated a high prevalence of mental health conditions in South Africa, exhibited in one study by attempted suicide rates of 7.8 per cent and rates of suicidal ideation of 19 per cent among high school students (Flisher et al. 1993). Another study found a 22 per cent prevalence rate of post-traumatic stress disorder (PTSD) among South African school children (Seedat et al. 2004). Post-partum depression rates as high as 34.7 per cent have been documented (Cooper et al. 1999), as have rates as high as 37 per cent for depression (Carey et al. 2003). These findings illustrate that South Africans face considerable mental health challenges. However, the small size of these studies and the fact that many were conducted several years ago suggest that further research is needed to determine the prevalence of mental health conditions in present-day South Africa (SAHRC 2019).

While the prevalence of mental health challenges in South Africa is difficult to estimate accurately, the WHO notes that psychosocial and intellectual disabilities are becoming more widespread (SAHRC 2019). By 2020, four out of the top ten causes of disability worldwide will be psychosocial or intellectual disabilities (SAHRC 2019). Depression is expected to be the second leading

cause of disability worldwide, behind only ischemic heart disease (WHO 2001). Some of the predominant mental disorders are discussed in depth below.

Anxiety disorders

In 2019, 301 million people were living with an anxiety disorder including 58 million children and adolescents (Institute of Health Metrics and Evaluation 2019). Anxiety disorders are characterised by excessive fear and worry and related behavioural disturbances (WHO 2022). WHO further asserts that symptoms are severe enough to result in significant distress or significant impairment in functioning. There are several different kinds of anxiety disorders, such as: generalised anxiety disorder (characterised by excessive worry), panic disorder (characterised by panic attacks), social anxiety disorder (characterised by excessive fear and worry in social situations), separation anxiety disorder (characterised by excessive fear or anxiety about separation from those individuals to whom the person has a deep emotional bond) and others (WHO 2022). As part of the South African Stress and Health (SASH) study, which investigated the lifetime prevalence of common mental disorders, anxiety disorders were found to be the most prevalent class of lifetime mental disorders (15.8 per cent) (Herman et al. 2009). The presence of any anxiety disorder was estimated to have the highest individual-level effect, with 12.7 days more per year of being out-of-role compared to those estimated for the average individual without the disorder (Herman et al. 2009; Mall et al. 2015). The treatment of anxiety disorders may be complicated by the potential presence of comorbid psychiatric disorders, including other anxiety disorders, mood disorders, substance use disorders and personality disorders (van Noorden et al. 2012).

Depression

In South Africa, adults living in neighbourhoods that experience relatively higher levels of social dysfunction, such as high crime rates and gangsterism, are more likely to be depressed (Tomita, Labys and Burns 2015). Depression is often defined through its symptoms, for example, sadness and feelings of hopelessness and helplessness (Mungai and Bayat 2019). The degree of severity to which an individual experiences these symptoms determine how ravaging their effects may be on the individual's quality of life (Mungai and Bayat 2019). In measuring the severity of depressive episodes, the International Classification of Diseases–10th Revision (ICD-10) criteria enable the specification of mild, moderate and severe depressive episodes (Mungai and Bayat 2019). The South African Stress and Health (SASH) study estimates that major depression was among the mental disorders with the highest lifetime prevalence rates (9.8 per cent) in South Africa (Stein et al. 2008). The lifetime prevalence rate was highest in the Eastern Cape, one of the poorest provinces in South Africa. Andersson et al. (2013) estimate the lifetime prevalence rate of depression to be 31.4 per cent in the Eastern Cape, with 15.2 per cent of the study participants depressed at the time of data collection.

Bipolar disorder

In 2019, 40 million people experienced bipolar disorder (Institute of Health Metrics and Evaluation 2019). People with bipolar disorder experience alternating depressive episodes with periods of manic symptoms (WHO 2022). Bipolar disorder (BD) is a chronic mental disease associated with functional and cognitive impairment in memory, attention and executive activities because of fluctuations in mood, energy and activity levels, as well as neuropsychological deficit (Best et al. 2015: 406; Goodwin et al. 2016: 495; National Institute of Mental Health [NIMH] 2016; Samame et al. 2017: 17). The International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10), describes BD as an illness characterised with mood fluctuations between manic and depressive episodes. This change is often associated with a change in total levels of activity (WHO 2016a). Merikangas et al. (2011: 545) found the average age to be 18.2 years for initial occurrence of BD I disorder and 1 per cent prevalence in one's lifetime, while that of BD II disorder is 20.3 years and 1.1 per cent, respectively. Higher rates are often found in women, although economic, social and ethnic factors are also likely to exert an influence (Kennedy et al. 2005: 257). In addition, the pattern of one's life, coupled with genetic factors, among others, is also capable of predisposing an individual to BD (Kennedy et al. 2005).

The 12-month prevalence of mood disorders in South Africa (SA) (Herman et al. 2009: 343) was comparable with other countries involved in the World Mental Health (WMH) survey (Merikangas et al. 2011: 245). The prevalence of mental disorders was very high in the Western Cape of SA and very low in the Eastern Cape (Herman et al. 2009: 343). In a systematic review of all Diagnostic and Statistical Manual IV (DSM -5) disorders from 1985 to 2002 in the Western Cape, it was found that the prevalence of mental disorders was 25 per cent in adults and 17 per cent in children and adolescents.

Post-Traumatic Stress Disorder (PTSD)

The prevalence of PTSD and other mental disorders is high in conflict-affected settings (Charlson et al. 2019). The authors further assert that PTSD may develop following exposure to an extremely threatening or horrific event or series of events. It is characterised by all of the following: 1) re-experiencing the traumatic event or events in the present (intrusive memories, flashbacks, or nightmares); 2) avoidance of thoughts and memories of the event(s), or avoidance of activities, situations, or people reminiscent of the event(s); and 3) persistent perceptions of heightened current threat (WHO 2022). More so, WHO further states that these symptoms persist for at least several weeks and cause significant impairment in functioning. Effective psychological treatment exists. In South Africa, a gendered vulnerability to PTSD and depression has been found. Specifically, women experience more depression than men, 28.5 per cent versus 24.4 per cent (Mutyambizi , Booysen and Stornes 2019) and more PTSD than men (Atwoli et al. 2013; Stein et al. 2008). Women are also more likely to report

more severe manifestation of these disorders than men (Williams et al. 2007). Depression and PTSD among South Africans lead to lost national earnings of US$3.6 billion (approximately R60.3 billion) annually, with women (US$6390, approximately R111 050) bearing larger losses than men (US$1313, approximately R22 818) (Lund, Stansfield and Da Silva 2013). In South Africa, sexual violence (GBV) perpetrated against women is, unfortunately, a common criminal offense and this violence is associated with multiple, potentially adverse and long-lasting physical and mental health consequences, including the development of PTSD (Thomas 2017a). Studies conducted in South Africa and other African countries show that 20 to 30 per cent of women develop PTSD after rape (White et al. 2015). Women in general are more likely to develop PTSD than men (Silove et al. 2017). However, not all individuals exposed to a traumatic event go on to develop PTSD (Thomas 2017b).

Schizophrenia

Schizophrenia affects approximately 24 million people or one in 300 people worldwide (Institute of Health Metrics and Evaluation 2019). People with schizophrenia have a life expectancy of 10 to 20 years below that of the general population (Laursen, Nordentoft and Mortensen 2014). Schizophrenia is characterised by significant impairments in perception and changes in behaviour. Symptoms may include persistent delusions, hallucinations, disorganised thinking, highly disorganised behaviour, or extreme agitation (WHO 2022). Ninety per cent of people with untreated schizophrenia live in low- and middle-income countries (WHO 2018) where lack of access to mental health services prevails. Prevalence data on mental disorders including schizophrenia, in South Africa is limited (Meyer, Matlala and Chigome 2019). The Global Burden of Disease study estimated that the 12-month prevalence for any mental, neurological and substance use disorders in South Africa in 2016 was 15.9 per cent, with schizophrenia contributing 0.2 per cent (Institute of Health Metrics and Evaluation 2019). One study in South Africa indicated that mental health stigma perpetuated by family members, peers, community members and healthcare providers was rife, often leading to delays in help-seeking among patients (Egbe et al. 2014). An online study using Twitter to investigate stigmatising and trivialising attitudes across a range of mental and physical health conditions found that mental health stigma is common on social media with schizophrenia being the most stigmatised condition (Robinson et al. 2019).

Disruptive behaviour and dissocial disorders

Forty million people, including children and adolescents, were living with conduct-dissocial disorder in 2019 (Institute of Health Metrics and Evaluation 2019). Many times, childhood disruptive behaviour involves conduct such as temper tantrums, physical aggression such as attacking other children, excessive argumentativeness, stealing and other forms of defiance or resistance

to authority (Stadler 2017). These behaviours are often tolerated by parents and teachers at first and only attract notice when they interfere with school performance or family and peer relationships, since they frequently intensify over time. It is important to recognise that childhood disruptive behaviour problems in early childhood are associated with several negative long-term outcomes such as antisocial behaviour, adolescent delinquency and substance abuse (Butler 2005).

A study by the South African Human Rights Commission in 2008 on school-based violence confirmed media reports and complaints from educators, showed that violence in many South African schools has reached alarming proportions (South African Human Rights Commission [SAHRC] 2008; Serame et al. 2013: 2). These findings also illustrate the seriousness of the problem in the South African context (Rossouw 2003). This research confirms the need to further investigate child disruptive behaviour problems in the South African context and address the serious nature of this behaviour.

The South African Police Service has estimated that 43 per cent of South African youth are at risk of becoming offenders (Bezuidenhout and Joubert 2003). This estimate confirms that high levels of disruptive behaviour in our youth exert a strong influence on the crime statistics of our country (Vogel 2008). This context, therefore, again highlights the importance of not underestimating the extent and seriousness of learner misconduct in the South African context (Rossouw 2003).

Neurodevelopmental disorders

Neurodevelopmental disorders are behavioural and cognitive disorders that arise during the developmental period and involve significant difficulties in the acquisition and execution of specific intellectual, motor, language, or social functions (WHO 2022). Two hundred million children with disabilities live in low and middle-income countries including South Africa (Durkin 2002; World Health Organization and World Bank 2011). Infant mortality rates in these countries are decreasing and leading to a higher prevalence of neuro-developmental disorders (NDDs). In South Africa, there is an increased awareness of the incidence of childhood neurological and developmental disabilities, while there remains a limited understanding of developmental disorders particularly Autism Spectrum Disorder (ASD) (Franz et al. 2018). The fact that the 'data available from clinical case registries in large academic facilities has gone unpublished, leaves no data on the prevalence, causes, risk factors and intervention models for ASD in South Africa and because of this misfortune, ASD has received diminutive attention as a public priority' (Kauchali 2008: 5). Research indicates that ASD exists worldwide among all cultures, races and groups (Mubaiwa 2008). Parents and children from non-dominant cultures in each society are however faced with triple-layered problems: they are culturally different; they may be linguistically different; and they have exceptionality that is shot throughout with unique behavioural repertories (Trembath, Balandin and Rossi 2005).

Suicide

The South African Depression and Anxiety Group (SADAG) (2021) reports that there are 23 known cases of suicide in South Africa every day and for every person who commits suicide, 10 have attempted it. Before COVID-19, the organisation fielded 600 calls a day. As of September 2021, that number had risen to 2 200 calls a day – an increase of nearly 40 per cent (SADAG 2021). Suicidal behaviour describes a spectrum of negative thoughts and includes non-fatal suicides with varying degrees of intent and lethality, which may lead to (fatal) suicide (Leadholm et al. 2014). Suicidal behaviour is caused by an imbalance between factors that increase distress and decrease restraint (Leadholm et al. 2014). It is estimated that more than 800,000 suicides occur every year, with 79 per cent occurring in low- and middle-income countries (World Health Organization [WHO] 2023). Furthermore, it is estimated that there is a 25:1 ratio between non-fatal suicides and fatal suicides (Nock et al. 2010). A past non-fatal suicide attempt is perhaps the best indicator that a patient is at increased risk of suicide (Olfson et al. 2003). Risk factors for suicide may be both individual and familial (Sadanand et al. 2021). Familial risk factors may be caused by a family history of suicidal behaviours (Apter and Gvion 2006) and familial or genetic associations with suicidality (Sokolowski et al. 2015). Individual risk factors for suicide include high levels of hopelessness, poor problem-solving skills, and a history of aggressive behaviour (Sadanand et al. 2021). In addition, exposure to suicidal behaviour and thoughts may be associated with an increased risk of suicide, non-fatal suicide, and suicidal ideation (Sadanand et al. 2021).

The prevalence of suicidality in the South African communities points to the mental health crisis that we are facing as a society (SADAG 2021). SADAG (2021) asserts that we cannot talk about suicide without talking about depression, which is another of the prevalent mental health issues in South Africa. The lifetime prevalence of depression in South Africa is 9.7 per cent or 4.5 million and 70 per cent of people who attempt suicide have a mental health illness (SADAG 2021). In the South African context, previous studies on suicidal behaviour are scarce, probably because it is assumed that suicidal behaviour occurs less frequently in the local communities (Schlebusch 2005). More recent studies have shown that suicidal behaviour amongst the youth has increased significantly in parts of Africa, including South Africa (Sadanand et al. 2021). SADAG (2021) asserts that we live in a stressful society. More so, the lootings and their aftermath in July of 2021 point to the socio-economic challenges, violence and fragmented homes and communities we live in. Furthermore, we must seek to understand the reasons for the increased suicide rates and, more devastatingly, the extent of these rates among young people (SADAG 2021). Du Toit et al. (2008) found that of the 258 patients who presented with suicidal behaviour in Bloemfontein, the majority were female (68.9 per cent). Possible risk factors contributing to suicidal behaviour are financial difficulties, interpersonal relationship problems and mental health illnesses (Du Toit et al.

2008). Mental health issues, a history of deliberate self-harm, poor self-esteem and feelings of hopelessness are seen among patients presenting with nonfatal suicide (Moosa et al. 2005). Patients likely to cause deliberate self-harm are likely to have reported financial stress, interpersonal relationship problems, lack of tertiary education and past psychiatric illness as the main reasons contributing to suicidal behaviour (Van Zyl et al. 2021). The current increasing trend of patients presenting with non-fatal suicide in South Africa will further impact the nation's healthcare services and place added strain on the resources of South Africa (Moosa et al. 2005).

Kinyanda et al. (2009) reported suicide rates of 15–20 per 100,000 from 2005 to 2007 in northern Uganda. In South Africa, divergent cultural and religious perceptions of suicidal behaviour have also influenced the assumption that suicidal behaviour is not a significant problem in parts of Africa (Schlebusch 2012). Despite an increase in research investigating suicidal behaviour in Africa, the rates are still likely to be underreported and a good understanding of the full burden of suicidal behaviour is limited (Sadanand et al. 2021). This is largely due to a lack of research infrastructure and funds, a lack of expertise in suicide research and inadequate inter-African research collaborations (Sadanand et al. 2021). Furthermore, limited, and outdated studies, as well as a lack of standardised research designs and assessment instruments, also contribute to the under-reporting of data (Palmier 2011). Suicidal behaviour in most parts of Africa still carries negative cultural sanctions, thereby perpetuating nonreporting (Hawton, Saunders and O'Connor 2012).

Suicidal behaviour and its consequences are a global threat with an estimated 60 per cent increase over a couple of decades (Naidoo and Schlebusch 2013). As a major health problem in South Africa, it is estimated that about 6500 suicides and 130,000 non-fatal suicides occur annually within the country, with at least one suicide taking place every 40 seconds, compared with one non-fatal suicide every three seconds (Naidoo and Schlebusch 2013). The suicide rates in South Africa range from 11.5 to 25.0 per 100 000 of the population (Masango, Rataemane and Motojesi 2008). Approximately 11.0 per cent of all non-natural deaths in South Africa are because of suicide (Masango et al. 2008).

Non-fatal suicide patients who present to a healthcare establishment frequently require medication, counselling, a social worker, psychological and psychiatric evaluation, and therapy (Nakin et al. 2007). Social workers play an important role towards determining and addressing risk factors for suicidal behaviour (Nakin et al. 2007). Social workers assist in patient and family counselling and aid patients in fulfilling their basic needs, including housing, access to food, social services, and healthcare (Nakin et al. 2007). Social workers therefore play a significant role in increasing community awareness and engaging people around issues of mental health for psychoeducation and empowering them with resources and skills to better manage mental health challenges.

Mental disorders affect people of all categories of a life span. More so, there are different types of mental disorders. There is a high prevalence of mental disorders in the country, hence services or strategies are required to alleviate the impact as well as the symptoms of mental disorders.

Needs and challenges of Mental Health Care Users (MHCUs)

Mental disorders affect both the MHCUs and their family members (Tristiana et al. 2017: 1). A mental health care user is a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, state patient and mentally ill prisoner and where the person concerned is below the age of 18 years or is incapable of taking decisions (Department of Health [South Africa] 2002). Maslow's hierarchy of needs is often represented in a hierarchical pyramid with five levels (Maslow 1943). The four levels (lower-order needs) are considered physiological needs, while the top level of the pyramid is considered growth needs. As lower-level needs must be satisfied before higher-order needs, this can influence behaviour. The levels are as follows:

- Self-actualisation – includes morality, creativity, problem-solving
- Esteem – includes confidence, self-esteem, achievement, respect
- Belongingness – includes love, friendship, intimacy, family
- Safety – includes security of the environment, employment, resources, health and homeownership
- Physiological – includes air, food, water, sex, sleep and other factors affecting homeostasis (Maslow 2013)

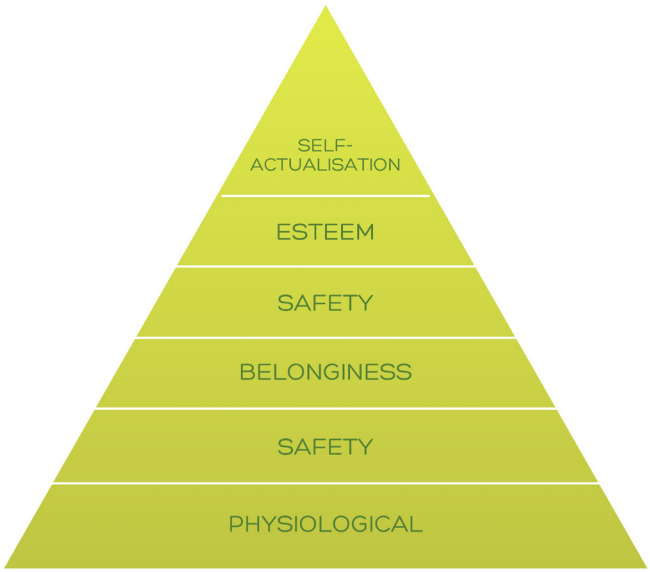

Figure 5.1: Maslow's hierarchy of needs pyramid (Maslow 2013)

For over 50 years, Abraham Maslow's hierarchy of needs has been one of the most cited theories of human behaviour (Kenrick et al. 2010). Maslow's theory is often depicted as a pyramid that places physiological needs (such as food, water

and air) at the base, followed by safety, belonging and esteem needs moving up the pyramid (Kenrick et al. 2010). Maslow's hierarchy culminates in the concept of self-actualisation, representing the aspiration to realise one's full potential (Maslow 1943, 2013). This closely aligns with the central aim of the mental health recovery paradigm, emphasising individuals' endeavour to achieve their utmost capabilities (Substance Abuse and Mental Health Services Administration [SAMHSA] 2011). Furthermore, SAMHSA (2011) acknowledges crucial facets of the recovery journey, including health, home, purpose, and community, as integral elements.

Of note, Maslow's hierarchy of needs has been applied in an African context. Ngu (2017) asserts that Maslow's hierarchy of needs has existed for some time and offers a wealth of insights into how Africans think (Ngu 2017). One category of a growth requirement is self-actualisation (Ngu 2017). Before someone is self-motivated to take the step toward self-actualisation, which is where people, communities and idealistically our nations should be, their deficiency needs, which are related to their well-being, must be properly satisfied (Ngu 2017). A citizen of a developing African nation's main concern is simply getting by, which includes finding work, maintaining relationships with family, finding housing and hoping for the best (Ngu 2017). Corruption and inequities, favouring upper-class families while excluding the middle class and limiting their human and social potential, suppress the minimal freedom necessary for men and women to engage at a cognitive level (Ngu 2017).

Many people lose sight of the goals they may have for themselves, their families and their communities because of the sadness that these systems promote. As their vision dims, the people continue to exist physically but decline intellectually, emotionally, spiritually and ideologically because they are deprived of the chance to express inspiration. The application of Maslow's hierarchy of needs in the African context is applicable here. South Africa is a country rife with inequality and it is also characterised by corruption. In this case, the people who are suffering are people of low socio-economic status. The vulnerability is exacerbated by lacking basic needs such as physiological needs – food, clean water and air, to mention a few.

Manamela, Ehlers, van der Merwe and Hattingh (2003) conducted a study in Limpopo and the findings revealed that the patients had physiological, psychological, social, emotional and spiritual needs. Furthermore, the participants desired services such as vocational training, individual or family assistance, accommodation, legal assistance and medical and psychiatric care. It is therefore important that MHCUs be engaged in meaningful activities and have their needs met in the process.

People with the lowest socio-economic status (SES) have eight times greater relative risk for living with mental disorders than those of the highest SES (Cohen 1993). They are also four times more likely to be unemployed or partly employed, one-third more likely not to have graduated from high school and three times more likely to be divorced (WHO 2009). More so, the South African society is faced with exceedingly high rates of interpersonal violence, with age-standardised mortality rates at seven times the global rate (Norman et al. 2007). Williams et al. (2007) have also emphasised the importance of

considering traumatic events in the context of other traumas, considering the cumulative effect of trauma exposure and the graded relationship between multiple traumatic events and distress. This is especially relevant in the South African setting, where the average person with a history of trauma exposure experienced 4.3 of such occurrences on average (Atwoli et al. 2013). Apart from PTSD (a well-documented consequence of trauma exposure), previous trauma exposure has also been linked to an increased vulnerability to other forms of psychopathology, including depression, social anxiety, substance abuse, dissociative symptoms, personality disorders, aggressive behaviour, sexual dysfunction, self-mutilation and suicidal tendencies, as well as problems with self-esteem, parenting and an increased risk for later victimisation (Allen and Lauterbach 2007; Bandelow et al. 2004; Bedard-Gilligan et al. 2015; Bolton et al. 2004; Callahan et al. 2003; Fichter et al. 2011; Ford and Smith 2008; Munjiza, Law and Crawford 2014; Pine, Costello and Masten 2005). In a study conducted by Subramaney (2006) at a South African trauma clinic, it was found that other psychiatric disorders, including major depressive disorder, were more frequently diagnosed among patients reporting traumatic stress than PTSD.

Chapter Four can be referred to in the discussion around the social determinants of mental health as this statement resonates well with the ACEs. The social determinant of mental health has an impact on all the categories of the life course. Hence, the intervention in this regard should be a life course approach, as alluded to in Chapter Four.

Mental disorders have diverse and far-reaching social impacts, including homelessness, limited education opportunities, lack of employment and limited income-generating opportunities (WHO 2009). A major upset in one's normal life and outlook can easily lead to a downward spiral, which all too often results in homelessness. For example, when a person has been diagnosed with a mental disorder, some families are not willing to accept the member back into the family. Hence, you find some people with mental disorders roaming around the streets without anywhere to go (being homeless). In her study, Bila (2017) found out that many MHCUs who were admitted to the Limpopo hospitals had been abandoned by their families. They were confined in the hospitals and could not get a leave of absence or be reintegrated to the community. These MHCUs were homeless whilst they had families, concurring with Bila's study. Research has shown that homelessness and mental disorders are interdependent variables in that one can cause the other and vice versa. Some scholars contend that a mental disorder itself contributes to homelessness as the person's mental illness impairs his or her ability to function (Ambrosino and Ambrosino 2008). Family breakdown, depression, as well as economic and material deprivation, also give rise to MHCUs' homelessness because they become materially, socially and emotionally drained of resources (McNaughton 2008). However, Sullivan, Burnam and Koegel (2000: 444) contend that 'mental disorder may play a role in initiating homelessness for some but is unlikely in and of itself to be a sufficient risk factor for homelessness'. Nevertheless, some homeless people suffer from mental disorders when they are already on the streets, which can be attributed to the conditions and stresses to which they are exposed and the associated stigma. Substance abuse is also regarded as

a reason for homeless persons becoming mentally ill (Sullivan et al. 2000) or a consequence of time spent on the streets (Christensen 2014). The lack of social connection, work skills and ability to focus and communicate clear ideas and goals leads to withdrawal from everyone and everything they may have held dear. The person living with a mental disorder may also show very little emotion or concern due to the manifestation of a mental disorder. Some mental disorders manifest in blunted affect or dissociative state. To qualify this statement, the WHO (2022) states that a mental disorder is characterised by a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour. Moreover, it is usually associated with distress or impairment in important areas of functioning. Therefore, this can make it difficult for loved ones to continue supporting him/her. A person with a mental disorder also tends to isolate, often making it hard to keep track of him/her at all (Brandt et al. 2022).

Education is often denied to persons with mental disorders. For instance, in many low- and middle-income countries (LMICs), children with mental disorders are institutionalised and these institutions frequently do not offer education (Open Society Institute 2005a; Open Society Institute 2005b; Open Society Institute 2005c). When children and adults with mental disorders do have educational opportunities, instead of receiving the support they need, they are often discriminated against, rejected and ridiculed in school (Funk et al. 2012). All children, including those with mental disorders, have a right to free and compulsory primary education and to secondary education and further education or training (Human Rights Watch 2012). All people with mental disorders have the right to continue learning and to learn and progress on an equal basis with all people (Human Rights Watch 2015). Human Rights Watch (2015) questions whether the government of South Africa has prioritised access to a quality, inclusive education for children with disabilities, especially mental disorders – as it committed to do 13 years ago in its 'Education White Paper 6' – and highlights numerous forms of discrimination and obstacles that children with disabilities face in trying to access such education that fosters inclusion, not segregation or integration. The key findings are as follows:

- **Discrimination accessing education:** children with mental disorders continue to face discrimination when accessing all types of public schools. Schools often decide whether they are willing or able to accommodate students with disabilities or needs. In many cases, children with intellectual disabilities, multiple disabilities and autism or foetal alcohol syndrome are particularly disadvantaged. In most cases, schools make the ultimate decision – often arbitrary and unchecked – as to who can enrol.
- **Discrimination due to a lack of reasonable accommodation in school:** many students in mainstream schools face discriminatory physical and attitudinal barriers they need to overcome to receive an education. Many students in special schools for children with sensory disabilities do not have access to the same subjects as children in mainstream schools, jeopardising their access to a full curriculum.
- **Discriminatory fees and expenses:** children with disabilities who attend

special schools pay school fees that children without disabilities do not and many who attend mainstream schools are asked to pay for their own class assistants as a condition of staying in mainstream classes. Additionally, parents often pay burdensome transport and boarding costs if special schools are far from families and communities and, in some cases, they must also pay for special food and diapers.

- **Violence, abuse and neglect in schools:** students are exposed to violence and abuse in many of South Africa's schools, but children with disabilities are more vulnerable to such unlawful and abusive practices.
- **Lack of quality education:** children with disabilities in many public schools receive low quality education in poor learning environments. They continue to be significantly affected by a lack of teacher training and awareness about inclusive education methodologies and the diversity of disabilities, a dearth of understanding and practical training about children's needs according to their disabilities and an absence of incentives for teachers to instruct children with disabilities.
- **Lack of preparation for life after basic education:** the consequences of a lack of inclusive quality learning are particularly visible when adolescents and young adults with disabilities leave school. While a small number of children with disabilities successfully pass the secondary school certificate, or matric, many adolescents and young adults with disabilities stay at home after finishing compulsory education; many lack basic life skills. Their progression into skills-based work, employment, or further education is affected by the type and quality of education available in the special schools they attend.

Therefore, segregation and lack of inclusion permeate all levels of South Africa's education system and reflect fundamental breaches of the Convention on the Rights of Persons with Disabilities. Barriers to inclusive education begin in the very early stages of children's lives because children are classified according to their disabilities. Thus, the inclusion of children with disabilities including mental disorders in mainstream education needs to be advocated for. More so, disability-specific or remedial classes should be offered.

Mental disorder is linked to high unemployment rates, pushing people into poverty and robbing them of social networks and status in their communities (Funk et al. 2012). People with a mental disorder are two to three times as likely to be unemployed as people with no disorders (Organisation for Economic Co-operation and Development [OECD] 2012). This gap represents a major loss to the economy, as well as for the individuals and their families (OECD 2012). Increasing job insecurity and pressure in today's workplaces could drive a rise in mental health problems in the years ahead (OECD 2012). Over the past decade, there has been a rise in the proportion of workers within the OECD exposed to work-related stress or job strain (OECD 2015). And in the current economic climate, more and more people are worried about their job security. Discrimination against people with mental disorders who are looking for work is strong and constant across nations with various income levels (Thornicroft et al. 2009). Several studies have demonstrated that unemployment can result

in mental health deterioration because unemployed individuals are stripped of certain functions of employment, including time structure, social contact, a collective purpose, status, activity, goals, physical security and a valued social position (Kawachi and Wamala 2006). Unemployment is usually discussed as a cause of financial strain and distress (Kingdon and Knight 2006; Livingstone and Lunt 1992; Lloyd and Leibbrandt 2014; McKee-Ryan et al. 2005; Mossakowski 2009). Simultaneously, it has been suggested that acute and chronic stressors follow the unemployed because the reduction in economic resources can be stressful for the unemployed individual and their family; moreover, such stressors have been found to relate to changes in physiological regulation, which leads to poor health. Stable employment, a secure income and social capital predict good mental health (Goldsmith, Veum and Darity 1997). Social capital can be viewed as the quality of social relationships within communities, including a sense of belonging and norms of cooperation and trust.

According to Statistics South Africa (StatsSA) (2017), over 2.8 million people in South Africa live with disabilities. They experience high levels of unemployment and often remain in low-status jobs, earning less than the average remuneration (StatsSA 2017). Multiple barriers hinder the capacity of persons with disabilities to find employment and enjoy full and effective participation in the labour market on an equal basis with others (Health and Welfare Sector Education and Training Authority [HWSETA] 2019).

These factors have been widely documented and include barriers to education, a dearth of reasonable accommodation, lack of accessibility to infrastructure and to information, limitations to their legal capacity, as well as attitudinal barriers from society (HWSETA 2019). In addition, disability is often equated with an inability to work (StatsSA 2017). In the past, these factors have had a significant negative impact on the employment of people with disabilities (HWSETA 2019). For over 74 years, the Pietermaritzburg Mental Health Society (PMBMHS) has created awareness around the rights of people with mental disorders (PMBMHS 2019). The PMBMHS is a non-governmental organisation providing services to persons living with mental disorders (PMBMHS 2019). This includes social work, residential care, protected employment, mental health awareness and community development, among many others (PMBMHS 2019). Their vision as an organisation is to empower people to ensure optimum quality of life while their mission is to work with the community to achieve the highest possible level of mental health (PMBMHS 2019). This is done by (PMBMHS 2019: n.p.):

- Enabling people to participate in the identification of individual and community mental health needs and by responding appropriately;
- Developing effective but affordable services to meet the needs of people having difficulty coping with everyday situations or who are affected by a mental disability such as mental disorder, intellectual disability, or emotional disturbance;
- Creating public awareness of mental health issues;
- Striving for the recognition, promotion and protection of mental health rights for all people;

- Aspiring towards a caring and equal service system with a just and fair society; and
- accepting the uniqueness of each individual and recognising the potential of people. Its management is responsive and based on participation, mutual trust and respect.

Many people living with disabilities struggle to find employment, proper education and as a result, find themselves vulnerable and excluded (HWSETA 2019). This violates their dignity and limits their ability to advance their livelihoods (HWSETA 2019). The HWSETA has partnered with PMBMH for a mental health awareness project (HWSETA 2019). Learners with mental health disorders have been placed with employers for on-the-job training in environments that can accommodate their disabilities for a period of 12 to 18 months (HWSETA 2019). All selected learners received work skills training in preparation for the placement. The project is taking place in the uMgungundlovu and Msunduzi municipalities in KwaZulu-Natal (HWSETA 2019). A total of nine different companies are hosting the trainees. An employment officer and social worker have been assigned to each learner, who is responsible for monitoring the learner's progress in the workplace (HWSETA 2019). This initiative is appropriate as it can be replicated in all provinces of South Africa, the lives of people with mental disorders can be improved and they may also have prospects of employment opportunities.

Inequitable care and treatment for both mental and physical illnesses are some of the most prominent factors contributing to greater morbidity and mortality rates among people with mental disorders (WHO 2009). In low- and middle-income countries (LMICs), between 75 per cent and 85 per cent of persons with serious mental problems are unable to receive the therapy they require, compared to 35 per cent to 50 per cent of people in high-income nations (Rathod et al. 2017). This may still be an underestimation of the treatment gap's extent (OECD 2012). Many people have insufficient care in addition to poor or no access to care. The right to the enjoyment of the highest attainable standard of physical and mental health is enshrined in many international and regional human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention on the Rights of the Child (CRC); and the Convention on the Rights of Persons with Disabilities (CRPD); the African Charter on Human and Peoples' Rights (ACHPR); and the African Charter on the Rights and Welfare of the Child (ACRWC) (see Chapter Four).

However, studies have shown that people with mental disorders are often marginalised and discriminated against in their enjoyment of the right to health (WHO 2001). Several barriers on both societal and organisational levels contribute to this, such as comorbidity, stigmatisation, lack of affordable mental health services and a general shortage of human resources for mental health care in many countries (Corrigan 2003). Extensive research has been conducted on the right to health, while less so on the barriers to care (Andersson et al. 2013). In a South African setting, studies have shown that various barriers exist in the implementation on the right to health for people with mental

disabilities (Burns 2008). For instance, in a systematic review of mental health services research in South Africa, Petersen and Lund (2011) indicate that there has been significant progress in the decentralisation of mental health service provision. However, they still find substantial gaps in service delivery, mostly due to insufficient resources to adequately support community-based services (Petersen and Lund 2011). Their review points to barriers to mental health care delivery such as the decreasing number of mental hospital beds; early discharge due to shortage of beds; dehumanising treatment and human rights abuses in psychiatric institutions and general hospitals; insufficient training of medical staff; lack of cooperation between traditional healers and modern medicine; and stigmatisation; and comorbidity (Petersen and Lund 2011). In their study conducted in the Eastern Cape, Andersson et al. (2013) identified five barriers regarding mental disorders: (i) lack of information and knowledge about existence and treatability of mental disorders, (ii) information and knowledge is stigmatised due to cultural perceptions of mental disability in society, (iii) the consequences of certain traditional cultural beliefs of the community, (iv) lack of organisational capacity and (v) lack of resources.

The barriers cited above are indeed present. As the result of misconceptions about mental disorder, this has also led to the belief that mental disorders are incurable, that people who suffer from them are not respected as members of their communities and that resources to provide services and support are not allocated. Abandonment against their will in under-resourced, unsanitary and abusive institutions or prisons is a common result (Kakuma 2010). People with mental disorders frequently face human rights abuses in their daily lives in the community, with guardians making decisions regarding where they live, their travels, their personal and financial affairs and their medical treatment (WHO 2005). This was also evident in the study conducted by Bila (2017) where caregivers decided to stop the treatment for MHCUs as they felt it was not good for them.

Current proposed solutions: Strategies on how to support the mental health care users

The National Institute for Health and Care Excellence (NICE) Guidelines (2012) provides strategies to support mental health care users and caregivers. Details are provided in Table 5.1:

Table 5.1: Possible strategies on how MHCUs and caregivers can be supported

General	Work in partnership with people using mental health services and their families or caregivers. Offer help, treatment and care in an atmosphere of hope and optimism. Take time to build trusting, supportive, empathic and non-judgemental relationships as an essential part of care.
When working with people using mental health services:	• Aim to foster their autonomy, promote active participation in treatment decisions and support self-management. • Maintain continuity of individual therapeutic relationships wherever possible. • Offer access to a trained advocate.
PROVIDING INFORMATION	
When working with people using mental health services:	Ensure that comprehensive written information about the nature of and treatments and services for, their mental health problems is available in an appropriate language comprehensive information about other support groups, such as the third sector, including voluntary organisations, is made available.
Ensure that you are:	• Familiar with local and national resources (organisations and websites) of information and/or support for people using mental health services. • Able to discuss and advise how to access these resources. • Able to discuss and actively support service users to engage with these resources.
AVOIDING STIGMA AND PROMOTING SOCIAL INCLUSION	
When working with people using mental health services:	• Consider that stigma and discrimination are often associated with using mental health services. • Be respectful of and sensitive to service users' gender, sexual orientation, socio-economic status, age, background (including cultural, ethnic and religious background) and any disability. • Be aware of possible variations in the presentation of mental health problems in service users of different genders, ages, cultural, ethnic, religious or other diverse backgrounds.
DECISIONS, CAPACITY AND SAFEGUARDING	
Health and social care professionals should ensure that they:	• Understand and apply the principles of mental health appropriately. • Are aware that mental capacity needs to be assessed for each decision separately. • Understand how the Mental Health Act (1983; amended 1995 and 2007) and the Mental Capacity Act (2005) relate to each other in practice.

IMPROVING MENTAL HEALTH CARE	
ENGAGING MENTAL HEALTH CARE USERS IN IMPROVING CARE	
When providing training about any aspect of mental health and social care:	• Involve people using mental health services in the planning and delivery of training. • Ensure that all training aims to improve the quality and experience of care for people using mental health services; evaluate training with this as an outcome. • Health and social care providers should consider employing service users to be involved in training teams of health and social care professionals and supporting staff (such as receptionists, administrators, secretaries and housekeeping staff) in 'person-centred care'. • Such training should be tailored to the needs of people who attend mental health services and should be evaluated using experience of care as an outcome. Service users themselves should be provided with training and supervision to undertake this role. • Managers of health and social care providers should consider employing service users to monitor the experience of using mental health services, especially inpatient services, for example by paying them to undertake exit interviews with service users who have recently left a service. • Offer service users training to do this. • Service managers should routinely commission reports on the experience of care across non-acute and acute care pathways, including the experience of being treated under the Mental Health Act (1983; amended 1995 and 2007). These reports should: » include data that allow direct comparisons of the experience of care according to gender, sexual orientation, socio-economic status, age, background (including cultural, ethnic and religious background) and disability; » include analyses of data from multiple sources, particularly data collected by service users monitoring service user experience and complaints; and » be routinely communicated with the health and social care providers' board (Nice 2012)
ASSESSMENT	
On arrival at mental health services for assessment, service users should be greeted and engaged by a receptionist and other staff in a warm, friendly, empathic, respectful and professional manner, anticipating possible distress. Before the assessment begins, the health or social care professional undertaking the assessment should ensure that the service user understands:	• the process of assessment and how long the appointment will last; • that the assessment will cover all aspects of their experiences and life; • confidentiality and data protection as this applies to them; and • the basic approach of shared decision-making.

When carrying out an assessment:	• Ensure there is enough time for the mental health care user to describe and discuss their problems. • Allow enough time towards the end of the appointment for summarising the conclusions of the assessment and for discussion, with questions and answers. • Explain the use and meaning of any clinical terms used. • Explain and give written material in an accessible format about any diagnosis given. • Give information about different treatment options, including drug and psychological treatments and their side effects, to promote discussion and shared understanding. • Offer support after the assessment, particularly if sensitive issues, such as childhood trauma, have been discussed. • If a service user is unhappy about the assessment and diagnosis, give them time to discuss this and offer them the opportunity for a second opinion. • Copy all written communications with other health or social care professionals to the service user at the address of their choice unless the service user declines this. • Ensure that if a service user needs to wait before an assessment, this is for no longer than 20 minutes after the agreed appointment time; explain the reasons for any delay. • Ensure that waiting rooms are comfortable, clean and warm and have areas of privacy, especially for those who are distressed or who request this or are accompanied by children. • Inform service users of their right to a formal community care assessment (delivered through local authority social services) and how to access this. • Inform service users how to make complaints and how to do this safely without fear of retribution.

COMMUNITY CARE	
When communicating with service users use diverse media, including letters, phone calls, emails or text messages, according to the service user's preference.	
Develop care plans jointly with mental health care users and:	• include activities that promote social inclusion such as education, employment, volunteering and other occupations such as leisure activities and caring for dependents; • provide support to help the service users realise the plan, and • give the service user an up-to-date written copy of the care plan and agree on a suitable time to review it.
Support mental health care users to develop strategies, including risk and self-management plans, to promote and maintain independence and self-efficacy, wherever possible. Incorporate these strategies into the care plan.	
Health and social care providers should ensure that mental health care users:	• can routinely receive care and treatment from a single multi-disciplinary community team; • are not passed from one team to another unnecessarily; and • do not undergo multiple assessments unnecessarily.
Ensure that service users have timely access to the psychological, psychosocial and pharmacological interventions recommended for their mental health problems in NICE guidance. Mental health and social care professionals inexperienced in working with service users from different cultural, ethnic, religious and other diverse backgrounds should seek advice, training and supervision from health and social care professionals who are experienced in working with these groups.	

HOSPITAL CARE	
When a service user enters the hospital, greet them using the name and title they prefer, in an atmosphere of hope and optimism, with a clear focus on their emotional and psychological needs and their preferences. Ensure that the service user feels safe and address any concerns about their safety. Give verbal and written information to mental health care users and their families or caregivers with the agreement from the service user, about:	• the hospital and the ward in which the service user will stay; • treatments, activities and services available; • expected contact from health and social care professionals; • rules of the ward (including substance misuse policy); • service users' rights, responsibilities and freedom to move around the ward and outside; • mealtimes; and • visiting arrangements. • Make sure there is enough time for the mental health care user to ask questions.
Offer service users in the hospital:	• Commence formal assessment and admission processes within two hours of arrival. • Shortly after service users arrive in the hospital, show them around the ward and introduce them to the health and social care team as soon as possible and within the first 12 hours if the admission is at night. If possible, this should include the named healthcare professional who will be involved throughout the person's stay. • Offer service users in the hospital: » daily one-to-one sessions lasting at least one hour with a healthcare professional known to the service user; » regular (at least weekly) one-to-one sessions lasting at least 20 minutes with their consultant; and » an opportunity to meet with a specialist mental health pharmacist to discuss medication choices and any associated risks and benefits. • Ensure that the overall coordination and management of care takes place at a regular multi-disciplinary meeting led by the consultant and team manager with full access to the service user's paper and/or electronic record. Service users and their advocates should be encouraged to participate in discussions about their care and treatment, especially those relating to the use of the Mental Health Act (1983; amended 1995 and 2007). • However, these meetings should not be used to see service users or carers as an alternative to their daily meeting with a known healthcare professional or their weekly one-to-one meeting with their consultant. • Health and social care providers should ensure that service users in the hospital have access to the pharmacological, psychological and psychosocial treatments recommended in NICE guidance provided by competent health or social care professionals. • Psychological and psychosocial treatments may be provided by health and social care professionals who work with the service user in the community. • Ensure that service users in the hospital have access to a wide

	range of meaningful and culturally appropriate occupations and activities seven days per week and are not restricted to 9 am to 5 pm. • These should include creative and leisure activities, exercise, self-care and community access activities (where appropriate). • Activities should be facilitated by appropriately trained health or social care professionals.
DISCHARGE AND TRANSFER OF CARE	
Anticipate that withdrawal and ending of treatments or services and transition from one service to another, may evoke strong emotions and reactions in people using mental health services. Ensure that:	• such changes, especially discharge, are discussed and planned carefully beforehand with the service user and are structured and phased; • the care plan supports effective collaboration with social care and other care providers during endings and transitions and includes details of how to access services in times of crisis; • when referring a service user for an assessment in other services (including for psychological treatment), they are supported during the referral period and arrangements for support are agreed upon beforehand with them; and • agree discharge plans with the service user and include contingency plans in the event of problems arising after discharge. • Ensure that a 24-hour helpline is available to service users so that they can discuss any problems arising after discharge. • Before discharge or transfer of care, discuss arrangements with any involved family or carers. Assess the service user's financial and home situation, including housing, before they are discharged from inpatient care. • Give service users clear information about all possible support options available to them after discharge or transfer of care. • When discharge plans are initiated by the service, give service users at least 48 hours notice of the date of their discharge from a ward. • When preparing a service user for discharge, give them information about the local patient advice and liaison service (PALS) and inform them they can be trained as an advocate or become involved in monitoring services if they choose (NICE 2012).

Ideally, all guidelines should be applied contextually, and it is well established that there may be barriers to the full application of guidelines even in well-resourced contexts (Man et al. 2018). The NICE guideline on the management of behaviour that challenges is explicit in its requirements of a contextual understanding of the organisational design and family environments of service-users before individualised interventions are implemented (NICE 2015). In clinical practice, it does not make sense to apply guidelines which depend on evidence that does not apply in a particular context (Coetzee et al. 2019). For example, it is incongruent to recommend diverse media when communicating with service users, including letters, phone calls, emails, or text messages, because due to the high level of illiteracy amongst MHCUs and their caregivers, this might be impossible to apply in practice, especially in South African rural areas. The NICE Guidelines are designed for use in the UK, a country in which there are certain standards of care within the health system, as well as expectations regarding how the country context operates

(Coetzee et al. 2019). The UK is a stable, industrialised country with a health system which, despite shortcomings, functions efficiently (Coetzee et al. 2019). Most families of persons with mental disorders live in low- and middle-income countries, commonly in conditions of poverty (Emerson, Yasamy and Saxena 2012). Social and health systems in these countries may vary considerably from highly resourced countries, such as the UK or Australia, for a wide range of reasons, including a lack of resources (Adnams 2010).

Ideally, guidelines should be developed for care in poorly resourced contexts and there have been developments in the global health field which have taken these inequities into account (Coetzee et al. 2019). There is an expanding literature on the use of community health workers in low-income contexts and in what has been called task shifting or task sharing – some care tasks and interventions which would usually be undertaken by relatively highly paid specialist personnel have been shown to be effectively delivered by less qualified personnel and family members (Swartz et al. 2014). These interventions may include supporting families of people with mental disorders and linking these families to available community support outside the formal health system. Countries which cannot afford high-cost care are generally not able to fund the research from which to develop optimal local practice guidelines (Coetzee et al. 2019). Hence, the NICE guidelines are ideal for mental health services in South Africa. Although NICE Guidelines do not apply throughout contextually, it remains important to retain the principles behind these guidelines in local contexts. For example, in the South African context it will be salient to identify and use different pathways to facilitate respite for parents and families. The focus would not be on a respite service such as recommended by the NICE Guidelines, but rather the involvement of older siblings and other relatives as temporary caregivers in the home environment of the person with mental disorders. However, this does not exclude recruitment of wider community resources and development of focused non-profit organisations to meet the need for respite care. It would also be important to identify how the principle of respite care is, or could be, applied in more poorly resourced contexts and countries. Hence, Maharaj (2021) developed guidelines within the South African context.

A study was conducted in KwaZulu-Natal by Maharaj (2021) and the guidelines were developed to enhance Person-Centred Care (PCC) for MHCUs in community psychiatric clinics. It was important to identify the above to determine how the integration of services correlated to MHCUs and PCC. Figure 5.2 depicts the guidelines of Maharaj.

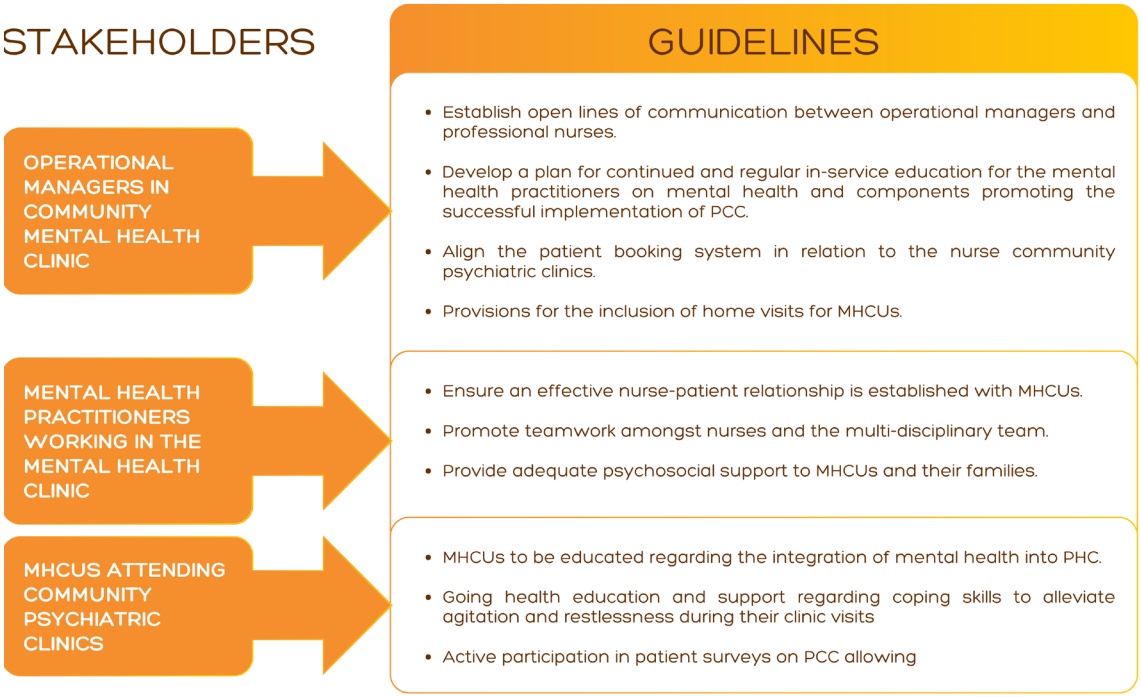

Figure 5.2: Proposed guidelines for MHCUs in the mental health clinics, adapted from Maharaj (2021).

The above guidelines aim to assist operational managers in achieving their goals related to PCC. Managers have the responsibility to support the individual and joint efforts of staff to ensure that the overall goals of the healthcare services are met (Folkman, Tveit and Sverdrup 2019). This guideline was directed to the operational managers as it is a part of the leadership and corporate governance domain for senior management according to the National Core Standards (NCS) (Department of Health [South Africa] 2011). Clear lines of communication should be established to effectively implement changes in community psychiatric clinics (Maharaj 2021). This guideline was developed as professional nurses reported not being adequately informed of proposed changes in the psychiatric clinic (Maharaj 2021).

A programme should be drawn up in consultation with professional nurses regarding their educational needs and required updates. This planned programme entailing topics for regular in-service education should be available to all professional nurses. A regular in-service programme will allow professional nurses to keep up to date with information related to improving the quality of nursing care in line with the NCS. Clinical competence is based on the theoretical and practical skills that nurses are required to possess to provide efficient patient care. To achieve a positive result, clinical competencies should routinely be assessed (Prentice et al. 2020: 4). In addition, Jardien-Baboo et al. (2016: 402) state that patients are evolving constantly and therefore ongoing education should be ensured.

The booking of MHCUs should be done in conjunction with the number of

professional nurses who are available to consult with MHCUs (Maharaj 2021). If bookings are done according to staggered appointment times, this may assist in reducing the waiting times of MHCUs (Maharaj 2021). It could also prevent long queues, allowing professional nurses to dedicate more time to providing holistic PCC (Maharaj 2021). An effective booking system could alleviate the strain caused by staff shortages (Maharaj 2021). It is noted that the guidelines are meant for professional nurses, however, the guidelines are appropriate for other team members who can adapt them in their areas of operation.

In recent years a renewed effort to address the treatment gap through task-shifting has shown promising results in several LMICs (Araya, Alvarado and Minoletti 2011; Patel et al. 2009). Task shifting involves shifting basic responsibilities to non-specialist health professionals or paraprofessionals (community workers) to reduce the population burden and to release specialised health resources for more complex tasks (Patel et al. 2009; van Ginneken et al. 2013;). There is a growing body of evidence suggesting that non-health cadres, such as lady health workers (LHWs,) can work effectively in addressing a wide range of public health issues including mental health (Chibanda, Mesu and Kajawu 2011). In Chile, low-intensity low-cost treatments for depression delivered by LHWs have been successfully integrated into primary health care (Araya et al. 2011). These types of interventions include psychoeducation, components of cognitive behavioural therapy (CBT), problem-solving therapy (PST) and self-help approaches (Chibanda et al. 2011). LHWs are available and affordable and thus, appear to be one of the most appealing cadres to incorporate in the implementation of task-shifting interventions in LMIC (Chibanda et al. 2015). However, in accordance with the World Health Organization (WHO) guidelines, it is imperative to ensure that they receive adequate training, supervision, support, career incentives and clear job descriptions to prevent overloading of these vital resources and undermining retention rates (Chibanda et al. 2015). In Zimbabwe, a prevalence above 20 per cent of common mental disorders (CMDs) has been reported amongst adult primary care attendees (Chibanda et al. 2011).

In Zimbabwe Chibanda et al. (2011) piloted a task-shifting programme called The Friendship Bench and showed evidence of the feasibility and acceptability of using LHWs to deliver a psychological intervention for CMD]. The Friendship Bench programme consists of a cognitive behaviour therapy (CBT) based intervention that emphasises the use of problem-solving therapy (PST) for the treatment of CMD (Chibanda et al. 2015). It is delivered by trained LHWs who are employed by the city health authorities in the city of Harare, Zimbabwe (Chibanda et al. 2015). The intervention consists of six sessions of 30-45 min of structured PST, delivered in a discrete area outside of the clinic building on a bench (The Friendship Bench) (Chibanda et al. 2015). The PST components consist of problem listing and identification, problem exploration, developing an action plan, implementation and follow up (Chibanda et al. 2015). They have found preliminary evidence of a clinically meaningful improvement in CMD using this locally adapted PST approach. In a cohort (n = 320) of patients recruited at primary health care facilities the mean score of a locally validated screening tool for CMD, the Shona Symptom Questionnaire (SSQ-14) [15]

fell from 11.3 (SD 1.4) before treatment to 6.5 (SD 2.4) after 3-6 sessions on the Friendship Bench (Chibanda et al. 2011).

By promoting open communication, the Friendship Bench (FB) initiative encourages people to open up about mental health issues, thereby counteracting the stigma of mental illness (Ouansafi et al. 2021). Since its formation in 2006, the programme has trained more than 700 grandmothers to lend a supportive ear to those dealing with mental illness (Huaxia 2024). There are now more than 120 Friendship Benches dotted across healthcare centres in Harare, the neighbouring town of Chitungwiza and in Gweru and to date, more than 80,000 people have accessed treatment free of charge (Huaxia 2024). The concept has now been expanded to other countries, providing a blueprint for alleviating challenges of mental health. The idea is being implemented in Malawi and Tanzania and has been adopted even in developed countries such as the United States (Huaxia 2024).

In 2016, the FB intervention was scaled up across Harare, Gweru and Chitungwiza and surrounding peri-urban communities in collaboration with the respective city health departments (Chibanda et al. 2016). The FB programme was established in 72 City Health Primary Health Care (PHC) clinics that are established in 36 sites (different clinic types can be found at the same site). This scaling- up exercise involved the training of more than 300 Lady Health Workers (LHWs) in the three cities in Zimbabwe. Maintenance funding for FB activities is provided by the city health department (Verhey et al. 2021). All LHWs working for the FB PHC clinics in Harare, Gweru and Chitungwiza received the standard manualised training and supervision. While existing scientific evidence has shown that under ideal randomised trial conditions the FB intervention leads to clinically significant reductions in symptoms, little implementation research has been carried out regarding the performance of FB under routine conditions as the model is being further scaled up across Zimbabwe (Verhey et al. 2021).

Figure 5.3: Rosemary Choga (L), a community healthcare worker, listens to a client while seated on a 'Friendship Bench' in Budiriro, Harare, capital of Zimbabwe, March 18, 2021. (Xinhua/Tarafa Mugwara) (Huaxia 2024)

Figure 5.4: Grandmothers working with the Friendship Bench project chat before counselling sessions begin (Mberi 2018).

The FB is applicable as an indigenous way of providing mental health services. The FB can be applicable in the South African rural areas due to the fact people in these areas prefer to not go to the hospitals. FB can be a convenient and indigenous way of addressing mental disorders. It is also appealing as it takes place within the convenient location of MHCUs' communities.

Caregivers of mental health care users

A mental disorder is a catastrophic stressor that overwhelms and deteriorates a family's ability to cope with day-to-day activities (Saunders 2003). Due to the nature of familial contact and the caregiving role of a person living with a mental disorder, families are the major victims of members with mental disorders (Saunders 2003) Because mental disorder has a contagious influence on others, the entire family must adjust to the behaviours of a family member with a mental disorder (Karp 2001). Families are the primary caregivers for most people with mental illnesses, putting them in difficult situations (Marsh 1999).

Families provide emotional, physical and financial assistance to their mentally ill family member/s (Biegel et al. 2007). Most families, on the other hand, are unprepared to take on these critical tasks and many struggle to adapt and handle the situation (Marsh 1999). Families in Ethiopia faced significant social, economic, family and work-related challenges because of caring for members with mental disorders (Shibre et al. 2003). A systematic review in South Africa (Rowaert, Van de Velde and Lemmens 2016) of eight studies concluded that families of MHCUs experienced significant stress because of

violence, dual stigmatisation and disintegration of family relationships. Studies that compared the stigma attached to mental illness in general and when it is linked to offending produced conflicting results (Mothwa, Moabi and van der Wath 2020). Brooker and Ulmann (2008) found that respondents were much less sympathetic towards psychiatric patients who had committed a crime, whilst Mezey, Youngman, Kretzschmar and White (2016) found similar levels of stigma in the general adult and MHCUs. In the study of Mothwa et al. (2020) in South Africa, participants experienced judgmental attitudes from community members. They ascribed the lack of support from community and family members to stigmatisation. Without social support, families feel lonely and abandoned.

The tasks and roles of caregivers caring for persons with mental disorders

Chadda (2014) asserts that the family caregiver plays multiple roles in the care of persons with mental illness, including taking day-to-day care, supervising medications, taking the MHCU to the hospital and looking after financial needs. Furthermore, the family caregiver also needs to contend with the behavioural disturbances caused by the MHCU. Caregiving takes time and energy, financial, emotional and other resources (MacCourt, Family Caregivers Advisory Committee, Mental Health Commission of Canada 2013). A study in Canada conducted by MacCourt et al. (2013) that included family caregivers of adults living with mental illness, found that family caregivers assist with organising, supervising, or carrying out shopping, banking, bill payments, meal preparation and housekeeping; they monitor symptoms, manage problematic behaviours, situations and crises; and provide companionship and emotional and financial support.

Similarly, Mavundla, Toth and Mphelane (2009) conducted a study in Limpopo, the findings of which revealed that the participants provide basic support, such as food preparation and the provision of shelter, taking of medication and personal hygiene. Furthermore, because MHCUs experience problems in maintaining personal and environmental hygiene, they often require assistance. Additionally, some MHCUs have impaired motor control and are unable to physically care for themselves properly. Therefore, inter alia, most caregivers reported that MHCUs need food, which they bought, cooked and served to them every day. Some participants reported this task to be more challenging than thought as their relatives sometimes refused the meals that they had prepared. It is often necessary that adequate shelters be built to provide protection and safety for these MHCUs. The findings of a study by Mavundla et al. (2009) reveal that caregivers invest a considerable amount of time and effort in accessing the medication needed by MHCUs with schizophrenia. They accompany these MHCUs to and from the clinics to collect their medication or often collect the medication on their behalf when they refuse to collect it themselves. In rural South Africa, this may take many hours (Mavundla et al. 2009). Furthermore, participants in this study also needed to

supervise the MHCUs to ensure that their medication was taken correctly and often tried to educate them on how to take their medication (Mavundla et al. 2009). Caregivers have a critical role to play in taking care of MHCUs. In some cases, the MHCUs are totally dependent on the caregivers.

Caregivers' burden

The burden on the family refers to the consequences for those in close contact with a severely disturbed person with mental health problems (Chan 2011). Some authors further distinguish between objective and subjective burden. Objective burden relates to the patient's symptoms, behaviour and socio-demographic characteristics and factors such as changes in household routine, family or social relations, work, leisure time and physical health (Chan 2011). The subjective burden refers to the mental health and subjective distress among family members (Reine et al. 2003). From the 1970s to the 1980s, the term caregiver burden has been used to describe the adverse consequences of mental disorders for family caregivers (Chan 2011).

With the advent of deinstitutionalisation, most people with mental disorders in the community are now cared for by their families (Chan 2011). Approximately 25 per cent to 50 per cent of people with mental disorders who are discharged from the hospital stay with their families, relying on their help and have their families' continuing support (Chan 2011). The World Federation of Mental Health (2010) stipulates that caregivers' burden is a global issue, whereby often family caregivers receive little recognition for this valuable work and policies in most countries do not provide financial support for the care services they provide (World Federation of Mental Health 2010). Caregivers' physical and emotional health is often neglected as they try to combine work, family and caregiving (Chan 2011). In the year following the start of caregiving, many caregivers endure severe stress, despair and/or anxiety due to a lack of personal, financial and emotional resources (World Federation of Mental Health 2010). Since the early 1950s, when mental health facilities began discharging MHCUs into the community, the negative implications of caring for families of people with serious mental disorders have been researched (Reine et al. 2003). Schulze and Rössler (2005) found that caregiver burden with regard to mental disorders was disproportionately high in England, Denmark, the Netherlands, Italy and Spain. When the caregiver lived with an MHCU, the caregiver's burden was even greater (Schulze and Rössler 2005). Similar findings have been evident in Southern Africa. In a qualitative study conducted by Seloilwe (2006) in Botswana, among family members of MHCUs with mental disorders, the findings revealed that family members had become the primary source of psychological support and that they perceived the situation as burdensome because of inadequate resources. One sympathises with the caregivers, in some instances they are overwhelmed and not knowing what to do. In South Africa, there are no respite services hence the caregivers suffered from burnout and feel burdened to take care of the MHCU. Hence, the needs of the caregivers should be taken into cognisance.

Needs of caregivers

Cheng and Chan (2005) indicate that the family is the primary long-term caregiver and that mental health practitioners should assist by assessing families' needs in terms of caring for MHCUs more effectively and providing education, in particular enhancing family members' understanding and expectations of the illness and the provision of care. Furthermore, studies in the United Kingdom (UK) conducted by Nolen-Hoeksema (2001) and the World Federation of Mental Health (2010) established that several common needs and concerns emerged from caregivers' reports, despite their individual and cultural differences. These needs are emotional support, relief from isolation, access to reliable and satisfactory services, information and recognition of their role and contribution, which can all work well in supporting caregivers (Department of Health, Social Services and Public Safety [UK] 1999). Family caregivers are an irreplaceable asset for the mental health services system and the pillars on which the system currently rests; addressing the needs of these caregivers is therefore crucial for the survival of the system (Shankar and Muthuswamy 2007). According to Lefley (1997), family caregivers are a vulnerable group whose demands may be equal to or even greater than those of the people they help. The health risks associated with caregiving are mental exhaustion, stress, boredom, frustration and easily getting upset (Shankar and Muthuswamy 2007). Norwitz et al. (2023) summarised the demands associated with caregiving as follows: Caregivers are also less healthy than non-caregivers, with higher rates of chronic illnesses like high blood pressure, heart disease, diabetes and arthritis than their non-caring colleagues. They might also be exhausted and have a weakened immune system. They may disregard their own needs, resulting in a greater mortality rate than non-caregivers of the same age. Given these risks, caregivers must look after themselves and lower their stress, sadness and anxiety levels (Norwitz et al. 2023).

Caregivers were stressed by feelings of helplessness and loss of control, exhaustion, loneliness, fears for their (and their relative's) safety amid escalating mental health crises and anxiety for their relative's future (Shankar and Muthuswamy 2007). Caregivers who try to balance caring with other activities such as work, family and leisure interests may find it difficult to focus on the positive aspects of caregiving and have more negative reactions, such as a sense of burden (Pusey-Murray and Miller 2013). Mental disorders can result in a few psychosocial issues, including diminished quality of life for MHCUs' family members and an increase in social detachment among MHCUs and their caregivers (Iseselo, Kajula and Yahya-Malima 2016). Family members must be in the best possible social and psychological condition. According to reports, one family member's reduced function adds to the strain on other family members, causing some family members to then have a judgmental attitude toward the MHCU (Larson and Corrigan 2008).

A study conducted in Tanzania by Iseselo et al. (2016), offers insight into the social and psychological difficulties experienced by family caregivers. Their findings illustrate that the main challenges faced by caregivers of relatives with

mental illness are a lack of social support, stigma and conflict; also, family members may have to set aside a significant amount of their time to care for an ill family member. This can diminish caregivers' chances of obtaining or keeping a job or earning an income, which further increases the risk of poverty and poor mental health of the MHCU. Similar findings were reported in rural Ghana, where caregivers reported financial difficulties, social exclusion, depression and inadequate time for other social responsibilities as their main challenges (Ae-ngibise et al. 2015). Strategies to address the needs of the caregivers are of utmost importance. If the needs are addressed, the caregivers will have positive coping strategies.

Coping strategies of caregivers caring for persons with mental disorders

Mental disorders affect both MHCUs and their family members (Tristiana et al. 2017). According to a qualitative study conducted by Spaniol and Nelson (2015) in Switzerland, families of MHCUs often become physically and emotionally exhausted by the additional burden of caring for their loved ones. Some of their responsibilities (burdens) include seeking mental healthcare services and support for their mentally ill family members, educating themselves about mental illnesses, being mindful of the needs of other family members and finding time to care for themselves. In a study that was conducted in Columbia, Hartney and Barnard (2015: 355) argue that long-term continuous caregiving leads to significant stress, often referred to as the 'family burden' or the 'caregiving burden'. Mental health problems such as schizophrenia, mood, or substance use disorders exert a toll on the families of the MHCUs who are negatively affected both economically as well as emotionally. Despite the above concerns, literature shows that different families use different coping mechanisms when caring for their MHCUs (Ata and Doğan 2018; Ong, Ibrahim and Wahab 2016; Parks et al. 2018). For instance, Ong et al. (2016) identify coping mechanisms such as reinterpretation, positive life growth, social support, usage of religion or spirituality, active coping, acceptance and positive reframing as positively associated with lower distress. On the other hand, coping mechanisms such as self-blame, avoidance and mental disengagement are positively associated with higher distress (Ong et al. 2016).

In their quantitative study conducted in Turkey, Ata and Doğan (2018) state that families of MHCUs use coping mechanisms such as crying, denial, fury, withdrawal from social life, aggressive behaviours, positive thinking, getting information, getting support from family and neighbours and seeking social support. Researchers such as Parks et al. (2018: 242) argue that families use certain approach-oriented coping mechanisms, such as seeking information and positive communication. For instance, families making efforts to understand the mental illness that their MHCUs had were correlated with a higher level of education among families of the MHCUs, while avoidant coping mechanisms were more common among those with a lower education level and whose MHCUs had a severe mental illness. In a study conducted in the northwest of

South Africa by Modise, Mokgaola and Sehularo (2021) it was established that different coping mechanism used by family members included acceptance of the condition, respect and loving the MHCUs and access to spiritual support.

Weiten, Lloyd, Dunn and Hammer (2009) describe three broad types of coping strategies: appraisal-focused, problem-focused and emotion-focused coping. Problem-focused coping strategies are aimed at minimising or eliminating a stressor, whereas appraisal-focused coping aims to challenge one's assumptions. Emotion-focused coping strategies are directed toward changing one's emotional reaction. The goal of emotion-focused coping strategies is to change one's emotional reaction. Appraisal-focused coping, also known as adaptive cognitive coping, is concerned with how one thinks about a problem. Denial, distancing oneself and humour are all examples of appraisal-focused coping in some cases (Weiten et al. 2009: 105). Coping is understood as 'the process of managing external or internal demands that are considered taxing or exceeding the resources of the person' (Grover and Pradyumna, Chakrabarti 2015: 5). Besides, Grover et al. (2015) state that there is no formal classification of coping strategies and these are understood as adaptive versus maladaptive and problem-focused versus emotion-focused.

Grover et al. (2015: 6) define problem-focused coping as adaptive behavioural coping that includes dealing with the situation, taking charge, gathering knowledge, weighing the benefits and drawbacks and anticipating (proactive coping) and seeking social assistance (social coping). Disclaiming, escape avoidance, taking responsibility or blame, practising self-control and positive reappraisal were also recognised as emotion-oriented coping techniques by Folkman and Lazarus in Grover et al. (2015). Emotion-focused coping, according to Olff, Langeland and Gersons (2005), comprises distancing oneself, self-medication and dissociation, which they split into positive and negative emotion-focused coping techniques. Besides, Olff et al. (2005) suggest that negative emotion-focused coping, such as distancing or avoidance, can relieve suffering in the short term but is harmful and very inappropriate or detrimental in the longer term. On the other hand, Ben-Zur (2009) underscores that positive emotion-focused strategies such as seeking social support and positive reappraisal relate to a better outcome.

Indian studies have looked at the coping techniques of caretakers of people with mental disorders (MHCUs) (Grover et al. 2015). According to these studies, caregivers use a combination of adaptive and maladaptive coping mechanisms to deal with the MHCU's sickness (Aggarwal et al. 2011; Hedge 2013; Kate et al. 2013; Kate et al. 2014; Rammohan, Rao and Subbakrishna 2002). In terms of the most used coping strategies, a study by Nehra, Chakrabarti, Kulhara and Sharma (2005) suggests seeking practical help. A study by Chadda, Singh and Ganguly (2007) demonstrates the more frequent use of problem-focused coping strategies rather than social support and avoidance strategies. Another study, based on a family coping questionnaire, indicated that acceptance was the most used coping strategy used by 71 per cent of caregivers. Only about one-fifth to two-thirds of caregivers used coping strategies such as seeking information (40 per cent), positive communication (37 per cent), social interest (21 per cent), coercion (32 per cent), avoidance (35 per cent) and the MHCU's social

involvement (34 per cent) (Chandrasekaran, Sivaprakash and Jayestri 2002).

Clearly, information is critical if South African social workers are to provide services to the MHCUs and caregivers. Positive coping strategies will assist the caregivers to be able to take care of the MHCUs optimally.

Intervention and support of caregivers

Lippi (2016) indicates that caregivers also require therapy and intervention, aimed directly at improving their well-being. Furthermore, caregivers may require situation-specific therapeutic input intervention, which will address their concerns, fears and symptoms of depression and anxiety. O'Cathain et al. (2019: 2) define intervention as 'a combination of programme elements or strategies designed to produce behaviour changes or improve health status among individuals or an entire population. Interventions may include educational programmes, new or stronger policies, improvements in the environment, or a health promotion campaign. Interventions that include multiple strategies are typically the most effective in producing desired and lasting change.' Moreover, Lippi (2016) states that interventions may be implemented in different settings, including communities, worksites, schools, healthcare organisations, faith-based organisations, or in the home. Interventions implemented in multiple settings and using multiple strategies may be the most effective because of the potential to reach a larger number of people in a variety of ways. Evidence has shown that interventions create change by influencing individuals' knowledge, attitudes, beliefs and skills; increasing social support; and creating supportive environments, policies and resources.

Chan (2011) holds a view that family interventions should be implemented to improve care and that there are growing numbers of realistic indications supporting the argument that some family intervention strategies such as psychoeducation and support groups demonstrate a beneficial impact on the course of mental disorder.

Psychoeducation is defined as 'a strategy of teaching MHCUs and families about mental disorders, their treatments, personal coping techniques and resources' (Chan 2011: 344). It needs to be highlighted that this form of intervention was developed based on the observation that people can be better participants in their care if knowledge deficits are removed. Similarly, Pekkala and Merinder (2002) indicate that teaching skills such as problem-solving and communication would increase caregivers' coping ability. Sarkhel, Singh and Arora 2020) emphasise that there are various psychoeducation models in different parts of the world, such as individual consultation, family psychoeducation and therapy, as well as professionally led short-term family educational programmes and family-support groups.

The programme developed by the Psycho-educational Working Party of the Early Psychosis Prevention and Intervention Centre (EPPIC 2001) in Australia, focuses on early intervention for MHCUs with schizophrenia. A review of the literature has found that psychoeducation intervention is conducted in a variety of ways. In previous studies, the duration of psycho-education programmes

ranged from one to 18 months (Chan et al. 2009; Cheng and Chan 2005). Furthermore, these authors assert that psychoeducation programmes consist of 10 or more sessions and most have group interventions that include MHCUs and their family members.

Chan (2011) points out that psycho-education programmes have common content, such as the nature and treatment of schizophrenia, management of problem behaviour, related resources and ways of accessing these resources and problem-solving and coping skills. Previous studies have demonstrated that psycho-education interventions generally have positive outcomes on family caregivers and MHCUs, such as a reduction in caregiver burden (Chan et al. 2009; Cheng and Chan 2005). Chien (2008) points out that all family intervention programmes offer psychoeducation and psychosocial support to family members and some include the patient, although the theoretical orientation of these interventions varies considerably. Common elements in psycho-educational group interventions include the involvement of the family in:

- patient care provision,
- presentation of information about the mental illness and its management,
- discussion of the techniques for patient care such as communication, problem-solving, medication compliance and crisis intervention and
- development of social networks and coping skills.

The National Alliance on Mental Illness' Family-to-Family Program (Lippi 2016) is an example of an efficacy- and evidence-based programme that focuses on randomised controlled trials, a model like that of substance abuse recovery. The aims of this and similar programmes are to help families obtain information, access support and services, improve coping skills, engage in self-care, improve communication, increase empathy, solve problems and understand the research that promotes recovery (Lippi 2016). The concept encompasses the utilisation of individuals who have experience with living with illnesses such as schizophrenia for coaching, mentoring, teaching, copying and advocating guidance (Duckworth and Halpern 2014). The programme consists of the following: A 12-week skills-building course taught by family members (who have received specific training to lead and facilitate sessions) for family members, with sessions of two and a half hours each (up to 14 sessions) (Duckworth and Halpern 2014). Results of the training course encompass an improvement in knowledge, emotional- and problem-focused coping, problem-solving, family coping, the overall functioning of the MHCU (including self-maintenance, social functioning and community living skills), reducing stress, addressing the subjective view of the caregiver's burden and decreasing the number and duration of hospitalisation (Chien and Thompson 2013). Psychoeducation cultivates a shared decision-making approach that brings together the caregivers and the MHCU's treatment preferences (Xia, Merinder and Belgamwar 2011). Shared decision-making fosters autonomy, which results in decisions that better serve the individual's choices, values and interests. Shared decision-making provides an approach through which providers and consumers of health care

come together as collaborators in determining the course of care. Research has shown that shared decision-making increases consumers' knowledge about and comfort with the health care decisions they make. Psychoeducation can be offered to patients, family members, or both (Hodé 2013).

McFarlane et al. (2003) claim that effective family psychoeducation includes empathic engagement, problem-solving and communication skills, social networking, education on clinical resources and ongoing support. Moreover, Xia et al. (2011) assert that implementing recovery and wellness-oriented psycho-educational programmes and materials as part of standard treatment may improve mental and physical health outcomes in MHCUs with schizophrenia and their caregivers.

The development of mutual support groups in the 1990s formed part of the larger social movement of self-help organisations for people affected by a variety of chronic diseases and needs, inadequately addressed by traditional healthcare interventions (Chien 2008). Reay-Young (2001: 134) defines support groups as 'collectives of voluntary associating persons who share a common problem; they are self-governing, rely on the experiential knowledge of their members as the group's source of authority, provide mutual assistance which is at least emotional support and do not charge fees.' A report published in 1999 by the United States Office of the Surgeon General further defines support groups as being geared for mutual support, information and growth (and) is based on the premise that people with a shared condition who come together can help themselves and each other to cope, with the two-way interaction of giving and receiving help. Reay-Young (2001) points out that support groups offer many carers an avenue through which to 'unburden' themselves among people who have faced similar situations and at the same time provide carers with some sense of control over an otherwise chaotic life experience.

Mutual support is a participatory process of sharing common situations, problems and experiential knowledge of common concerns within a group session (Chien, Norman and Thompson 2006). Mutual support groups are characterised as MHCU-led and professional-controlled mental health interventions. They are participatory and involve giving and receiving help and learning to help themselves, as well as sharing experiences and knowledge around common concerns (Chien and Chan 2004). Chien and Norman (2009) point out that mutual support groups for family caregivers of persons with mental disorders are based on an empowerment-oriented model and provide opportunities for family caregivers to develop knowledge and skills in caring for a relative with mental disorders. Furthermore, Chien et al. (2006) assert that a support group that provides a peer-based support system allows individuals to take on meaningful roles within the group and their own families and inculcates a belief system that inspires members to strive for better mental health. Chien et al. (2006) further state that support groups require less intensive training than health professionals to serve as facilitators, compared with other treatment approaches. They also provide a flexible, interactive, MHCU-directed approach to help families cope with their caregiving roles. Saunders (2003) is of the view that mutual support group programmes provide social support, which enhances the implementation of the social networks of family caregivers. There is strong

evidence supporting the value of a support group for family caregivers of persons with a mental disorder.

Saunders (2003) asserts that research-based evidence appears to confirm the argument that support group intervention is helpful to people from different cultural backgrounds. For example, studies in Western and Asian populations found that family caregivers who participate in family support groups are associated with a significant improvement in the psychological adjustment of families (Chan 2011). Support group interventions are associated with a significant improvement in the family caregiver's ability to cope and consequently in the physical and mental condition and functioning of the MHCU (Chien et al. 2006). Social support theory holds that social support and social networking are two major mechanisms that may promote mental health (Chien 2008). Chien et al. (2006) indicate that social support may result in the following:

- Buffer the effects of stressful life events.
- Directly influence the occurrence of various mental disorders.

Support group initiatives can be regarded as adhering to these prescribed norms within the limits of available resources. Such services can help address the unmet supportive and rehabilitative needs of service users and their caregivers at their local Primary Health Care facilities (clinics). The nature of support group services is appropriate for providing continuous follow-up care for MHCUs and caregivers and holds the potential to bring about improvement in their mental health as well as their social well-being and quality of life. This is in line with the recovery model advocated in the Mental Health Policy Framework (Department of Health [South Africa] 2023. Community-based social support systems such as support groups can assist MHCUs in adjusting and reintegrating into community life once they have been discharged from the hospital and help them manage their symptoms (Meiring 2015).

Behavioural family therapy (BFT) is a family psycho-educative intervention, which addresses stress management and goal achievement (Berglund, Vahlne and Edman 2003). Research has shown that BFT is effective in reducing the stress experienced by service users and their families and that it can significantly reduce relapse rates and promote recovery, especially for those living with severe and persistent mental health problems (Asmal et al. 2014). Because of this, the focus of delivery has been on working with families where a member experiences psychosis. However, family interventions may be helpful to families experiencing a range of other mental health problems (Asmal et al. 2014).

Berglund et al. (2003) point out that positive results include decreased family burden, relapses and the dosages of neuroleptics taken by MHCUs; it also decreases feelings of resignation and increases optimism in caring for the MHCU. Families gain coping strategies and independence. Furthermore, Burbach and Stanbridge (2006) argue that the overall aims of BFT are increased understanding, stress reduction and improved communication and problem-solving skills within the family; this approach can be used effectively to help meet the needs of other families in contact with mental health services.

In addition, there is growing support for using the approach with families experiencing stress concerning long-term physical conditions (Burbach and Stanbridge 2006).

Family work using the behavioural family therapy model will typically include the following (Christenson et al. 2014):

- Meeting with the family to discuss the benefits of the approach.
- An agreement with the family that they are willing to try the approach.
- Assessment of individual family members.
- Assessment of the family's communication and problem-solving skills.
- Review of the assessment information on the family's resources, problems and goals.
- Meeting with the family to discuss/plan how to proceed and establishment of family meetings.
- Information sharing about the mental health issue and reaching a shared understanding.
- Early warning signs and relapse prevention work – development of 'staying well' plans.
- Helping the family to develop effective communication skills.
- Supporting the development of the family's problem-solving skills.
- Booster sessions.
- Review and ongoing support or closure.
- Multiple group family therapy is a combination of behavioural family therapy and formal psychoeducation, which also concentrates on problem-solving (Van Hazel et al. 2004).

Van Hazel et al. (2004) argue that multiple-group family therapy aims to have a positive effect on MHCU outcomes by decreasing symptoms and relapse rates and increasing social and vocational skills. A family-based group can provide a natural connection for group members to facilitate cohesion and create a context where similarities and differences can be acknowledged (Edwards 2001). Furthermore, Edward asserts that combining family therapy with group therapy has the following group therapy advantages: diminished isolation, equal power status which the group confers upon each family, abundant scope for indirect learning and the provision of role models through subgroupings. Lippi (2016) points out that group intervention consists of the following:

- Provision of new information.
- Presentations are given and families are provided with newsletters, pamphlets, lists of resources and websites and may borrow books and videos (relatives tend to find videos the most informative and presentations more informative than literature).
- Group discussions and sharing of experiences.
- Question and answer sessions.

Siegel (1999) also notes that lineage in the African family context is not only biological, nor is it always objectively genealogical, but can be sociological

as well. This means that lineage and kinship can be edited. People can be inserted, or insert themselves into certain lineages, often symbolically, but in a very meaningful and effective way. In addition, the notion of family often expands and, depending on place and context, non-blood relations and other kinds of relationships may assume familial significance and meaning. Families are expanded through marriages, for instance and it is also not uncommon for a close friendship to mature into 'family', or a friend to be named, regarded and treated as family in acknowledgement of the length of friendship and felt levels of closeness, trust and reliability. This is one way through which the family is linked to the broader community. As Siqwana-Ndulo (1998) stated, the institutions of family, marriage and household in African societies revolve around community. Thus, not only is the family formation broader, but its function is also grossly enhanced by being interlocked with the general community. In a study conducted by Bila (2017), neighbours played a critical role by informing the family when the MHCU is roaming around the village, letting the family know where they have seen the MHCU. This is critical as the neighbours are also watching out that the MHCU does not get lost in the community. In many instances, MHCU will tend to leave home unnoticed by the family.

Importance of families in recovery

Families can provide emotional, social and material support critical to the quality of life. For many people living with mental health problems and illnesses, family – whether made up of relatives or chosen from a person's broader circle of support – constitutes their primary source of support (Reay-Young 2001). Families can help recovery by expressing hope, building on people's ties to others and reminding them of their strengths and capabilities, assisting them in accessing and navigating the mental health system and sustaining their involvement in community life (McFarlane et al. 2003). With the MHCU's permission, the recovery-oriented practitioners consistently engage a person's family of choice as early as possible in the care process. Families also have the right not to participate in a caregiving role and this choice is respected (Mental Health Commission of Canada [MHCC] 2012). Recovery-oriented practitioners understand and show concern about the impact of mental health problems on the family (MHCC 2012); it is vitally important that they support families in finding hope, healing and when desired, reconnecting with society. Furthermore, recovery-oriented practice begins with the assumption that family can play a positive role in the journey to recovery and well-being, finding a balance between facilitating the family's ability to contribute to decision-making and respecting the privacy of the person living with a mental illness (MHCC 2012).

Chapter 6
Mental health policies and legislations

Introduction

The chapter pivots toward the intricate landscape of mental health policies and legislation. This section delves into the complex frameworks and legal structures governing mental health, shedding light on the pivotal role they play in shaping mental health care and support systems. The forthcoming discussions will revolve around the legislative mandates governing mental health care. A comprehensive exploration of these mandates will follow, offering detailed insights and in-depth analysis below.

Legislative mandates of mental health care

Mental health and human rights are linked in three important ways. First, mental health affects human rights; second, human rights violations affect mental health; and third, positive promotion of mental health and human rights is mutually reinforcing, as they are complementary approaches to advancing the well-being of persons worldwide (Gable and Gostin 2009). One way to prevent human rights violations from occurring is by reforming mental health laws to be more in line with the promotion of the human rights of persons with psychosocial disabilities. Internationally, the Convention on the Rights of Persons with Disabilities (CRPD), which came into force in 2008, serves as a comprehensive and legally binding framework for promoting and protecting the rights of persons with mental disorders (Drew et al. 2011). Globally, the CPRD has been celebrated as being the universal standard for the human rights of persons with disabilities (Drew et al. 2011). At the country level, law and policy reform has been identified as a key strategy to promote the human rights of persons with mental disorders. It is necessary to have a well-formulated mental health law in place for the protection of the human rights of persons with mental disorders (Drew et al. 2011).

Constitution of South Africa (SA)

Mkhize and Kometsi (2008) postulate that there has been gross violation of human rights in South Africa and all these actions were fuelled by the policy of apartheid. These acts occurred before the advent of the new democratic dispensation in 1994. On the other hand, Lund, Petersen, Kleintjes and Bhana (2012) allude to the fact that the South African government is working hard to improve mental health services since the demise of the apartheid system. In 1997, mental health was included in the White Paper for the transformation of the health system in South Africa, which stated that 'a comprehensive and

community-based mental health service should be planned and coordinated at the national, provincial, district and community levels and integrated with other health services' (Lund et al. 2012: 403).

The Constitution of the Republic of South Africa [i] ('Constitution') is the law against which all actions and omissions, be they legislative or a product of human design, are measured. According to the Constitution, the environment itself must not be harmful to a person's health or well-being. [ii] Section 27 of the Constitution dealing with socio-economic rights, including the cornerstone right to health care, provides that everyone has the right to access healthcare services [iii] and that the state must ensure the progressive realisation of this right. [iv] The Constitution also makes specific reference to a child's right to access to healthcare. [v] Section 152(1)(d) of the Constitution affirms that one of the objects of local government is 'to promote a safe and healthy environment'. Section 184 places a duty on the South African Human Rights Commission to obtain information from relevant government organs annually with regard to their activities in realising rights in the Bill of Rights. [vi] Schedule 4A of the Constitution specifies that health services are a concurrent responsibility of national and provincial governments. Schedule 4B specifies that oversight and regulation of municipal health services are a concurrent responsibility of national and provincial governments (Republic of South Africa [RSA] 1996).

Each person is guaranteed equal rights and benefits of the law under Section 9(1) of the Constitution, as well as a right to non-discrimination. Section 9(3) establishes a vertically applicable right, stating that the state does not discriminate unfairly against someone on one or more grounds, such as race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, faith, conscience, belief, culture, language or birth. In section 9(4), no individual may unfairly discriminate directly or indirectly against someone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, cases of abuse and birth. The only provisions of the Constitution that expressly mention disability are Sections 9(3) and 9(4) (Republic of South Africa [RSA] 1996).

Burke (2012) contends that when working with MHCUs, irrespective of the severity of their condition, the practitioner should take cognisance of and adhere to the principles of the Constitution of South Africa which protect MHCUs. Burke (2012) is correct in this and the way MHCUs are treated is a matter of concern; in many instances, the principles of the Constitution are overlooked by the mental health professionals. The Constitution states clearly that all people should be treated with dignity and respect (Burke 2012). Therefore, the Constitution is essential in the provision of mental health services and all mental health care practitioners should comply with these provisions. Furthermore, social workers should work collaboratively with MHCUs and their caregivers to improve their lives and functioning within society.

Chapter Two of the Constitution of South Africa contains the Bill of Rights, a human rights charter that protects the civil, political and socio-economic rights

of all people in South Africa. The rights in the Bill apply to all laws, including the common law and bind all branches of the government, including the national executive, parliament, the judiciary, provincial governments and municipal councils. Some provisions, such as those prohibiting unfair discrimination, also apply to the actions of private persons.

South Africa's first bill of rights was drafted primarily by Kader Asmal and Albie Sachs in 1988 from Asmal's home in Dublin, Ireland (Cockrell 1997). The text was eventually contained in Chapter 3 of the transitional Constitution of 1993, which was drawn up as part of the negotiations to end apartheid. This 'interim Bill of Rights', which came into force on 27 April 1994 (the date of the first non-racial election), was largely limited to civil and political rights (negative rights) (Rautenbach, Janse van Rensburg, and Pienaar 2009); the current Bill of Rights, which replaced it on 4 February 1997 (the commencement date of the final Constitution), retained all these rights and added several new positive economic, social and cultural rights. The Bill of Rights sets out the fundamental rights of all South Africans, including the right to dignity and the right to equality. The Bill of Rights also states when rights may be limited. This Bill of Rights is a cornerstone of democracy in South Africa (Republic of South Africa [RSA] 1996). Individuals have the right to receive benefits for mental health and substance abuse treatment on the same basis as they do for any other illnesses, with the same provisions, co-payments, lifetime benefits and catastrophic coverage in both insurance and self-funded/self-insured health plans (American Psychiatric Association [APA] 2007).

The African Charter on Human and Peoples' Rights (also known as the Banjul Charter) is an international human rights instrument that is intended to promote and protect human rights and basic freedoms in the African continent. It emerged under the aegis of the Organisation of African Unity (since replaced by the African Union) which, at its 1979 Assembly of Heads of State and Government, adopted a resolution calling for the creation of a committee of experts to draft a continent-wide human rights instrument, like those that already existed in Europe (European Convention on Human Rights) and the Americas (American Convention on Human Rights). This committee was duly set up and it produced a draft that was unanimously approved at the OAU's 18th Assembly held in June 1981, in Nairobi, Kenya (African Union 1981).

The right to mental health is guaranteed in different instruments in the African system. Article 16 of African Charter states that '[e]very individual shall have the right to enjoy the best attainable state of physical and mental health and states parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.' (African Union 1981). The obligation to protect therefore includes taking concrete and targeted steps towards the full realisation of the right and adopting legislation or other measures to ensure equal access to health-related services and health care. In the African system, the African Commission and the African Court on Human and Peoples' Rights (African Court) have not had the opportunity to determine many cases on mental health rights.

Seemingly, the African Charter on Human and Peoples' Rights (African Charter) (African Union 1981) does not provide for qualification of progressive realisation and maximum available resources for the realisation of ESC rights (Wachira and Cassell 2018). As a result, some authors argue that the ESC rights in the African Charter must be realised immediately (Wachira and Cassell 2018). However, given Africa's economic realities, this argument would have far-reaching implications for the very nature of ESC rights. In the African human rights system, economic, social and cultural (ESC) rights, including the right to health, are just as justiciable as civil and political rights (Wachira and Cassell 2018). This follows from the fact that the main human rights instruments have incorporated the ESC rights alongside the civil and political rights into one document (Wachira and Cassell 2018). The Commission confirmed the justiciability of ESC rights in the Ogoniland case where it held that no right in the African Charter cannot be made effective (Wachira and Cassell 2018). Some policies and acts are geared at improving mental health care, however, there is a lack of implementation that infringes the rights of MHCUs.

Mental Health Care Act no 17 of 2002 (MHCA)

The Mental Health Care Act 2002 (Act no. 17 of 2002), hereafter referred to as 'the Act', together with its regulations ushered in a new era for South African psychiatry by replacing the Mental Health Act of 1973. The Act was assented to on 28 October 2002, but commenced on 15 December 2004, taking many clinicians by surprise. In the wake of the implementation of the Constitution of the Republic of South Africa (promulgated in 1996, implemented in 1997) it was incumbent on lawmakers to ensure that all Acts of Parliament were amended and written to accord with the new Constitution (Republic of South Africa [RSA] 1996) and these are listed below:

- Promotion of Mental Health and Prevention of Mental Disorders
- Access to Basic Mental Health Care
- Mental Health Assessments in Accordance with Internationally Accepted Principles
- Provision of the Least Restrictive Type of Mental Health Care
- Self-Determination 6: Right to be Assisted in the Exercise of Self-Determination
- Availability of Review Procedure 8: Automatic Periodical Review Mechanism
- Qualified Decision-Maker
- Respect for the Rule of Law (World Health Organization [WHO] 1996)

The Mental Health Care Act of 2002 (MHCA 2002) (Department of Health [South Africa] 2002) was promulgated in South Africa against a backdrop of positive international developments in mental health legislation (namely the Mental Health Act 2007 [London]; Mental Health [Care and Treatment]

[Scotland] Act 2003) (Department of Health [UK] 2007; Jamaica Ministry of Heath 1998). Emanating from a new culture focussing on human rights within South Africa after the pivotal year of 1994, it was one of the legislations enacted to rid the country of its apartheid legacy. And with its history of mental health treatment, South Africa was in dire need of an act that reflected the new spirit. The MHCA 2002 (Republic of South Africa [RSA] 2002) is based on several important principles:

- People with mental health problems are regarded as 'users' since any individual is a potential user of mental health care services.
- Services should offer care, treatment and rehabilitation to users.
- The human rights of the mental health care user (MHCU) are not inferior to the welfare of general society.
- All health care practitioners are also regarded as mental health care practitioners (MHCPs) and should take some responsibility for mental health needs.
- Mental health care should be fully integrated with primary health care.
- Users have a right to be treated near to their homes and within their communities, as far as possible.
- Users have a right to be provided with care, treatment and rehabilitation, with the least possible restriction of their freedom.
- Users have a right to representation, knowledge of their rights and the right to appeal against decisions made by MHCPs.
- Mental health review boards should be created to act as independent 'ombudsmen' [sic] concerned with the rights of the user, to review decisions made in terms of the Act and to respond to and investigate appeals.

A major responsibility of district hospitals, in terms of the MHCA 2002, is to provide 72-hour admission and observation for MHCUs. This requirement has given rise to many problems, shared by most district hospitals throughout the country, which are very practical in nature and relate to the operational aspects of implementing this legal requirement. The problems do not relate to the idea or concept of an observation period, but to their translation into practice (Department of Health [South Africa] 2002). In defence of the principle of a 72-hour observation period, there are several good reasons for this practice:

- The most important is that, within a general medical environment, it allows for exclusion of medical causes of behavioural or psychiatric disturbance.
- Many users recover sufficiently to be discharged within the first 72 hours (for example in substance intoxication or withdrawal, acute trauma, parasuicide and brief psychotic disorders). Unnecessary admission to a psychiatric institution is unfair on users as it may cause humiliation and shame.
- Many MHCUs can receive care and treatment close to their homes and communities.

Translating legislation into reality regarding the care of MHCUs at district hospitals has been difficult owing to practical deficiencies and a lack of preparedness at the service level (Burns 2008). Burns further asserts that other nations also struggle with the painful realities of implementing legislation within poorly resourced and inadequately prepared circumstances. Moreover, deinstitutionalisation in the USA became a politically expedient (and necessary) project, commencing during the 1960s (Burns 2008). Large numbers of chronically institutionalised patients were discharged from psychiatric institutions with little planning or preparation in terms of community services and many ended up on the streets as homeless people, or in prison (Steadman et al. 1984) In the UK, deinstitutionalisation during the 1980s was also difficult, but it was perhaps better prepared with its policy of 'care in the community' (Leff 2001: 381). So, South Africa is not alone in the often painful task of transforming and modernising legislation and services in accordance with ethical principles of care (Burns 2008).

Furthermore, Burns (2008) believes that the legislation is not easy to change, and many would argue that good legislation should not be changed but rather be accommodated. This is true regarding the MHCA 2002 (Burns 2008). Acknowledging that preparation at the 'rock face' was not adequate, the solution is not to discard the Act's principles or intentions but rather to accommodate its requirements in part through improvisation and in part through careful planning (Burns 2008). This requires a commitment from health workers at all levels and, importantly, also requires commitment from administrators and the government. (Burns 2008). Mental health care has been sorely neglected in South Africa and transformation of the services requires political leadership and adequate funding (Burns 2008). Therefore, it has been noted that the Act is founded on the ten basic principles set out by the World Health Organization (WHO) guiding mental healthcare law (WHO 1996; Landman and Landman 2014). In essence, the era of a human rights-driven ethos in patient care had arrived. This is not to say that human rights were never previously a consideration, but the revised Act brought with it a raft of changes, not least of which was an explicit orientation towards what one might view as a more 'patient-centred' approach to psychiatric care (Szabo and Kaliski 2017).

Additionally, in the Mental Health Act (Department of Health [South Africa] 2002) the patient became a 'user', more specifically a 'mental health care user' and the psychiatrist became a 'mental healthcare practitioner' (MHCP); together professionals, given that the procedures accompanying the Act permit medical practitioners with experience in psychiatry, along with a range of allied health professionals (for example nurses, social workers and psychologists) play a potential role in the assessment of mental state contributing to the need for admission (Department of Health [South Africa] 2002). The term 'user' has somewhat negative connotations, yet in attempting to be seemingly more egalitarian in the approach to care, it was clearly felt that the word 'patient' conferred a status not befitting an individual seeking and requiring care (Szabo and Kaliski 2017). However, the word 'patient', derived from the Latin

patior (to suffer), would appear to be precisely what a person seeking care is experiencing – suffering – with the medical practitioner must assist in alleviating such suffering. A further requirement of the Act was that 'users' be treated in the least restrictive manner possible and ultimately with the least discomfort and inconvenience and so as close to their place of domicile as possible (Szabo and Kaliski 2017).

Lund et al. (2012: 404) contend that 'the act was promulgated to enshrine the human rights of people affected by mental disorders and set up mechanisms such as Mental Health Review Boards (MHRB), to protect and uphold those rights.' Burke (2012) argues that many past ethical abuses against people with mental disorders were corrected by the Act. The Act intends to bring synergy between mental health practices and the World Health Organization (WHO) principles and promote the human rights of MHCUs in South Africa (Lund et al. 2012). The implementation of this Act took place in 2004. It has been lauded as one of the most forward-thinking pieces of mental health legislation ever enacted. The extent to which it has changed mental health services and increased the standard of treatment, is a true indicator of its worth. Burke (2012) claims that the Act corrects many past ethical violations against people with mental illnesses. The Act aims to create a connection between mental health practices and WHO values, as well as to promote the human rights of people living with mental illness in South Africa (Lund et al. 2012).

The Act aims to facilitate the care, treatment, and rehabilitation of individuals dealing with mental illness. It delineates distinct admission procedures for such individuals, establishes Review Boards for each health establishment, delineates their powers and functions, addresses the administration of property for those with mental illness, repeals specific laws, and attends to related matters (Republic of South Africa [RSA] 2002).

The promulgation of the Mental Health Act is a progressive way of ensuring that the rights of MHCUs are adhered to, in addition to establishing control measures on how mental health services are rendered. There are different classifications of services provided at the admission process until the discharge process. The Act has therefore had an impetus role in mental health care.

National Disability Rights Policy (NDRP)

The NDRP was intended to update the White Paper on the Integrated National Disability Strategy (INDS) (Republic of South Africa [RSA] (1997c). The vision of this policy is aligned with the National Development Plan 2930 (NDP) and the National Commission and Planning (Republic of South Africa [RSA] 2011). The plan states that SA is 'an empowered and inclusive society that upholds the rights of persons with disabilities to equality, dignity and self-reliance' (Republic of South Africa [RSA] 2011: 10). The policy landscape of SA is changing, and mental health is recognised; however, implementation is slow. This policy aimed to update the White Paper on the Integrated National Disability Strategy (INDS). This policy's vision is in line with the National Development Plan

2030 (NDP) (Department of Social Development [DSD] 2015). SA is defined as 'an empowered and inclusive society that upholds the rights of persons with disabilities to freedom, dignity and self-reliance,' according to the plan (Republic of South Africa [RSA] 2011: 31). The purpose of the policy concerns:

> *Taking action to ensure that their rights as equal citizens are upheld. Removing discriminatory barriers to access and participation. Ensuring that universal design access informs the planning, budgeting and service delivery value chain. Recognising the right to self-representation. Acknowledging that not all persons with disabilities are alike and that personal circumstances, gender, age, sexuality, cultural backgrounds, and geographical location, require different responses. Embedding the obligations contained in the UN Convention on the Rights of Persons with Disabilities in legislation, policy and service delivery (DSD 2015: 31).*

Post-1994, the democratic government of the day introduced a social model approach to addressing disability (DSD 2015). The DSD states that the social model focuses on the abilities of people with disabilities rather than their differences or disabilities and reinforces the principles of full participation, inclusion and acceptance of people with disabilities as part of mainstream society. More so, the DSD asserts that the model requires an analysis of the social context and needs of people with disabilities and promotes broader systemic and attitude changes in society, mainstreaming of disability and the need for people with disabilities themselves to be part of determining their lives (DSD 2015).

The development of useful and enabling legislation by the South African government is an exciting aspect. The government is putting in place the necessary infrastructure and is attentive to the requirements of people with disabilities (PWD). She is worried, nevertheless, that PWD continue to experience significant levels of social, economic and political inequality and discrimination, which has a negative impact on their underdevelopment, marginalisation, unequal access to resources and lack of service provision.

Traditional Health Practitioners Act (No 22 of 2007)

Janse van Rensburg (2009) reported that the Traditional Health Practitioners Health Act was promulgated in response to the political and social changes that have occurred in SA since 1994. Burke (2012: 568) further asserts that 'cross-cultural diagnosis and treatment present serious challenges; thus, mental health professionals need to be trained to recognise and accommodate diverse customs and practices and to support people with a variety of needs.' Traditional healers, according to Skuse (2007), are a major source of psychiatric assistance in many parts of the world, including Africa. Traditional healers hold a belief system that is complementary to conventional medicine in terms of the origins of mental health issues and, as a result, the proper treatment of these

issues (Makhanya 2012). Burke (2012) goes on to say that cross-cultural diagnosis and care are difficult and that mental health providers must be qualified to recognise and accept different customs and traditions, as well as to serve individuals with various needs. The purpose of the act is to:

- Establish the Interim Traditional Healers Council of SA.
- Provide for the registration, training and practice of traditional healers.
- Serve and protect the interest of the public who use the services of traditional health practitioners.

Makhanya (2012) states that the Act has a fundamental importance in mental health care and it provides a definition of traditional health practice, namely:

- the performance of a function, activity, process, or service that includes the utilisation of traditional medicine or health practice or function.
- to diagnose and treat physical or mental illness.
- to rehabilitate a person to resume normal functions and to prepare a person physically and mentally for a phase of life changes (puberty, adulthood, pregnancy, childbirth and death).
- Indigenous treatment methods and the cultural relevance of these treatments in mental health care.

The role of traditional health practitioners (THPs) in their communities in South Africa has long been acknowledged. Although the practice of traditional healing was illegal (Freeman and Motsei 1992; Ross 2010) in terms of the Health Professions Act (HPA) prior to the democratisation of the country, there were organisations which registered THPs (Kale 1995) and THPs continued to practice in their communities (Campbell-Hall et al. 2010). It is reported that allopathic health care practitioners turned a blind eye to THPs and in some cases even collaborated with them informally (Van Niekerk et al. 2014). The publication of the White Paper on the Transformation of the Health System (Department of Health [South Africa] 1997) effectively decriminalised traditional health care and placed the role of THPs firmly on the health care transformation agenda.

THPs are recognised as an integral part of their communities, where they are highly regarded and often shape their communities' thinking (Kale 1995). Ordinarily, a distinction is made in the literature between three types of THPs: the traditional doctor/herbalist or *inyanga*, who has extensive knowledge of herbs and herbal treatment; the diviner or *sangoma* who makes use of divination by consulting the ancestral spirits and the bones to diagnose and treat patients (Ross 2010); and faith healers, *umprofethi* or *umthandazi*, who mix Christian practices with traditional beliefs (Ross 2010). While some authors such as Ross (2010) assert that ordinarily, the inyanga does not use divination and that the diviners do not use herbs, Freeman and Motsei (1992) indicate that the classification of THPs is artificial. Some diviners do use herbs to treat and some traditional doctors do make use of divination (Freeman and Motsei 1992). Kale

(1995) presented a breakdown of these three categories. Table 6.1 provides the services of traditional healers.

Table 6.1: Traditional healing agencies in South Africa

AGENT	SKILLS	METHOD OF SERVICE	NATURE OF SERVICE	ACCESSIBILITY
Isangoma: High Grade	Lower and middle-grade qualifications are a prerequisite 'Call' by spirits Apprenticed to an expert Medical skills acquired as in inyanga	1. Essentially diagnostic 2. Contact with a patient not needed for diagnosis 3. History, symptoms and nature of problem not revealed by patients	1. Conflict resolution 2. Revelation of misfortune and illness 3. Recommends solution 4. Provides expertise and leadership	Access is given to relatively few
Middle Grade	Lower-grade qualification a prerequisite 2, 3 and 4 as above	1. As above 2. Throws and reads 'bones' 3. As above	1, 2, 3 and 4 as above	Relatively accessible compared with the above
Lower Grade	1. First entry point to divination 2, 3 and 4 as above	1. As above 2. Divination through trance 3. As above 4. Cooperation of clients Sought	Confirms patient's beliefs	Much more accessible
Inyanga	1. Individual choice to become one 2. Apprenticed to an expert 3. As above	1. Knowledge of symptoms and patient's history is necessary 2. Contact with patient necessary	Comprehensive, curative, prophylactic, ritualistic and symbolic	Freely accessible
Specialist Spiritual Healer	Usual family prerogative Trances and contact with spirits	Essentially curative Essentially diagnostic	Consultant, special skills Lays on hands, prays, provides holy water and other symbols	Fewer in number Freely accessible

(Adapted from Abdool Karim, Ziqubu-Page and Arendse 1994.)

It should be borne in mind that THPs form part of the private healthcare sector and that patients must make out-of-pocket payments to them (Peltzer 2009) (medical aid schemes do not cover THPs' services). A decline in accessing THPs could be attributed to factors such as the expense of out-of-pocket payments to THPs and/or increased coverage of public health services and specifically primary health care services (Van Niekerk 2014). Unfortunately, there does not seem to be literature investigating reasons for this decline in accessing traditional healthcare services (Van Niekerk 2014).

Unfortunately, there does not seem to be literature investigating reasons for this decline in accessing traditional healthcare services (Van Niekerk 2014). Attempts have been made in South Africa to regulate THPs, with the promulgation of the Traditional Health Practitioners Act (Republic of South Africa [RSA] 2007) but Ross (2010) points out that this Act has been in abeyance because key role players cannot come to agreement. Studies have reported that patients often view the causes of disease, especially mental illness, differently from allopathic practitioners (Campbell-Hall et al. 2010), viewing it as having cultural causes and not biological or genetic causes as allopathic practitioners may assert (Petersen et al. 2009). Cultural causes of mental illness may include bewitching, rape and 'thinking too much' (Campbell-Hall 2010: 617) and because of the way in which this illness is viewed (that is, as having a cultural cause), patients may rather consult THPs. Surprisingly, Petersen et al. (2009) reported that approximately two-thirds of psychiatric patients consulted both the allopathic health care system and THPs.

There ought to be greater collaboration, or at least cooperation, between allopathic practitioners and THPs in the field of mental health. Many people start at the traditional healers before they can consult an allopathic practitioner. Therefore, the mental health practitioner should be sensitive to the cultural beliefs of the MHCUs.

The Mental Health Policy Framework and Strategic Plan 2023-2030

This strategy seeks to enhance the participation of mental health care users and their caregivers. It advocates for the rights of MHCUs through the identification of key activities that are considered catalytic to further transform mental health services and ensure that they are accessible, equitable, comprehensive and integrated at all levels of the South African health system (Department of Health [South Africa] 2023). The 2022 World Mental Health Report, *Transforming Mental Health for All,* by the World Health Organization, estimates that approximately 13 per cent of the global population lives with a mental disorder, with the prevalence in the African Region around 11 per cent (WHO 2022). This report highlights mental disorders as the leading cause of years lived with disability, accounting for one in every six years globally, and emphasises the substantial economic consequences associated with mental health conditions.

The significant burden related to mental illness extends beyond its direct impact, as it also affects the management of co-occurring physical conditions.

Mismanaged mental disorders can adversely influence treatment outcomes for both mental illness and concurrent physical health conditions.

The COVID-19 pandemic and other calamities have underscored the critical importance of mental health, evident in how the physical impacts of COVID-19 led to widespread mental and emotional distress. The Life Esidimeni tragedy serves as a pivotal reminder of the imperative to improve mental health care and avoid similar catastrophic experiences.

The National Mental Health Policy Framework and Strategic Plan 2023-2030 mirror South Africa's commitment to enhancing evidence-based mental health services. It follows the National Mental Health Policy Framework and Strategic Plan 2013-2020, formulated through extensive consultations with stakeholders and mental health experts. The revised plan underwent meticulous review and updates, incorporating feedback from diverse stakeholders, including mental health professionals and service users.

The department's collaborative approach, involving experts and mental healthcare users in consultations, ensures the formulation of evidence-based policies. The implementation of the National Mental Health Policy Framework and Strategic Plan 2023-2030 is anticipated to fortify the healthcare system, fostering a comprehensive, high-quality, integrated mental health system that encompasses promotion, prevention, care, treatment, and rehabilitation for all individuals in South Africa.

The National Health Act and National Health Insurance

The National Health Act (NHA), enacted in South Africa in 2003, was designed to streamline the operations of the national health system, aiming to deliver standardised and fair healthcare to all citizens (Republic of South Africa [RSA] 2003). In the country's two-tiered healthcare system, efforts are underway to establish a consolidated fund. This fund is intended to provide access to high-quality, cost-effective personal healthcare services to all South Africans, regardless of their socio-economic status (Republic of South Africa [RSA] 2013).

While the NHA oversees healthcare practices and endeavours to enhance access to quality services, the National Health Insurance (NHI) system seeks to secure the financial means to achieve this goal. Mandated under Section 27 of the Constitution, the NHI strives to achieve Universal Health Coverage (UHC) in South Africa. Its objective is to establish a unified fund that ensures access to superior personal healthcare services for all residents based on their health needs, effectively bridging the gap present in the nation's two-tier health system (Republic of South Africa [RSA] 2013).

Since the advent of democracy, South Africa's healthcare sector has undergone numerous reforms aiming to establish a more accessible, affordable, and equitable system capable of serving the entire populace. However, these past reforms have been insufficient and slow in meeting the nation's healthcare needs.

Equitable access to quality and affordable healthcare is a fundamental right

for all citizens. Fundamental shifts are imperative to fortify the healthcare system, which currently grapples with complexity and excessive costs, yielding health outcomes that do not align with the resources invested. Challenges persist in both the public and private sectors, rendering the healthcare delivery system unsustainable for servicing all South Africans.

In alignment with its commitment as a member of the United Nations community, South Africa has pledged to implement universal health coverage, ensuring that every individual can access comprehensive, high-quality health services without financial barriers. The National Health Insurance (NHI) serves as South Africa's strategy to achieve this universal health coverage, operating as a fund through which the government procures healthcare services for citizens from providers in both the public and private sectors. The NHI endeavours to enhance healthcare affordability by reducing costs for everyone, operating akin to a national medical aid scheme financed through taxes and contributions tailored to individuals' affordability levels. It aims to grant free healthcare access to all when needed, eliminating fees at healthcare facilities as the fund covers the costs of care (Parliament of the Republic of South Africa 2023).

The NHI Act was approved by the Portfolio Committee on Health in May 2023, and it was passed by Parliament in June 2023 and sent to the National Council of Provinces (NCOP) for concurrence (Parliament of the Republic of South Africa 2023). On 6 December 2023, the NCOP passed the NHI Bill and submitted it to the President for assent. Unfortunately, the NCOP did so without any substantial amendments to the Bill. This was despite significant concerns raised by multiple stakeholders throughout the parliamentary processes regarding the financial, constitutional, and operational viability of the NHI as proposed (Discovery 2024).

President Cyril Ramaphosa signed the Bill into law on May 15, 2024, and it was gazetted as the NHI Act on May 16, 2024, but no effective dates were specified (South African Government 2024). Significant flaws and legislative process issues may lead to legal challenges and delays.

The NHI bill has received mixed reactions, with some welcoming it and others remaining sceptical (BizNews 2024). The private sector, erstwhile opposition parties (the opposition parties have changed since the 2024 elections) and medical aid funds have threatened legal action, particularly objecting to section 33, which limits medical aid schemes to funding only services not covered by the NHI (BizCommunity 2024). Concerns about the government's ability to manage the NHI effectively due to a history of corruption and mismanagement persist (Msimanga 2024).

Furthermore, provinces, currently responsible for healthcare delivery per the Constitution, may challenge the new funding mechanism, as it bypasses the current provincial healthcare funding route (Msimanga 2024). The government currently plans to fund the NHI by removing the tax rebates paid to members of medical schemes and through new taxes, which will include additional personal income tax and employer and employee payroll tax (BizCommunity 2024). According to Solanki et al. (2024), the full realisation of the NHI could take 15

to 30 years, reflecting the experience of other countries with similar systems. It remains to be seen how, subsequent to the elections in May 2024, the government of national unity is going to affect developments going forwards.

President Ramaphosa has dismissed claims that the NHI will end private healthcare, emphasising the integration of private and public sector strengths to create a unified, high-quality health system (South African Government News Agency 2024). The NHI Fund will procure services from accredited providers, benefitting all South Africans, especially the poor, by freeing up their resources for essential needs and reducing medical aid costs (South African Government News Agency 2024). Ramaphosa highlighted the current system's unsustainability and inequality, advocating for strategic planning and resource allocation to achieve universal health coverage (South African Government News Agency 2024). He noted that state subsidies indirectly support the private sector, which primarily serves a minority, making private healthcare unaffordable without tax rebates, and stressed the need for efficient resource use to build an inclusive healthcare system (South African Government News Agency 2024).

In the current landscape of mental health care, it is imperative to recognise the significant progress achieved in heightening awareness and enacting policies geared towards enhancing support for MHCUs. There have been commendable efforts to enhance access to services and address the societal stigma associated with mental health. However, these positive advancements often collide with persistent challenges, notably in inadequate financial backing and resource allocation. Insufficient funding remains a significant barrier, hindering the development and sustenance of comprehensive mental health programmes. Moreover, while there has been progress, the integration of mental health care into broader healthcare systems still requires substantial refinement.

Moving forward, it is imperative to address these inadequacies head-on. Enhancing financial support and resource allocation to mental health care should be a priority. This includes not only increasing funding but also ensuring its effective utilisation and allocation to grassroots initiatives and community-based services. Additionally, providing comprehensive support and guidance to professionals, including social workers and other stakeholders involved in mental health care, is vital. This support should encompass continuous training, updated guidelines, and multi-disciplinary collaboration to deliver holistic care.

Furthermore, tackling the persisting stigma associated with mental health requires concerted efforts in public awareness campaigns and education initiatives. Empowering communities to understand and support mental health needs, alongside fostering a more inclusive society, is pivotal for sustainable progress. Lastly, ongoing monitoring and evaluation mechanisms must be in place to assess the effectiveness of implemented strategies continually. This iterative process allows for necessary adaptations and improvements, ensuring that Mental Health Care Users receive the comprehensive, stigma-free, and accessible care they rightfully deserve.

Chapter 7
Social work practice and mental health care

Introduction

Social work brings a distinctive social perspective to mental health, recognising the social experiences, causes of mental disorder throughout a person's life course and enhancing fundamental human potential and the opportunities they could access to bring about change (Allen 2014). Furthermore, social perspectives are rooted in acknowledging the importance of service users' most accurate first-hand accounts of their experiences and needs and involve working closely alongside people, using empathy and relationship-building skills to hear and see through the eyes of the service user, family and friends (Lamb 2014). Bland, Renouf and Tullgren (2009: 171) assert that 'social workers have particular expertise in helping people whose mental health problems coexist with other problems such as family distress, drug and alcohol abuse, disability, poverty and trauma'. This means that social workers are best located to recognise and respond to mental health problems because most of the time mental disorder is strongly correlated with social determinants of mental health (see Chapter Four). This makes social work an important affiliate of the multi-disciplinary team in the mental health facility and outpatient treatment. As important as the social work profession is, professionals are limited in terms of the scope of what they are educated in and authorised to perform, regarding roles, functions, responsibilities and activities in mental health-specific social work practice (Ashcroft, Kourgiantakis and Brown 2017). Research including specifics as to the role and responsibilities of social workers in the domain of mental health provision has been inadequately described, to a large extent (Lund et al. 2011; Ragesh, Hamza and Sajitha 2015). Karban (2011) argues that social work has a vital contribution to make to mental health care, based on the profession's values, knowledge and skills. There has also been some development in the anti-discriminatory and anti-oppressive practice of the 1980s and 1990s, accompanied by changes in the statutory and legislative role of social workers in mental health settings. These and other factors have all been influential in shaping the current situation and the potential future role that social work must play in the mental health field.

Allen (2014) asserts that social workers have a crucial part to play in improving mental health services and mental health outcomes for all citizens. Social workers bring a distinctive social and rights-based perspective to their work. Furthermore, social workers' advanced relationship-based skills and their focus on personalisation and recovery can support people in making a positive, self-directed change. Moreover, social workers are trained to work in partnership with people using these services, their families and carers, to optimise involvement and collaborative solutions. Social workers also manage some

of the most challenging and complex risks faced by individuals and society and make decisions with and on behalf of people within complicated legal frameworks as well as balancing and protecting the rights of different parties. This includes, but is not limited to, their vital role as the core of the Approved Mental Health Professional (AMHP) workforce (Allen 2014). The South African context requires a range of responses to address its vulnerable populations' urgent needs (Petersen and Pretorius 2022). Social work in health care responds to people's diverse and complex needs once they encounter any healthcare setting (Ashcroft 2014; Auslander 2001; Browne 2006; Dhooper 2012). This interface with health care settings places people in direct contact with social workers regarding disease and its impact, simultaneously allowing them to address other needs (Petersen and Pretorius 2022). Social work in health care fulfils the imperative role of addressing any social determinants of mental health to enable compliance and adherence to treatment (Bywaters and Ungar 2010; Moniz 2010). This implies that social work in health care is valued for counselling and addressing the social determinants of mental health (Petersen and Pretorius 2022).

Principles, values and ethics of social work in mental health

Given the rights of civil society and the ethical requirements of the profession, the emphasis is on developing social work practitioners who are not only skilled but also critically reflective, ensuring they can practice in line with the profession's core values (SAQA 2003). The overarching values that guide social work education and training are social justice and respect for all (SAQA 2003). Social work values can be viewed as a discourse through which the structure of the profession is maintained, justified and transmitted, lately becoming legitimised through formal codes of ethics (Spano and Koenig 2007). Additionally, Thompson (2009: 126) defines a value as something we hold dear, something we see as important and worthy of safeguarding. More so, social work principles refer to the way social workers act on the values, for example in terms of the value of social justice, the supporting principle would be that social workers are to challenge social injustice (Schenk et al. 2015). There are many reasons why the professions are guided by a code of ethics in their practice. For the social work profession in South Africa, as stated by the South African Council for Social Service Professions (2005), the code of conduct describes the standards of professional conduct required from social services practitioners in their daily activities. The Code of Ethics can therefore be referred to as the manual or the reference booklet for social work practice. Values and ethics of social work demonstrate that the values are integral to their practice, they uphold their ethical responsibilities and they act appropriately when faced with ethical problems, issues and dilemmas (the South African Council for Social Service Professions 2005).

Table 7.1: Code of ethics and guiding principles adapted from Dominelli (2009), SACSSP (2008a) and NASW (2019)

DOMINELLI	SACSSP	NASW
Individualisation	Social justice	Service
Purpose expression of feelings	Respect for people's worth and human dignity	Social justice
Controlled emotional involvement	Competence	Dignity and the worth of the person
Acceptance	Integrity	Importance of human relationships
Self-determination	Professional responsibility	Integrity
Confidentiality	Show care and concern for other's well-being	Competence
Non-judgemental attitude	Service delivery	

The guiding ethical values relate to the general approach as is reflected in the rules relating to the course of conduct to be followed by social workers (SACSSP 2008b). More so, in pursuit of quality services, social workers aspire and subscribe to ethical values and principles. As the profession has evolved some similarities between the SACSSP and NASW principles are notable. Social justice is common where social workers advocate for social change, particularly as it applies to vulnerable or oppressed groups of people such as MHCUs. Social workers are especially concerned with issues associated with poverty, unemployment, discrimination and other forms of social injustice. The role of the social worker is to promote sensitivity and understanding of marginalised groups and to ensure access to appropriate services by anyone needing them, regardless of cultural, ethnic or gender identity.

In addition to adhering to ethical principles, social workers are bound to abide by a detailed and comprehensive set of ethical standards governing their professional behaviour and relationships. The standards are organised into six categories: social workers' ethical responsibilities to clients, social workers' ethical responsibilities to colleagues, social workers' ethical responsibilities in practice settings, social workers' ethical responsibilities as professionals, social workers' ethical responsibilities to the social work profession and social workers' ethical responsibilities to the broader society (NASW 2019). Within these six categories of ethical standards are enforceable guidelines of conduct as well as aspirational ones. For example, an enforceable guideline is one involving informed consent. A client must receive a clear and understandable explanation of services offered and retain the right to consent to or refuse services. An aspirational guideline is broad and not easily measured. For instance, the initial ethical standard for social workers stipulates that they must prioritise the well-being of their clients as their foremost responsibility (NASW 2019). Social workers cannot render effective mental health services if they do not adhere to the values and ethics of social work.

The understanding of social work practice and mental health care

Social work is crucial in delivering and maintaining optimal mental health services. Good quality social work can transform the lives of people with mental health conditions and is an essential part of multi-disciplinary and multiagency collaboration (Lamb 2014). Furthermore, alongside professionals in the health, social care, housing, employment and other disciplines, social workers play a key role in identifying and accessing local services which meet people's needs at an early stage, helping to improve overall mental health outcomes and reducing the risk of crisis and more costly demands on acute health services.

The National Association of Social Workers emphasises that the ethos of social work is to protect human rights and intervene to prevent or end discrimination and inequality and to protect vulnerable people (NASW 2024c). The NASW makes it clear that social work has a dual mission, namely, to enhance human well-being and help meet their basic needs, with particular attention to the empowerment of vulnerable groups (NASW 2024a).

In South Africa, the social work professional is classified as a mental health practitioner (Mental Health Act [No 17 of 2002]; Department of Health [South Africa] 2002). However, it is notable that in practice, the role of social work in mental health is misunderstood. This assertion is in line with the findings which emanated from the studies conducted by Olckers (2013) and Ornellas (2014). Olckers (2013) asserts that there are controversies and questions relating to social work in mental health care. The questions relate to whether social workers are adequately trained to work in a mental health setting and are worthy of the designation of mental health team member. In effect, these controversies undermine the role of the social worker in a mental health setting.

Furthermore, Ornellas (2014) points out that due to the closing down of some mental health institutions in South Africa as part of the deinstitutionalisation process, poor development of community-based initiatives and NGO's single-minded focus on service delivery for MHCUs, the availability of adequate services and care has decreased significantly. Through a contract with the Life Healthcare group, the National Department of Health (NDOH) and, subsequently, the Gauteng Department of Health (GDOH) had been subsidising institutionalised care for people with mental disorders, an arrangement that ended on the 30th of June 2016 (South African Human Rights Council [SAHRC] 2019). In anticipation of the end of this contract, an estimated 1,418 MHCUs were rapidly transferred from the Life Esidimeni facility to hospitals and non-governmental organisations (NGOs), some of which were unlicensed. The transition of providers and the handling of transfers led to a tragic outcome, resulting in the loss of 144 mental health care users' lives and exposing 1,418 others to torture, trauma and detrimental health consequences. in a process that came to be known as the Gauteng Mental Health Marathon Project (GMHMP) (Makgoba 2017). As a result of this tragedy, Ornellas (2014) asserts that the effects

of deinstitutionalisation on the social work profession and the role of the social worker within mental health settings have been damaging.

According to Salize et al. (2008: 533), to determine the success of the deinstitutionalisation process, one needs to analyse aspects such as the interaction among various health and social functioning sectors, the extent of the patient shift between these sectors and 'whether potential shifts indeed correspond to the actual needs of the persons concerned, or whether referral patterns seem inappropriate, or there seems to be a potential systematic misuse of the referral or receiving sector'. Considering this within the South African context, despite the introduction of policy reformation post-apartheid, the actual implementation of deinstitutionalisation was poorly done. The process was largely focused on the emergency management of service users through 72-hour observation facilities, with very little corresponding development of long-term, sustainable community services toward the rehabilitation and reintegration of individuals living with mental disorders or MHCUs into society (Lund et al. 2010; Petersen et al. 2009). According to Lund et al. (2008), this process was implemented at a rapid rate, with poor understanding and management of the implications of such a transition, as it was primarily introduced as a cost-saving exercise based on international movements (Petersen et al. 2009). Therefore, in this regard the adoption of the policy of deinstitutionalisation (in terms of that which is outlined in the White Paper for the transformation of the health system, Health Policy Guidelines for Improved Mental Health in South Africa [1997] and the Mental Health Care Act [17 of 2002], has resulted in a fragmentation of specialised mental health services and poor quality of care available to the people with mental disorders as a whole within the South African context. The process of decentralisation and deinstitutionalisation has thus harmed service rendering and service availability for MHCUs (Lund et al. 2008; Petersen et al. 2009).

According to research conducted by Lund et al. (2008), deinstitutionalised care is not considered to be the cheaper option, when considering the resources required for the effective establishment of tertiary and community-based care (Petersen and Lund 2011; Lund et al. 2008). These authors' studies stressed the need to utilise the finances saved from reduced spending on psychiatric institutions to create adequate community services (Lund et al. 2008). An outpatient is an individual who receives medical and/or therapeutic care but is not hospitalised for 24 hours or more (Ornellas 2014: 57). Instead, services are rendered through a day clinic or associated non-governmental and/or non-institutional facility. Community-based care refers to services that are rendered through community structures and organisations, which are locally based and established within the patient's closely related physical and social environments (Lund et al. 2010: 48).

The Mental Health Care Act (17 of 2002) (see Chapter Six) legislates for less restrictive care and advocates for service rendering that is offered as close to the patient's community as possible (Ornellas 2014). The Act states that only when outpatient services are insufficient to address treatment needs,

should institutional care then be implemented to provide safe treatment and stabilisation services; this should, however, be for as short a period as is needed for the individual to return to community life (Ornellas 2014). According to such legislation, inpatient mental health care should preferably be offered in a general hospital setting, with specialised hospital care available for only more intensive mental health care, if required (Ornellas 2014). MHCUs who have lived in an institutional care setting for longer periods are identified as needing access to rehabilitation services post-release, to prepare them for a return to community life (Ornellas 2014). All MHCUs who require short-term or long-term support for work, study and family and community life should have full access to necessary psychosocial support services (Lund et al. 2010). To this end, the Act stipulates the development of community-based services and support systems that promote the MHCUs' recovery and reintegration into society (Lund et al. 2010).

The role of the social worker in outpatient and community-based care

In addition, Lund et al. (2008: 45) highlight that 'there is an existing gap regarding the availability of social work services within the mental health context. The process of deinstitutionalisation has made very little room for the practice of social workers within mental health; recent research found that within a population of 100,000 MHCUs, data recorded a capacity of only 0.40 social workers.' Social work as a profession has always been acknowledged for rendering services that aid and empower the downtrodden, assessing and incorporating debilitating environmental factors that can contribute to human problems (Ornella 2014). The International definition of social work, as adopted in 2014 by the International Federation of Social Workers (IFSW) and International Association of Schools of Social Work (IASSW), states that: 'The social work profession promotes social change, problem-solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.' (IFSW and IASSW 2014: para 1).

Social work intervention within the context of mental health care thus needs to be at all four levels: prevention needs to be implemented through educative means within communities, teaching groups about mental health, the incorrect stigma of this illness and how to properly administrate care for the MHCU; early intervention needs to take place through the rendering of services such as family counselling and awareness regarding mental disorders, working closely with clinic and hospital settings to ensure assessment and early diagnosis; statutory intervention through the means of outpatient and community based services that offer group support, therapy, caregiver and family support, medication administration and monitoring, assistance toward job and resource access; and

finally, reconstruction and after care, which is primarily through assisting in the reintegration of MHCUs into society and post-diagnosis or institutional care – this is probably one of the most important aspects required within the context of social work intervention in mental health care (Lund et al. 2010; Lund et al. 2012).

At a time of much change to professional roles and organisational structures, where concerns have been expressed about the distinctive role that social workers have to play in the broader provision of health and social services within the field of mental health, it is worth noting and reflecting on the role and contribution of social work in community mental health provision in statutory community mental health teams, integrated or multi-disciplinary teams and assertive outreach and crisis intervention teams (Ornellas 2014). With the increased focus being on outpatient services and a poor availability of specialised social workers in mental health (Lund et al. 2010; Lund et al. 2012) general social workers are now being faced with the task of reaching out to the MHCUs. The increasingly high influx of MHCUs into local communities that have little, if any, structured public health and community-based care systems, influences general social work practice, impacting areas of crime, family structure and functioning, child abuse, domestic violence, family violence and unemployment (Lund et al. 2010) and thus the generic social worker can no longer remain isolated from mental health care practices (Ornellas 2014).

The traditional role of social workers in mental health care primarily involved working with patients and families to facilitate effective communication between patients, families and health care teams (Gehlert and Browne 2012) in ways that would then decrease barriers caused by issues such as low health literacy. This is still a significant activity that needs to be undertaken by the social worker. However, their role has expanded to include many activities such as case management, within both in- and outpatient and community-based care, supported employment, residential care, psychosocial support, family therapy and support and assistance in basic reintegration into society and the needs associated with this (Barlow and Durand 2012; Johnson and Yanca 2007). According to Gehlert and Browne (2012), based on a comprehensive psychosocial assessment, social work interventions also need to include helping MHCUs and families to obtain and understand health information and apply that information to better their health after discharge. Ornellas (2014) believes that this is a service that is not rendered by any other mental health professional in both the in- and outpatient and community-based settings. Regarding case management specifically, the social worker can be found to have an important role to play in rendering services of assessment, planning, coordination of services and crisis intervention (Ornellas 2014). According to Johnson and Yanca (2007), services such as these are vital to advancing the quality of life of MHCUs and ensuring that their basic needs are being met. Case managers are also required to monitor a patient's needs regarding medication and symptomatic display, linking patients to the relevant services and treatment where necessary (Johnson and Yanca 2007). Social work in mental health has a critical role to

play in outpatient and community-based mental health services. Therefore, it is also critical that developmental social work be discussed in the context of mental health care.

Developmental social work and mental health

Before 1994 South Africa followed a residual approach to welfare, according to which welfare has a safety-net function, coming into effect only when people have exhausted their resources (Midgley 1996). The nature of social work was curative and rehabilitative and social workers used methods such as casework and therapy to support client systems (Department of Social Development [South Africa] 1997). In the post-apartheid dispensation, the country needs an alternative welfare approach that would address poverty and inequality on a larger scale (Holscher 2008). The developmental social welfare paradigm was introduced in the White Paper for Social Welfare in 1997 as noted in Chapter Seven. The nature of social work was now supposed to be developmental and preventative and the main vehicle to be used to achieve this was and is community development (Mansvelt 2018). Social workers have been very slow to change from casework to community development (Mansvelt 2018). Community work (or macro-level work, which development is part of) has never been the preferred method of work of social workers (Mansvelt 2018). Internationally, Aviram and Katan (1991) found that social work students in Israel prefer casework and counselling to community work and most aspire to open private practices after they have graduated. Macro-level intervention is therefore essential due to the fact that it is all about the empowerment of MHCUs. Due to the current nature of social work, which is developmental and preventative, social workers have a responsibility to assist the MHCUs in achieving optimal functioning, such as being able to be employed and having a house or a family. This statement is reminiscent of the findings of a study in 2017 in Limpopo (Bila 2017). The participants expressed their desire to be gainfully employed, akin to individuals unaffected by mental disorders. Additionally, they conveyed aspirations for establishing their own families and owning homes. This underscores the essential needs of MHCUs outlined in Chapter Five.

The developmental approach to mental health supports social workers' obligation to the services they provide with the need to promote a clearer and more inclusive society (Lombard and Bila 2020). The UN Agenda 2030 for Sustainable Development Goals concept is to leave no one behind – this is fundamental to social work and remains at the essence of mental health care (Lombard and Bila 2020). Developmental social work is evolving as a new paradigm in social work worldwide that seeks to infuse social development theory and practice into social work processes (Midgley and Conley 2010; Patel 2005). Developmental social work is receiving increasing international recognition and much may be learned from its application in different societal contexts (Patel and Hochfeld 2012). A developmental approach to integrated socio-economic development can be seen as being focused on

the strengths of the individuals and the community to embark upon activities that contribute meaningfully to planned socio-economic development initiatives. Communities should promote their capacity for growth as well as the development of institutions, processes and programmes (Department of Social Development [DSD] 2009). Moreover, the DSD (2013) asserts that a developmental approach is an integral factor in the delivery of integrated social welfare services. Additionally, Lombard and Bila (2022: 109) assert that 'a developmental approach emphasis on structural injustices that hinder human progress and mental health ... is a universal, human rights-based approach in which participation, social and economic development, micro and macro practice and partnerships are equally important and are integrated to promote and protect mental health.' More so, a developmental approach to social work holds a human rights-based approach, people's participation, the integration of economic and social development, bridging micro and macro practice and partnerships (Patel L. 2015).

New social welfare thinking has been infused with notions of social transformation, human emancipation, reconciliation and healing and the reconstruction and development of society. These ideas are enshrined in the Constitution of the Republic of South Africa 1996 (Act No 108 of 1996) and the subsequent adoption of relevant policies and legislation to reflect the vision and values of a new society (see Chapter Six). This approach is based largely on the White Paper for Reconstruction and Development (1994) (Republic of South Africa 1994), which has socio-economic development through poverty alleviation as one of its goals.

The purpose of developmental social welfare is to enhance social functioning and human capacity, promote social solidarity through participation and community involvement in social welfare, promote social inclusion through the empowerment of those who are socially and economically excluded from the mainstream of society, protect and promote the rights of populations at risk, address oppression and discrimination arising not only from structural forces but also from social and cultural beliefs and practices that hamper social inclusion and contribute significantly to community building and local institutional development (Department of Social Development [DSD] 2013).

Developmental social work is committed to social justice and human rights, emphasising the dignity and self-determination of service users (Lombard 2007: 307). It challenges structural injustices that lead to marginalisation and promotes social integration through empowerment and advocacy to eradicate poverty and inequality. This approach connects personal experiences with broader structural contexts, utilising various methods, including policy formulation and advocacy, while ensuring the participation of service users in all processes and promoting sustainable development (Patel 2005: 206).

The Integrated Service Delivery Model (ISDM) (Department of Social Development (DSD) 2005) emphasises that developmental social welfare services are classified in terms of levels of intervention, namely prevention; early intervention; statutory, residential and alternative care; and the reconstruction

of aftercare services. All services are aimed at promoting the optimal functioning and the reintegration of beneficiaries into mainstream society. Core services are further classified into five broad categories: promotion and prevention; rehabilitation; protection; continuing care (continuum of care); and mental health and addiction services (DSD 2005).

More so, the developmental social work approach is relevant to mental health care. In most instances, MHCUs are marginalised and discriminated against and it is the role of a social worker to empower the person to be able to stand up for his or her rights. For example, give the person all the information and encourage them to make decisions about their well-being, encourage the MHCUs to exercise their rights and improve their self-esteem and confidence, and support them to manage and overcome the stigma of having a mental disorder. What is very critical is to allow the MHCUs to voice out their views and be able to make informed decisions.

Functions of social workers in mental health care

Social work in health care plays an essential role in counselling people affected by the disease, its impact and losses (Petersen and Pretorius 2022). Social work also addresses a wide range of social issues, challenges and needs that patients and their families may face (Petersen and Pretorius 2022). When an MHCU enters a healthcare setting because of disease or loss, other psychosocial and socio-economic needs tend to surface or become more pronounced. Even though the mandate of the social worker in a health care setting is focused on counselling to sustain emotional and physical well-being and address the impact of disease, attending to the social determinants of health (SDH) (that is, discharge planning, addressing compliance and other social issues) may be more important. Social workers in health care are ideally positioned to detect and address the SDH early in the process. Therefore, social work in health care may be viewed as comprehensive and holistic and inclusive of a wide range of services that are not limited to biopsychosocial assessment, therapeutic interventions, discharge planning and care, education, brokering and mediations (Auslander 2001; AASW 2016a, 2016b; Bentley 2002; Browne 2006; Carbonatto 2019; Davis et al. 2004; Dhooper 2012; Gehlert 2006; Ruth and Marshall 2017; Segal et al. 2018). Globally and in the South African context, the role of social work in health care has been of great value and importance because of its unique position in the health sector.

The social work profession has a dual mission to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed and living in poverty (NASW 2009b). Heller and Gitterman (2011) note the fact that people who are living with mental health issues encounter impediments in all areas of their lives daily. In accordance, with the social work profession's mission, social workers assist clients to restore their optimal levels of overall functioning in various domains (Heller and Gitterman 2011). The function

of social work is to assist clients and their families to cope with the tasks and struggles in day-to-day living and influences (Heller and Gitterman 2011). Allen (2014) proposes five key areas of practice that should frame the deployment and development of social work in mental health, namely:

- Enabling citizens to access the statutory social care and social work services and advice to which they are entitled, discharging the legal duties and promoting the personalised social care ethos of the local authority.
- Promoting recovery and social inclusion with individuals and families.
- Intervening and showing professional leadership and skill in situations characterised by high levels of social, family and interpersonal complexity, risk and ambiguity.
- Working co-productively and innovatively with local communities to support community capacity, personal and family resilience, earlier intervention and active citizenship.
- Leading the Approved Mental Health Professional workforce.

Allen (2014) is of the view that these areas of practice should shape role descriptions, continued professional development (CPD) opportunities and curricula, and social work leadership in all adult mental health work contexts. Furthermore, social work functions should not expect to reflect all five key areas but rather be used as a guideline.

Olckers (2013) indicates that various resources indicate the presence and need for the role of social work in mental health. There are currently important debates and controversial statements regarding the functions of social work in mental health in South Africa. Furthermore, regarding the question of the role of social work in mental health, it can be concluded that the social worker has a definite role to play in mental health. It would therefore be applicable that a continuing professional development (CPD) training programme for social workers in mental health could be of value. The function of a social worker varies slightly according to the different mental health settings and countries. Social work has been carried out in many different places and with many different groups (Blewitt, Lewis and Tunstill 2007).

Table 7.2: Summary of the functions of social workers in mental health as outlined by Olckers (2013) and the Department of Social Development (DSD, 2015):

FUNCTION	DESCRIPTION
Helping people to obtain tangible services	Assisting individuals in accessing essential services and resources
Tracing families of people living with mental disorders	Tracing families of people living with mental disorders
Conduct thorough psychosocial assessments with individual and family	Performing detailed assessments of the mental health needs of both individuals and their families
Be involved in the discharge planning	Participating in planning for a patient's discharge from mental health facilities
Be involved in the ward rounds	Taking part in regular ward rounds to monitor patients' progress
Develop an individual care plan	Creating personalised care plans for individuals with mental health issues
Rendering reunification services	Supporting the process of family reunification and reintegration
Provide family support	Offering emotional, psychological, and practical support to families
Conduct home visits	Visiting patients at home to assess their environment and provide ongoing support
Conduct awareness campaigns	Running campaigns to raise awareness of mental health issues
Helping communities or groups provide social and health services	Assisting communities in organising and offering social and health-related services
Participating in relevant legislative processes	Involvement in the development and implementation of relevant mental health policies
Prevention and promotion services	Maintaining, restoring, and improving psychosocial functioning through various activities
Social services support services	Helping people use their problem-solving and coping skills more effectively
Facilitating interaction and strengthening relationships within the resource system	Encouraging better relationships between people and resource systems
Assist with the disability grant application	Helping individuals apply for disability grants
Establishing initial linkages between people and resource systems	Creating connections between individuals and necessary resource systems
Render aftercare services	Providing ongoing care and support following treatment or discharge
Counselling individuals, families, and groups	Providing therapeutic support to individuals, families, and groups

Multi-disciplinary teams in mental health service provision

The multi-disciplinary team consists of professionals from various fields who collaborate towards common goals, requiring a commitment to role identification (Craven and Bland 2013). Olckers (2013) notes that the roles of mental health practitioners have evolved, leading to overlapping professional elements. In South Africa, interactions occur between health-related issues (such as heart diseases, depression, and stress), social challenges (child abuse, substance abuse, and violence), and socio-economic factors (unemployment, limited education, and poverty) (Olckers 2013: 38). Teamwork is essential for effective collaborative care to adequately support families and individuals (Craven and Bland 2013), and it is a critical component of quality mental health practice to address the needs of individuals with mental health issues (Wilson et al. 2008).

Junor, Hole and Gillis (1994: 20) state that an MDT is known to 'maximise clinical effectiveness'. It is not just a matter of getting different mental health professionals together and magically multi-disciplinary teamwork happens. Teams need to have shared goals and values, need to understand, and respect the competencies of other team members, need to learn from other disciplines and respect their different views and perspectives. Individual team members may need to reassess exclusive claims to specialist knowledge and authority to form effective multi-disciplinary teams, which can provide the best possible care to the individual service user. Taberna et al. (2020) assert that good teamwork enables the provision of effective and comprehensive care. Meeting the patient's needs is the primary task of the multi-disciplinary team. All relevant professionals should be able to contribute to this task while maintaining good inter-professional relationships.

Taberna et al. (2020) emphasise several factors to enhance multi-disciplinary team (MDT) functioning. A clear written philosophy should provide a shared vision, with well-documented roles and responsibilities, developed in collaboration with users. There should be clear guidelines on care providers and weekly MDT clinical review meetings. Additionally, weekly or bi-weekly partnership forums with service user representatives, managers, and patient advocates should assess the unit's functioning, along with monthly business meetings and six-monthly stakeholder forums. A lead clinician must ensure MDT meetings occur, team-building activities should be held every six months, and procedures for resolving disagreements should be in place. Shared in-house MDT training and education should happen monthly, and documentation, such as MDT case notes, should be shared. Patients should also receive multi-disciplinary care planning.

Brooklyn and Suter (2016) assert that social workers face several challenges in multi-disciplinary teams, including marginalisation, difficulty in being heard by medical colleagues, exclusion from decision-making, low professional status, and a lack of respect from peers. Kirschbaum (2017) attributes the

underutilisation of social workers to differing perceptions among health professionals regarding treatment approaches for MHCUs. Medical professionals tend to justify their decisions, while social workers rely on tacit knowledge gained through experience. In contrast, Bila (2017) conducted a study in Limpopo revealing that social workers felt highly regarded by their peers, suggesting that their absence negatively impacts team effectiveness. This finding contrasts with existing literature, indicating that the experiences of social workers in multi-disciplinary teams can vary significantly.

Chapter 8
Intervention methods employed by social workers in mental health

Introduction

A good knowledge of the medical and psychiatric history of the MCHUs will give the social worker a clearer picture of their past or present state of health to design or formulate different care plans for both acute and chronic cases (Webber et al. 2014). When a social worker first engages with a person who needs help, the social worker will perform a social work assessment to help them formulate an intervention plan for the client (Webber et al. 2014).

After a thorough psychosocial assessment, the social worker will understand the nature of the mental disorder and guide him/her in planning appropriate social work interventions based on the medical and social issues diagnosed (Webber et al. 2014). As a matter of fact, with a thorough understanding of the various mental disorders, the social worker would be able to differentiate one from the other, manage follow-up psychiatric cases and refer cases for early diagnoses and treatment to psychiatrists or other members of the medical team (Webber et al. 2014). All members of the medical team play various significant roles in bringing about the wellness, stability, and recovery of the MCHU (Ajibo 2020). Reflecting the complexity and inter-connectedness of the MHCUs' lives, social workers in mental health care intervene at the level of individuals (micro-level), their families and close relationships (meso-level) and their communities and wider social relationships (macro-level) (Webber et al. 2014). Interventions at each level are focused on different aspects of an individual's life and require different sets of skills, knowledge and expertise (Webber et al. 2014). The focus on care management, care coordination and making referrals to other agencies has diminished social work in mental health care expertise in intervening directly with individuals and their social environments (Webber et al. 2014). Webber is of the view that this must change for the profession to be able to develop and define its professional practice.

The process begins with a holistic assessment which identifies intervention options at micro-, meso- and macro-levels (Rapp 1998; Webber et al. 2014). Assessments must characterise subsequent interventions and be strengths-based, recovery-oriented and systemic (Webber et al. 2014). They need to identify an individual's strengths and focus on the goals they wish to achieve, in addition to providing an in-depth understanding of their social circumstances and context (Rapp 1998; Webber et al. 2014). Eco-maps (Webber et al. 2014) provide the basis for assessing the relationships and assets of an individual, their family and wider social context and should be used routinely. The chapter focuses on the assessment and intervention methods.

Assessment

The Policy Guidelines are issued in line with section 21 of the National Health Act which prescribes that the Director-General must issue guidelines for the implementation of national health policy (Department of Health [South Africa] 2002). The Policy Guidelines are aimed at providing guidance to Heads of Health and health care providers on the requirements for listing facilities to conduct 72-hour assessments, the procedures to be followed when conducting 72-hour assessments on involuntary mental health care users and clinical management guidelines relevant to the 72-hour assessment procedure (Department of Health [South Africa] 2002). As with all other health interventions, a 72-hour assessment must be conducted in a safe and secure ward (Department of Health [South Africa] 2002). The due process regarding the application, assessment and approval for involuntary care, treatment and rehabilitation must be observed (Department of Health [South Africa] 2002). Users who cannot give consent and are posing a danger to themselves and others require special attention and clinical management to ensure that they are not harmed or harm others (Department of Health [South Africa] 2002). In this regard, frequent observations and assessments should be conducted to determine the impact of the intervention (Department of Health [UK] 2011).

Procedures to be followed when conducting 72-hour assessments are listed in Table 8.1.

Table 8.1: Procedure to be followed when conducting a 72-hour assessment, adapted from Department of Health (South Africa) (2002)

DOMINELLI	SACSSP	NASW
Admission	Written application by a spouse, next of kin, partner, associate, parent, or guardian – if possible – or Healthcare Professional (HCP) Mental Health Act (MHCA 04) Two Mental Healthcare Practitioners (MHCPs) examine the user and submit findings to the Head of the Health Establishment (HHE) X2 (MHCA 05). HHE decides (on inpatient or outpatient care) and gives notice to the applicant (MHCA 07). Admission and continue with the 72-hour assessment. Within 24 hours after the expiry of the 72-hour assessment, MHCPs record the findings and outcome of the 72-hour assessment (MHCA 06). OR Warrants care on an inpatient basis. Transfer to a psychiatric hospital	Applicant must have seen Mental Health Care User (MHCUs) within seven days of making the application. If applicant is HCP reasons why application made by him/her, steps taken to locate user's relatives to be stated. The MHCP must not be the person making the application. One MHCP must be qualified to do a physical examination. If the application is not approved. HHE informs applicant. Discharge if no further care, treatment, rehabilitation is warranted (MHCA 06). Further involuntary admissions in psychiatric hospitals only. If appeal is upheld, user must be discharge. (MHCA 14) Involuntary outpatient: schedule of conditions. (MHCA 06 and MHCA 10)

	(which may be sections of a general hospital designated as such) for further inpatient involuntary care. (MHCA 06; Transfer MHCA 11) In seven days, HHE (72-hour assessment facility) must request the Mental Health Review Board (MHRB) to approve further involuntary admission. Notice given to applicant regarding decision and request to MHRB. (MHCA 08) MHRB must consider the request within 30 days, notify the applicant and HHE of the decision and inform the High Court if continued involuntary admission is necessary. (MHCA 14) MHRB must consider appeals in 30 days. (MHCA 15) On the recommendation of treating MHCPs, HHE can convert a user to voluntary assisted care or discharge the user at any stage during admission. OR Can discharge the user as a voluntary or involuntary outpatient. (MHCA 12) HHE may request transfer to a maximum-security facility if previously absconded or attempts to abscond. OR Inflict harm or risk of harm to others in HHE. (MHCA 19) In case of emergency, can transfer with the concurrence of HHE (max security), pending a decision of MHRB. (MHCA 19)	

On receipt of an application (form MHCA 04), the head of the health establishment (HHE) must have the user assessed by two mental healthcare practitioners (MHCPs), one of whom must be a medical practitioner. The second MHCP may be another medical practitioner, a clinical psychologist, a social worker, or nurse or an occupational therapist with mental training (Narsi 2022). The MHCPs assess the user and submit their independent written findings on MHCA 05 (Narsi 2022). Therefore, the social worker has a critical role in compiling a report of his/her assessment findings. A social worker has a critical role in the 72-hour assessment.

Social workers who evaluate and treat mental health conditions most often see clients with primary psychiatric disorders, or mental disorders that are not demonstrably caused by one or more verifiable medical conditions (Pollak and Miller 2011). Misdiagnosing a medical condition as a mental disorder can delay appropriate medical care and lead to serious negative health outcomes. This error in clinical judgment may increase the risk of ethics complaints and

malpractice suits based on negligent diagnosis (Shapiro and Smith 2011). Social workers and other nonmedically trained mental health clinicians, including social workers and psychologists, may be especially vulnerable to this error in diagnostic decision-making (Rothbard et al. 2009). The Australian Association of Social Workers (AASW) (2015) outlines social assessment in mental health as a collaborative process with clients to understand their challenges and strengths. This biopsychosocial approach considers physical, psychological, and social factors, including social functioning, financial needs, family dynamics, and cultural influences. Information is gathered from clients, their families, and other professionals, and the assessment evolves continuously to offer a comprehensive view of the client's situation (AASW 2017).

Social work considers the reciprocal impact of people and their environments in assessing human behaviour. From this perspective, problems in social functioning might result from stressful life transitions, relationship difficulties, or environmental unresponsiveness (Corcoran and Walsh 2010) and all other areas. Much changed as the profession grew and developed, incorporating ecological, bio-psychosocial, cognitive, family-centred, and various other approaches as indicated by the workplace setting, theories of practice, or client or patient needs (Heinonen and Metteri 2005). The values and interests of the social work profession require a broad approach to assessment and formulation that integrates social justice, ecological, systemic, biological, cultural, spiritual, and psychological perspectives (Dean and Poorvu 2008). The social worker in the mental health setting is expected to have adequate skill in clinical evaluation (history taking and Mental Status Examination). Knowledge of the Diagnostic and Statistical Manual (DSM) or International Classification of Diseases (ICD) is critical so that social workers can be conversant with other mental health professionals. Biopsychosocial (BPS) framework and spiritual assessment can be used for assessment, goal formulation and intervention planning (Corcoran and Walsh 2010). A biopsychosocial-spiritual perspective recognises the importance of whole-person care and considers a client's physical or medical condition; emotional or psychological state; socio-economic, sociocultural, and socio-political status; and spiritual needs and concerns (NASW 2016).

Intervention modalities of social work in mental health care

Social work is uniquely positioned as the only profession authorised to perform statutory duties such as adoption and foster care, with specific responsibilities defined by the South African Council for Social Service Professions (SACSSP 2011). Among these responsibilities is the undertaking of ecometric testing and assessments, which employ various structured assessment technologies – like scales, questionnaires, and protocols – to ensure accuracy and accountability during client evaluations (Roestenburg 2011; SACSSP 2011). Case management is another crucial aspect of social work practice, involving professionals who help clients set goals, access services, and advocate for their needs (Norlin and Chess

1997). Additionally, core domains of social work include casework, group work, community work, supervision, administration, and research.

These methods are particularly relevant in healthcare settings, where social workers apply a holistic approach to understanding human behaviour, integrating psychological treatment methods to address personality problems. Intensive practices in mental health care aim to provide corrective emotional experiences, facilitating the development of adaptive responses. Strategies employed include casework, insight therapy, crisis intervention, supportive therapy, counselling, and cognitive behaviour modification therapy.

a. **Insight therapy:** In mental health care, treatment techniques often focus on fostering patients' insight into their fears, conflicts, and perceptual distortions, which may be unconscious but contribute to pathological behaviour (Shah et al. 2013). Social workers effectively use insight therapy, especially for patients with ego strength to confront their issues (Gonzalez and Betzaida 2022). This therapy emphasises current feelings and behaviours in relationships rather than past experiences. For example, a young college student facing academic and relational challenges may show absenteeism and temper outbursts, benefiting from a supportive environment that encourages self-awareness and improved behaviours (Gonzalez and Betzaida 2022). Insight therapy can lead to corrective emotional experiences and positive outcomes when applied during stressful situations, often eliminating the need for long-term interventions while supporting parents and significant others in adjusting their responses (Gonzalez and Betzaida 2022). This approach is applicable in the South African context, though addressing stigma and discrimination surrounding mental disorders is essential to create safe spaces for MHCUs to express their feelings without judgment.
b. **Crisis intervention:** A crisis develops over time and can manifest in various ways when individuals face situations beyond their adaptive capacity (Shah et al. 2013; SocialWorkin 2022). Homicidal or suicidal behaviours indicate a profound sense of helplessness and require urgent crisis intervention (Gonzalez and Betzaida 2022). Other crises, such as oppositional behaviour in adolescents or hunger strikes by elderly parents, also necessitate social work intervention (Gonzalez and Betzaida 2022). Social workers in hospitals often manage these cases using casework techniques to provide understanding and support (SocialWorkin 2022). By building rapport and adopting a non-judgmental approach, they help clients develop the ego strength needed to cope with their challenges (Shah 1996). Crisis intervention is critical in South Africa, as noted by Fiona Singh from Weskoppies Hospital in 2022, with organisations like SADAG offering support through hotlines. Wallerstein (1988) refers to crisis intervention as an ego-strengthening therapy that helps individuals manage mental conflicts during crises.
c. **Supportive therapy:** Supportive therapy is distinct from psychoanalysis

and psychodynamic psychotherapy, primarily serving mature individuals facing temporary turmoil due to severe environmental pressures (Gonzalez and Betzaida 2022; Yzaguirre et al. 2022). These individuals often seek to restore a previous adjustment rather than make significant changes. Social workers in mental health care are particularly well-suited for this approach, which addresses the pervasive impact of mental disorders on daily functioning through various psychosocial strategies. These strategies include Assertive Community Treatment (ACT), supported employment, cognitive remediation, and social skills training, all of which have empirical support for their effectiveness in reducing relapse rates, improving symptoms, and enhancing social functioning (Garety et al. 2000; Mueser and Bond 2000; Bustillo et al. 2001). Additionally, supportive therapy is applicable in South Africa, as highlighted by Fiona Singh from Weskoppies Hospital, who discussed the use of psychoeducation and social skills training in interventions (Singh 2022). Bila (2017) also noted that social workers provide these supportive therapies in mental health settings.

d. **Cognitive behaviour modification therapy:** Alcoholism and drug addiction have posed a special challenge to mental health professionals (Legg 2019). This speciality is called addictionology (Legg 2019). With the knowledge and experience of counselling and cognitive behaviour modification therapy, the social worker in mental health care can work with these patients to prevent or postpone relapses (Gonzalez and Betzaida 2022). The methods used are (i) motivating the MHCU to give up addictive substances on a 'one day at a time' basis to lead a drug-free life; (ii) confrontation; (iii) understanding the psychodynamics of a patient's dependence on addictive substances; (iv) helping him verbalise his difficulties without fear, shame and guilt; and (v) by learning assertive training, value clarifying, behaviour modification and character restructuring (Shah et al. 2013; Gonzalez and Betzaida 2022).

Van Breda and Addinall's (2021) study for CSWs in South Africa established that cognitive behavioural therapy (CBT) ties in second place on the list of clinical social workers (CSWs), as reported by nearly half the participants were CSWs (46 per cent). This approach is found to be particularly useful for clients presenting with trauma, linking with crisis intervention (joint 2nd place) and trauma counselling (4th place at 44 per cent). Mindfulness and psychoeducation (in joint 9th place at 25 per cent of participants) are also useful trauma counselling techniques (Briere and Scott 2006). This cluster of models points to the prominence of trauma for South African CSWs. CBT's strong evidentiary basis also makes it an attractive model (Murray et al. 2015). The techniques that were discussed above are applicable in the South African context. Most of the information discussed concerns, for example, how social workers in mental health care operate in South Africa. However, insight therapy was something new. While all the techniques discussed above are based on the casework

method, group work in mental health care is another category requiring examination.

Group work in mental health

Since the early 20th century, social workers have played an important role in the coordination and provision of services in various healthcare settings, including primary care facilities, hospitals, speciality clinics, schools, home healthcare settings, hospice care settings, continuing care settings, private physician groups and research settings (Drum et al. 2011). While social casework and social diagnosis have historically been the predominant model of social work practice in health care coordination and provision, group work has played an important role in health promotion and the assessment and treatment of diseases and disorders within health care settings (Furr 2008). Today, several types of groups are used in healthcare settings to address many different issues, including but not limited to treating mental disorders and their related effects on MHCUs and their families, substance abuse treatment and recovery (Drum et al. 2011).

Group workers in health care settings incorporate a bio-psycho-social perspective in their practice, which seeks to recognise the whole person, as he/she exists within his/her environment. Moreover, different types of groups can be implemented in the mental health setting.

Mutual aid/empowerment

Mutual aid is seen as a process whereby group members help themselves by helping one another and derive empowerment through the process (Gitterman and Shulman 2005; Steinberg 2010). The processes of mutual aid help group members experience the universal nature of their problems, reduce isolation and stigma associated with these struggles and hear perspectives, challenges, and solutions from other members (Gitterman and Shulman 2005). Mutual aid groups are described as 'an alliance of individuals who need each other, in varying degrees, to work on certain common problems' (Schwartz 1994: 18).

Psychoeducational groups

In healthcare settings which operate under a medical model of care, patients may struggle with the sequelae of their medical conditions, such as anxiety, depression and difficulties adhering to treatment (Gitterman and Shulman 2005). Furthermore, MHCUs may also need support in understanding their medical conditions and the lifestyle changes needed to manage them. Psychoeducational groups are often delivered to individuals with medical needs, to educate patients and/or their families about medical conditions and to teach skills required to help manage the conditions and the stress that often accompanies them (Steinberg 2010). The psychoeducational support offered in the groups may be informed by already developed treatment manuals or by

materials developed by facilitators specifically for the group (Steinberg 2010).

Groups are generally facilitated in a structured manner, such that material is presented by the leaders, skills are taught and practised, and members are encouraged to talk about what they have learned and how they will apply it outside the group (Gitterman and Shulman 2005). Leaders must be well-prepared ahead of time with content developed in advance and be skilled in facilitating group processes (Gitterman and Shulman 2005). Typically, skill-building groups have 10-12 sessions and educational groups tend to be shorter, from 3-5 sessions. Evaluation in these groups tends to examine the acquisition of knowledge and/or skills (Gitterman and Shulman 2005).

Therapy and support groups

Therapy and support groups provide members with opportunities to address behaviour change through cognitive behavioural techniques (Drum et al. 2011). For example, a facilitator might work with a group in early recovery from heroin on challenging negative and faulty thinking around methadone maintenance treatment. Therapy groups also provide members with opportunities to explore personal issues through process-oriented techniques, such as working with trans youth as they navigate negative family reactions to their decision to begin hormone treatment (Drum et al. 2011). Support groups help members identify coping strategies for dealing with stressful life events, often in a caring and empathetic environment, such as a support group for people living with a chronic illness (Drum et al. 2011).

Self-help groups offer a similarly supportive environment without formally trained facilitators (Donovan et al. 2013). Examples of this include Alcoholics Anonymous, Narcotics Anonymous and several other 12-step fellowships (Donovan et al. 2013). These various types of treatment groups offer members important opportunities to experience all the benefits groups have to offer, including empathy, feedback, mutual aid and support (Drum et al. 2011).

Single session groups

Single-session group practice has been seen as a source of significant benefits, both for participants and for the delivery of social work services (Kosoff 2003). These groups are a venue for the provision of information, connection, social support and the sharing of experience. They create a feeling of inclusion in a community of people who are in the same boat (Steinberg et al. 2023). Single-session groups can also be models of anti-oppressive practice based on social justice, social action, advocacy, community, and diversity. As a strengths-based practice that utilises purposeful activity and mutual aid, single-session groups are particularly useful in healthcare and can fulfil important needs for patients, families, staff, and the organisation (Kosoff 2003).

Single-session groups are suited to today's fast-paced hospital environments and are commonly delivered in hospital settings (Steinberg et al. 2023). They

include groups operated in clinics, in hospital units and on weekend family days (Steinberg et al. 2023). These groups are either newly formed for each session or have an open format, with new members joining and/or attending each session They tend to maintain an agenda and include all stages of groups within a single session, except for the conflict stage (Steinberg et al. 2023). They are often used to impart information related to the health issue or to bring people together who share a health issue to offer one another support, insights into coping strategies and resources available outside the hospital (Kosoff 2003). They require organised facilitators who must engage with members quickly, allow for maximal participation, keep the agenda moving and terminate the group with minimal unresolved matters (Kosoff 2003).

Community work in mental health

There is growing recognition internationally of the social determinants of mental health and of how social inequalities leave those with the least social and economic agency at the most risk of mental disorders (World Health Organization 2014). A comprehensive mental health service is consequently required to provide support that goes beyond medical treatment to consider the whole person in their environment, an approach that is sometimes referred to as the biopsychosocial model. Social workers play an important part in this process. Within multi-disciplinary teams they have been reported to support their non-social work colleagues to ensure the delivery of support that places the service user and their social and familial networks at the heart of practice, providing non-judgemental, strengths-based input that promotes self-determination and long-term recovery (Abendstern et al. 2014, 2019; Allen 2014; All-Party Parliamentary Group on Social Work 2016). Evidence provided by service users and carers indicates that they appreciate social workers for their capacity to view them comprehensively, collaborate with them, and offer transparent communication (Allen 2014)

Service users have reported that social workers when compared to their health colleagues, deliver more person-centred support (Boland et al. 2019). Despite such endorsement, the social work membership of community mental health teams (CMHTs), the cornerstone of mental health services, appears under threat (Association of Directors of Adult Social Care Services [ADASS] 2018; Lilo 2017; McNicoll 2016). A therapeutic group programme is legally compulsory in all psychiatric hospitals in South Africa. The programme at M-Care Optima is carefully compiled such that every group benefits the MHCU with great value but that the programme in total will have a therapeutic effect. Continuous participation in this form of treatment is highly recommended (Department of Health [South Africa] 2022).

Figure 8.1: MC-Optima group therapy (Department of Health [South Africa] 2022)

The World Health Organization's (WHO) 'Guidance on community mental health services: promoting person-centred and rights-based approaches', released in June 2021, provides examples of community-based mental health care that is both respectful of human rights and focused on recovery. Volunteers have the following roles: to raise awareness in the community about mental health issues; to identify individuals experiencing distress and provide four to six sessions of counselling; to refer people who may have a severe mental health condition to the public mental health service; and to support people in need with access to social care benefits (World Health Organization [WHO] 2021a).

For many years people with mental disorders have been removed from their communities and kept in psychiatric hospitals or institutions (WHO 2003a). There is a great deal of evidence from around the world, including from South Africa, that this practice can lead to stigmatisation and human rights abuses, which in turn can contribute to a further deterioration in mental health (Porteus 1998; WHO 2003a). During the last 50 years, many high-income countries have begun to develop community mental health services (CMHS), as the old institutions have been closed (Lamb 1998; Thornicroft and Tansella 1999; Geller 2000). These reforms have been driven by advances in pharmacological and psychosocial interventions, the growth of human rights movements and associated changing public perceptions of mental disorders (WHO 2001). There is evidence to show that CMHS are both more clinically effective (Leff et al. 1994; Marks, Connolly and Muijen et al. 1994) and more cost-effective than institutional care (Knapp et al. 1997, 1998). CMHS provide an ethical basis for care that respects the rights of people with mental disorders.

They allow for the delivery of care near the places where people live and work and therefore improve the accessibility of services. Furthermore, people who receive such services indicate their preference for the community over hospital-based care (Boardman et al. 1999; Hobbs et al. 2000). WHO and other international agencies have repeatedly endorsed the development of

CMHS and encouraged the downscaling of psychiatric institutions (WHO 2001). In South Africa, at the policy level, the national Department of Health has committed itself to a comprehensive, community-based mental health service that is integrated into general health care (Department of Health [South Africa] 1997). Unfortunately, there has been limited implementation of this policy in service delivery and CMHSs are generally under-resourced and inequitably distributed (Lund and Flisher 2003). Mental health staffing and service utilisation in South Africa tend to be focused on institutional urban settings. For example, 83 per cent of public sector psychiatric staff are in hospital settings and 34 per cent of psychiatric patient contacts with services are inpatient admissions (Lund and Flisher 2003).

In South Africa, community-based mental health care is a requirement of the Mental Health Care Act of 2002 (Department of Health [South Africa] 2002) and a central objective of the National Mental Health Policy Framework and Strategic Plan 2023–2030 (MH Policy) (Department of Health [South Africa] 2023) as mentioned in Chapter Six. The advantages of community mental health services (CMHS) over psychiatric hospital-based care lie not only in that they meet the legal and human rights of MHCUs to receive care close to home but also in their modelled cost-effectiveness in terms of improved population coverage (Lund and Flisher 2009). Three core components are listed on page 23 of the MH Policy: community residential facilities, daycare, and outpatient services. The bulk of care should be provided by primary health care (PHC) practitioners, with specialist supervision and care for MHCUs with more complex conditions requiring specialised assessment and/or intervention (Department of Health [South Africa] 2012). The MH Policy positions the specialist CMHS back-to-back with general hospital acute psychiatric units within an intervention pyramid (Robertson and Szabo 2017). They are tasked with providing continuity of care for the MHCUs after hospital discharge, facilitation of hospital referrals, supervision of PHC, community outreach and engagement with non-health sectors such as the South African Police Service, local schools and non-governmental organisations (Robertson and Szabo 2017). Areas for strengthening district health services are also identified within the MH Policy and modelled norms and standards for both adult and child and adolescent CMHS are referenced (Department of Health [South Africa] 2012, Lund and Flisher 2003, 2009; Lund et al. 2009; Flisher et al. 2003).

Social workers have been members of CMHTs from the outset and regarded as core members since the 1990s (Onyett 2003), despite being employed by Local Authority (LA) Social Services Departments, unlike their health and medical colleagues. This remains the case today with many social workers working in CMHTs seconded from their LA to an NHS trust. Integrating health and social care has been a policy goal of all UK governments for more than 20 years (Cameron et al. 2014; Heenan and Birrell 2017) with integrated health and social care CMHTs regarded as the best way of delivering comprehensive mental health services, particularly to people with complex needs, despite limited evidence of effectiveness (Brown et al. 2003; Cameron et al. 2014). Social work

membership has been viewed as a key marker of progress in this area (Brown et al. 2003). Evidence suggests that the social work membership of CMHTs has been rising with an average of 3.4 per team in 2007, compared to 1.9 in 1994, although social workers remain a much smaller percentage of these teams compared to mental health nurses (Evans et al. 2012; Onyett and Heppleston 1994).

Johnson and Yanca (2007) indicate that services such as CHM are vital to advancing the quality of life of MHCUs and ensuring that their basic needs are being met. Case managers are also required to monitor an MHCU's needs regarding medication and symptomatic display, linking patients to the relevant services and treatment where necessary (Johnson and Yanca 2007). With the increased focus being on outpatient and community-based services and a poor availability of specialised social workers, general social workers are now being faced with the task of reaching out to this vulnerable group. The high influx of MHCUs into local communities, a lot of whom are unstable and untreated, is also influencing general social work practice, impacting areas of crime, family structure and functioning, child abuse, domestic violence, family violence and unemployment (Ornella 2014). A study by Skeen et al. (2010) suggests that social factors such as stigma and discrimination attached to mental illness tend to have negative effects on the functioning and recovery of the mentally ill individual, leading to a decrease in the desire to make adequate use of the services available to them and to adhere to the established treatment regimes. Factors of poverty, poor home circumstances and experiences of crisis and emotional traumata can also be viewed as being both stimulants for the onset of a mental illness, as well as barriers to recovery (Barlow and Durand 2012; Skeen et al. 2010).

For this reason, support in terms of mental disorders, working with the family and assisting in adequate reintegration of the patient into society, over and above clinical services, is incredibly important and should be considered when reflecting on the need for social work services within mental health care (Barlow and Durand 2012; Brown et al. 1996; Johnson and Yanca 2007). Social, cultural, and economic conditions have significant and measurable effects on both individual health status and the delivery of health care (Ornella 2014). According to Brown et al. (1996), one result of this growing awareness of the social context of health has been increased demands for social work services within the healthcare setting. Based on Ornella's (2014) study, social workers in South Africa have a critical role in the CHM.

Levels of intervention in mental health

The purpose of social work is to solve problems in human relationships and empower people so they can improve their well-being (Ashcroft et al. 2017). Social work interventions can generally be described as scientifically established processes and patterns social workers apply to cases of individuals, groups, and communities (Ebue et al. 2017). Social work theory generally places such

interactions into three levels of intervention: micro-, meso- and macro-levels (Ashcroft et al. 2017).

Micro-level interventions

Interventions at the micro-level aim to meet fundamental human needs at the base of Maslow's hierarchy of needs (Maslow cited in Webber 2014). They are focused on an individual's need for shelter, food, and drink (Webber 2014). Social workers have been unfairly touted as being only responsible for housing and benefits in mental health services, but they must not neglect the fundamental importance of having a place to live and food to eat (Webber 2014). After all, interventions such as supporting an individual to claim the benefits they are entitled to (Frost-Gaskin et al. 2003) and improving housing conditions (Thomson et al. 2013) have a positive impact on mental health. Mental health social workers have the lead responsibility for adult safeguarding in mental health services. Keeping people safe involves ensuring appropriate support is provided and investigating potential abuse (Webber 2014). However, safeguarding procedures should not discourage positive risk-taking where it is appropriate (Webber 2014). Action planning with individuals helps them to take control of their recovery (Webber 2014). Wellness Recovery Action Planning (WRAP) is an effective way to support individuals in managing their mental health (Cook et al. 2013).

WRAP builds upon an individual's strengths and focuses on the actions an individual takes to self-manage their mental health (Cook et al. 2013). Mental health social workers need to work co-productively with individuals to develop plans, including joint crisis plans, which include an individual's preferences (Thornicroft et al. 2013). Individuals must be at the centre of their own care and support planning (Webber 2014). Mental health social workers' dual identification with the institutions which employ them and with MHCUs can help to facilitate this (Nathan and Webber 2010). As gatekeepers to personal budgets and in the future personal health budgets, mental health social workers can help people develop creative solutions to meet their goals, self-manage their mental health and improve their well-being (Webber 2014). When people are given genuine choice and control over their care and support using personal budgets, their outcomes improve (Webber et al. 2014). Although they may not deliver them themselves, mental health social workers need to make use of evidence-informed social interventions where appropriate (Webber et al. 2014). For example, supported employment improves vocational outcomes for people with severe mental health problems (Kinoshita et al. 2013), volunteer befriending supports people in their recovery from severe mental disorders (Mead et al. 2010) and people with a diagnosis of mental disorders have benefitted from arts-based therapies (Ulrich 2007; Ruddy and Milnes 2005). Micro-level interventions frequently require people to be motivated to set goals for themselves and work towards them (Webber 2014). Therefore, mental health social workers will need to be skilled (Webber 2014) in motivational

interviewing (Smedslund et al. 2011) and solution-focused therapeutic approaches (Gingerich and Peterson 2013) to support people to work towards change. These skills will also be required for social interventions at the meso- and macro-levels (Webber 2014).

This is also applicable in the South African context. In a study conducted by van Breda and Addinall (2021), it was established that the most prevalent practice modality is working with individuals (micro-level of intervention), reported by 52 per cent of clinical social work participants as comprising at least 70 per cent of their clinical practice time. Additionally in the same study, most participants (68 per cent) reported spending 50–80 per cent of their clinical time on work with individuals. Only a tenth (9 per cent) of participants reported that 90-100 per cent of their practice was with individuals, suggesting that an exclusively individual-client practice is uncommon in South Africa. This study is similar to how micro-level of intervention is operated in South Africa. However, some modalities or techniques are not practical in the South African context, such as working with budgets. This is a challenge due to the history of South Africa when it comes to the funding of mental health services – the tragedy of Life Esidimeni is an example of this matter.

Meso-level interventions

Social relationships are essential for mental health (Kawachi and Berkman 2001). Emotional support, associated with recovery from psychosis (Tempier et al. 2013) and depression (Webber et al. 2011), is typically provided by close friends and family members. To help ensure a supportive network is available to people during episodes of mental distress and its aftermath, mental health social workers need to work with the people surrounding the individual (Webber et al. 2014). This small group is defined by the individual in the process of drawing the eco-map during initial assessments (Webber 2014). Systemic practice is not new in mental health social work. For example, working with a family to reduce expressed emotion is known to be effective in reducing relapse in mental disorders (Pharoah et al. 2010). However, new approaches which see an individual's family or close social group as assets in that person's recovery are emerging (Webber 2014). For example, family group conferences, primarily used in children's services, are increasingly being used in adult services (Webber et al. 2014). These bring together all those involved in a person's care and support to discuss concerns and an individual's goals (Malmberg-Heimonen 2011). This mobilisation of an individual's close network helps to provide emotional support and other social resources, producing short-term benefits for the individual (Malmberg-Heimonen and Johansen 2013). Notably, a model of crisis care used in Finland is currently being trialled in the UK (Webber et al. 2014). The open-dialogue approach involves practitioners trained in family therapy working with an individual's family or network when they are in crisis (Webber et al. 2014). This approach involves working with the local community as well as an individual's family so that everyone in contact with that person is involved in

discussions about their care and support (Webber et al. 2014). It has been found to reduce hospitalisation and the use of neuroleptic medication and is also suggested to be associated with a reduced incidence of psychosis (Aaltonen, Seikkula and Lehtinen 2011; Seikkula et al. 2011). Mental health social workers are ideally placed to lead its introduction into NHS mental health trusts in the UK (Webber et al. 2014).

Group work is one of the social work interventions that can potentially not only bring about social change and transformation but also promote the development, problem-solving and empowerment of participants (Lee 2012). To understand the importance of group work (meso-level of intervention) in the South African context, it is necessary to trace the impact of colonialism and apartheid on the country's citizens and how these forms of governance created a highly traumatised, unequal, racially polarised, and divided society (Chikane 2015; Ndebele 1991; Terreblanche 2012). This historical perspective is needed to understand the potential value of social group work to facilitate healing, promote development and transformation and overcome social problems that originated from past political and social divides. Within professions such as social work, the individual became the primary focus for interventions with minimal reference to sociocultural factors or the wider group milieu (Rasool and Ross 2016). Moreover, Rasool and Ross (2016) assert that group work (meso-level of intervention) has a crucial role to play in social healing, empowerment of previously marginalised communities such as MHCUs, facilitating indigenous leadership, increasing cross-cultural understanding, and enhancing the holding and containment function of society. Group work is a goal-directed professional method and tool aimed at meeting treatment or socio-emotional needs and accomplishing tasks (Toseland and Rivas 2012). This method has been used in a range of statutory, voluntary, and private sectors to enhance the quality of life of people in a very broad range of situations including MHCUs (Strydom and Strydom 2010). Group work is usually more cost-effective than individual therapeutic interventions because it assists between 10 and 15 people who share a common concern at one time, as opposed to only one or two individuals (Rasool and Ross 2016). Therefore, meso-level intervention can surely bring about change in the lives of MHCUs. Furthermore, this approach is frequently used in the mental health facilities or hospitals. This assertion is confirmed by Ms Singh (2022) who indicated the methods that are rendered by social workers at Weskoppies as meso-level intervention or group work.

Macro-level interventions

MHCUs require more than a supportive family and network to get on and get ahead with their lives (Webber et al. 2014). Tangible support (such as the provision of favours or cheap goods) and informational support (such as where to find a job) are found in wider community networks and, when accessed, are associated with the community integration and social participation of people with mental health problems (Townley et al. 2013). Social resources in wider

social networks, known as social capital, help people to increase their wealth, power and status in addition to their mental health (Lin 2001).

As MHCUs have access to less social capital than the general population (Song 2011; Webber and Huxley 2007), there is a role for mental health social workers in supporting them to develop more resourceful networks. Interventions that use asset-based approaches, support the development of social skills, build trusting relationships between workers and service users and find community resources, can enhance the community participation of people with mental health problems (Newlin et al. 2015). For example, the Connecting People Intervention (Webber et al. 2015) engages people with others in their local community or networks in the pursuit of their recovery goals. High fidelity in the intervention model is associated with increased access to social capital and enhanced perceived social inclusion (Webber et al. 2019).

A good knowledge of local community networks is required for these interventions to be effective, which requires a team approach and an outward-focused orientation (Webber et al. 2014). Community capacity building is also essential for the success of personalisation (Webber et al. 2014). If personal budgets are to help individuals achieve a sustainable recovery, they need to utilise community resources and develop new networks which can provide access to social capital that will help people get on and get ahead with their lives (Webber et al. 2014). This illustrates that intervention at the macro level supports work (Webber et al. 2014) at the micro or meso-level and highlights their interconnections. Supporting people in their process of recovery involves work at all intervention levels to engage with the development of their social identity, relationships and participation in community life (Webber et al. 2014).

Community development (macro-level of intervention) is an integral part of South African social work, yet it is not the method of choice for many social workers. According to the Bachelor of Social Work Draft Standards Statement (Council for Higher Education [CHE] 2015: 5), the purpose of the Bachelor of Social Work degree is 'to provide a well-grounded, generic, professional education that prepares reflexive graduates who can engage with people from micro to macro levels of social work, within a dynamic socio-political and economic context.' The standards are underpinned by the developmental social welfare paradigm (which has been discussed in Chapter Seven) that was adopted for South Africa in the White Paper for Social Welfare (Department of Social Development (DSD) 1997). According to this paradigm, individuals, groups, families, and communities must be empowered to actively participate in their development, especially the MHCUs (Department of Social Development (DSD) 2013: 13). Several different approaches have emerged in the literature under the umbrella term 'community development'. One of these is asset-based community-driven development (ABCD) which moves from a problem- and needs-based approach to a strength- and asset-based view of communities (Kretzmann and McKnight 1993). This approach applies to working with communities focussing on addressing mental disorders.

The asset-based approach to community development (ABCD) was

developed by Kretzman and McKnight in 1993. In reaction to the focus on the needs and problems in community development theory, they argued that it is not only more positive for development workers and community members to be driven by assets and strengths but also that the cycle of dependence often emanating from community development could be prevented (Kretzman and McKnight 1993). Although ABCD was developed and originally tested in the United States of America and Western countries, a few research projects have been undertaken on the implementation of the approach in third-world countries like South Africa (Eloff and Ebersohn 2001), Zimbabwe (Chirisa 2009) and Ethiopia (Yeneabat and Butterfield 2012; Mengesha, Meshelemiah and Chuffa 2015) over the past twenty years. The indirect conclusion from all the projects referenced here was that there is a lot of promise and potential in applying ABCD in the context of African development. ABCD can apply to social work in mental health; tapping the strengths of MHCUs is of utmost importance.

Intervention strategies employed by social workers in mental health

Intervention strategies in social work aim to assist individuals in need by promoting client ownership of their situations and fostering trust (Beckett and Horner 2016; Parker 2013). These methods help clients achieve optimal outcomes through direct services, systemic change, or advocacy (Rogers et al. 2020).

Counselling, a key psychosocial intervention, provides professional guidance to individuals using psychological methods (Lazarus and Freeman 2009). It targets specific symptoms and helps individuals manage unwanted emotions by allowing them to discuss concerns with knowledgeable professionals (Grace College Online 2021). Informal counselling often occurs through friends or community leaders and is perceived as beneficial by many (Brown et al. 2014; Jorm et al. 1997). Effective communication between health workers and MHCUs is crucial for successful treatment outcomes (Lazarus and Freeman 2009; Da Rocha-Kustner 2009).

Communication in mental health care can range from empty reassurances to effective counselling that helps MHCUs articulate their issues (Da Rocha-Kustne 2009). However, limited staffing, consultation time, and inadequate training hinder informal counselling's effectiveness. Lazarus and Freeman (2009) suggest training health personnel in informal counselling could improve quality. Psycho-educational counselling provides information on symptoms and coping strategies, aiding MHCUs in applying this knowledge (Conradi et al. 2007). A pilot study in Goa found MHCUs beneficially recalled stress-reduction techniques from psychoeducational sessions (Chatterjee et al. 2008). Still, caution is warranted regarding the findings of Conradi et al. (2007) on relapse prevention interventions.

Family-based interventions: A guiding principle is that the MHCU's family members should be involved and engaged in a collaborative treatment process

to the greatest extent possible. Family members generally contribute to the patient's care and require education, guidance, support, and training to help them optimise their caretaking role and improve their well-being. Clinicians must understand that families often experience considerable stress and burdens in providing such caretaking (American Psychological Association [APA] 2010). Family intervention can be very important for individuals who have contact with their families. This is usually not done in private therapeutic sessions in which the MHCUs and their family member(s) sit and talk with a therapist (NASW 2016). Rather it is most often done in group settings, where family members talk with family members of other MHCUs. The MHCUs themselves may or may not also be a part of the group, depending on how a specific group is designed. Participants are educated about the illness, what to expect from a family member who has the mental disorder and how they can best help.

There is also a strong focus on how to take care of oneself when caring for an MHCU and also aimed at enhancing optimal functioning of the family system where a mental disorder may have demanded role changes in the family unit (NASW 2016). Learning to care for oneself while helping someone else can reduce possible stresses created by being a caregiver and can help foster better and healthier relationships between those involved. This, in turn, can help the individual with schizophrenia reduce the stress in his or her life, enabling him or her to focus time and attention on other aspects of li Referral involves the transfer of responsibility of all or part of the care of an MHCU (Bower and Gilbody 2005: 839). Although it may occur within a primary care team, it usually involves referral to a specialist at the primary care level or, where necessary, secondary, or tertiary levels of care. Typical examples of referral within the health services would be a referral to a psychologist for brief psychotherapy, or to an inpatient unit at a district hospital. Referrals may also be made to services in other sectors, for example, social or employment services for assistance necessary to support recovery. The referring service or health worker, for example, may retain responsibility for certain aspects of care such as monitoring MHCUs' response to psychotropic medication (Lazarus and Freeman 2009).

Mutual support groups: The development of mutual support groups in the 1990s was part of the larger social movement of self-help organisations for people affected by a variety of chronic diseases and needs inadequately addressed by traditional healthcare interventions (Heller et al. 1997). Mutual support groups are distinguished by their client-led nature, contrasting with the professionally controlled approach of traditional mental health interventions.

They are participatory and involve giving and receiving help and learning to help themselves, as well as sharing experiences and knowledge about common concerns (Chien, Chan and Thompson 2006). Building on an empowerment-oriented model, mutual support groups for family caregivers of MHCUs, provide opportunities for family caregivers to develop knowledge and skills on caring for a relative with mental disorder, peer support, establishing harmonious family life and engaging professionals as collaborators instead of authoritative experts (Chien 2008). A variety of mutual support group programmes provide social

support and enhance the social networks of family caregivers implemented. There is strong evidence supporting the value of a support group for family caregivers of MHCUs (Chien 2008). Support group interventions are associated with significant improvements in the family caregivers' ability to cope and in their caregiving role and, consequently, an improvement in the clients' physical and mental conditions and functioning (Chien et al. 2006).

Social skills training is defined as using behavioural techniques or learning activities that enable patients to acquire instrumental and affiliative skills in domains required to meet the interpersonal, self-care and coping demands of community life (Benton and Schroeder 1990). The goal of social skills training is to remedy specific deficits in patients' role functioning. Thus, training is targeted rather than broad, and it is a highly structured approach that involves systematically teaching patients specific behaviours that are critical for success in social interactions (APA 2010). Social skills training can also include teaching patients how to manage antipsychotic medications, antidepressants, and mood stabilising medications, identify side effects, identify warning signs of relapse, negotiate medical and psychiatric care and express their needs to community agencies and interview for a job (APA 2010). Social skills training can also be effective in increasing the use of specific social behaviours such as gaze and voice volume. Skills are taught through a combination of the therapist's modelling (demonstration); the patient's role-playing, usually to try out a particular skill in a simulated interaction; positive and corrective feedback to the patient; and homework assignments, by which the patient can practice a skill outside the training session (APA 2010). Social skills training can be provided individually, but it is usually conducted in small groups of six to eight patients, for cost reasons and so that patients can learn from one another. Large groups (more than 10 patients) are not advised, as patients do not have adequate opportunity to rehearse (APA 2010).

An empowerment approach followed by the SA Federation of Mental Health promotes human rights focus and approach by conducting provincial empowerment workshops where community members and family members of MHCUs are taught how to develop a self-advocacy strategy and are thereby enabled to address community and local issues that undermine self-sufficiency for mental health clients. Besides developing greater awareness regarding human rights issues and their association with mental illness, this can be regarded as an example of a social skills training programme that aims to develop self-sufficiency (APA 2010).

Vocational rehabilitation and/or Educational Assistance (done in collaboration with an occupational therapist) are often very important for an individual with mental disorders (Turner 2005). In most cases, the onset of a mental disorder happens at such a time as to disrupt their high school or college education or disrupt their entrance into the workforce. Furthermore, the mental disorder and sometimes the medication side effects, make it more difficult for an individual with mental disorders to learn or complete tasks than other non-afflicted individuals. Vocational rehabilitation and/or educational assistance

can help an individual learn to compensate for these challenges. This can help individuals with schizophrenia to complete their educational objectives and to hold a job in which they want to work. Having a job that one wants to do and enjoys is important for everyone, but having a job can be particularly rewarding for someone who struggles with the problems associated with having a mental disorder (Turner 2005).

Even though healthcare professionals acknowledge the importance of work, they often hold the view that people with mental disorders would be better suited to low-skilled and low-responsibility or non-competitive work (that is voluntary or sheltered). Some healthcare professionals interviewed perceived that certain jobs might be specifically assigned to people with severe mental illnesses, defined as being less stressful roles with greater flexibility. There was also a suggestion that within the health sector, the role of employment for recovery is not given priority and may not even be considered as an outcome by some mental healthcare teams (Bevan et al. 2013). On the other hand, many experts support the view that people diagnosed with mental disorders as a group should not be overlooked for any role because of their condition, but that the abilities and skills of each need to be assessed and built upon (Bevan et al. 2013). There is also evidence that a supportive work environment enables people with mental health conditions to remain in work by making them feel that their needs are validated and that they can ask for help and support when it is needed. Support may just be ensuring there is someone to talk to when they become stressed and that reasonable adjustments are put in place, such as flexible working times and rearranging workstations. Clear pathways to support must be in place so it is easy to see that further support is available and how it can be accessed (Bevan et al. 2013).

Recently, in South Africa, the occupational functioning of individuals with mental disorders has become a target for intervention (Nuechterlein et al. 2008). MHCUs experience major issues in social functioning with a return to work (RTW) and maintenance of employment being one of the main areas in which they have trouble (Abbas and Soeker 2020). To improve functioning and facilitate the process of MHCUs returning to competitive employment, supported employment is recommended and has been recognised as a form of evidence-based practice (Van Niekerk et al. 2011). In a study conducted by Abbas and Soeker (2020), they recommended that therapists encourage support from family, friends, employers, and work colleagues during the RTW process of their clients. It is further recommended that therapists network, collaborate and establish working relationships with relevant stakeholders to ensure a holistic supported employment approach to the RTW process. Therefore, social workers as members of the MDT can collaborate with OTs to ensure that the MHCUs are supported holistically, especially in supported employment.

Assertive Community Treatment is a treatment model recommended for individuals who have repeated hospitalisation, or who have a particularly difficult time functioning in the community on their own. A team of providers is created to serve a group of MHCUs (APA 2010). The team should have at least

one psychiatrist, social worker and other mental health professionals. These professionals, including case managers, work as a team instead of each person only having responsibility for their specific MHCUs. This team should also be able to go into the community and reach out to consumers, if needed, instead of waiting for consumers to come to a clinic. Such programmes are expensive, however, and so usually only modified versions are available (APA 2010). Bond et al. (2001) assert that the development of Assertive Community Treatment (ACT) as a community care approach can be attributed to Leonard Stein and Mary Ann Test, who pioneered it in Madison, Wisconsin during the 1970s. Furthermore, Nolen-Hoeksema (2011) asserts that ACT programmes offer an inclusive service for people with mental disorders, depending on the expertise of mental health practitioners – social workers and psychologists to meet the variation of MHCUs' needs 24 hours a day. In addition, Bond (2002) states that ACT often is regarded as a way of developing services to provide tangible assistance vital for the community incorporation of clients with severe mental illness (SMI). Nolen-Hoeksema (2011: 253) indicates that 'some people with mental disorders lack families to care for them.' She points out that even those with families have such an extensive range of needs – for example, monitoring and adjustment of their medications, occupational training, assistance in receiving financial resources, social skills training, emotional support and sometimes basic housing – and therefore comprehensive community-based treatment programmes are necessary.

Some essential features of ACT include (adapted from Bond and Drake 2015: 240–242):

- **Multi-disciplinary staffing** – An ACT team consists of mental health professionals representing different disciplines essential for the comprehensive care of people with serious mental illness. Fully staffed ACT teams include psychiatrists, nurses, social workers, employment specialists and substance abuse counsellors.
- **Integration of services** – In most places, the social service system is fragmented, with different agencies and programmes responsible for different aspects of the client's care. Through the multi-disciplinary team, the ACT team provides an integrated approach in which treatment issues (medications, physical health care, symptom control), rehabilitation issues (for example employment, activities of living, interpersonal relationships, housing), substance abuse treatment, practical assistance, social services, family services and other services are tailored to the needs and goals of each client.
- **Team approach** – ACT teams have shared caseloads in which several team members are in frequent contact support with an MHCU. The ACT team meets daily to discuss clients, problem-solve and plan treatment and rehabilitation efforts. The entire team has a responsibility for each client, with different team members contributing their expertise as appropriate. One advantage to the team approach is increased continuity of care over time.

- **Low client-staff ratios** – Client-staff ratios are small enough to ensure adequate individualisation of services. The 10:1 ratio is frequently used as a rule of thumb. In recent years, there has been increasing recognition that the caseload ratio needs to consider caseload characteristics. For MHCUs with the most debilitating conditions, an even smaller ratio may be optimal, whereas, for more stable clients, a ratio of 20:1 may be appropriate.
- **Locus of contact in the community** – All members of the ACT team conduct home visits. Most contacts with clients and others involved in their treatment (such as family members) occur in clients' homes or community settings, not in mental health offices. A rule of thumb is that 80 per cent or more of contacts should be out of the office, recognising that some types of office contact are appropriate. Home visits also facilitate medication delivery, problem-solving, crisis intervention and networking.
- **Medication management** – A top priority for ACT is the effective use of medications, which necessitates careful assessments of diagnosis and target symptoms, well-reasoned choices of medications (including the novel antipsychotics, antidepressants, and mood stabilisers), appropriate dosing and duration of therapy and management of side effects, following evidence-based practice guidelines. ACT teams are involved in the delivery of medications for clients when this assistance increases the appropriate use of medications.

- **Focus on everyday problems in living** – ACT teams focus on a wide range of ordinary daily activities and chores, depending on a client's most pressing needs; for example, securing housing, meeting appointments, cashing cheques, and shopping. ACT teams also help clients learn to develop skills and support in natural settings.
- **Rapid access** – ACT teams differ sharply from most social services in that they respond quickly to client emergencies, even when they occur after regular business hours. Stein and Test envisioned this programme element to include 24-hour coverage. Staff often establish ways to anticipate trouble and keep crises from erupting and the need for 24-hour coverage is curtailed in a proactive ACT team (Bond and Drake 2015: 242).
- **Assertive outreach** – ACT teams are persistent in engaging reluctant clients, both in the initial stages and after enrolment. ACT teams do not automatically terminate clients who miss appointments. Outreach stresses relationship-building and tangible help, especially around finances and housing. Some ACT teams have a client assistance fund to pay for emergency expenses.
- **Individualised services** – Treatments and supports are individualised to accommodate the needs and preferences of the MHCUs, who represent a very heterogeneous population. Because of a broad knowledge of community resources and the wherewithal to access them, ACT teams often increase options available to clients beyond what they would

otherwise have; for example, in choosing where they live.

- **Time-unlimited services** – Clients do not 'graduate' from the programme when their situation stabilises but continue to receive ACT assistance on a lifelong basis. This allows for the development of long-term, stable, trusting therapeutic relationships (Bond and Drake 2015: 242).

The ACT model is appropriate for individuals with the most severe mental disorders and the greatest level of functional impairment. These clients are frequently placed in hospital psychiatric units, and they usually have a very poor quality of life (Torrey et al. 2001). According to Burns and Firn (2002), assertive outreach should be an intensive, community-based programme, which offers frequent and comprehensive support to patients to primarily improve their quality of life (Smith and Newton 2007). Such teams follow a multi-disciplinary approach and typically share caseloads of 8-15 MHCUs (Botha, Koen and Galal 2014). Clearly, there is a need for a renewed approach to address the revolving door phenomenon facing many psychiatric hospitals in South Africa (Botha et al. 2014). However, the service models used in the developed world may not be realistic or feasible in our setting (Botha et al. 2014). With limited funds and strained resources, the key would be to find a more cost-effective way to provide a similar service to as many MHCUs as possible, without compromising the quality of the service being delivered (Botha et al. 2014). In South Africa, similar attempts have been made to address the challenges of finding a cost-effective community-based initiative. As part of a provincial initiative, the Western Cape Province launched three Assertive Community Treatment (ACT) teams in 2007, namely Valkenberg, Lentegeur and Stikland catchment areas. The teams followed a modified version of the ACT model, particularly in terms of caseloads and visit frequency (Botha et al. 2014). Each team comprises a principal medical officer (PMO), a chief professional nurse (CPN) and a senior social worker (SSW). The purpose of the service is to provide a follow-up programme for patients identified as being high frequency (revolving door) users of the acute inpatient system (Botha et al. 2014). Such a follow-up was aimed to be more comprehensive in comparison to standard care, facilitating existing services rather than duplicating them (Botha et al. 2008). Furthermore, preliminary reported results indicated a reduced number of admissions and shorter stays in hospital (Botha et al. 2008). Early indicators of social functioning also show improvement in occupational status for some MHCUs. Feedback from carers and community mental health workers has indicated that teams reduce pressure on existing services and families (Botha et al. 2008). Clearly, despite the issues that still exist, the initiative seems to be a much-needed step in the right direction (Botha et al. 2008). Interestingly, current literature seems to support the view that assertive treatment approaches are more likely to succeed in under-resourced settings where standard community services are less comprehensive (Tyrer 2007). When one looks at the key elements of the ACT model as set out by Burns and Firn (2002), local teams follow the same modus operandi, deviating primarily in the size of caseloads and continuity of

care (Botha et al. 2008). Wider implementation of the principles of assertive outreach with more teams in more areas should be considered in the planning of future services (Botha et al. 2008).

The Western Cape has proven to address the needs of MHCUs; however, this approach has not yet been tried in some other provinces. If there could be a dedicated budget, this programme would be beneficial in practice. The Gauteng province has, however, followed suit. The Chris Hani Baragwanath Hospital (CHBAH) ACT programme is an adaptation of the original Assertive Community Development principles, modified for the current stage of the overall project at Baragwanath Hospital (Mbele and Edgar 2015). This programme was designed through a collaboration of psychological literature and occupational therapy principles (Mbele and Edgar 2015). The multi-disciplinary team frequently evaluates aspects of the programme to improve adherence to the programme, internalisation of information and subsequently prevent relapse (Mbele and Edgar 2015). At the end of each rotation, the MHCUs are also requested to provide feedback on their experiences (Mbele and Edgar 2015). The following notes the aggregate of the opinion vis-à-vis what worked and what did not work (Mbele and Edgar 2015). The psychological component of the CHBAH ACT Program (CAP), aims to provide the index psychiatric patient with a foundational management of mental illness. It combines aspects of the Unified Protocol (UP) for Transdiagnostic Treatment of Emotional Disorders (Barlow et al. 2011), Cognitive Processing Therapy (CPT): Veteran Military Version (Resick, Monson and Rizvi 2007), Mood Charts (Miklowitz et al. 2008), daily routines (Beck 2011) and eight steps to mental wellness (Cummings and Bentley 2013). Social workers employed on ACT teams fulfil a variety of roles (Cooley 2012). They play an important role in the assessment process and a key role in coordinating the treatment plan outcomes (Cooley 2012). Social workers are often referred to as case managers, although this role is not always defined (Cooley 2012). In a survey conducted by Cooley (2012) in Minnesota, participants identified several key responsibilities for social workers in Assertive Community Treatment (ACT). These include providing vocational resources, assisting clients in setting individual goals, and coordinating the development and implementation of treatment plans. Social workers are also responsible for organising medical and dental care, teaching skills to improve client functioning, providing therapy, and ensuring the follow-through of treatment plans.

These responsibilities can be adapted by social workers working in the MDT. Currently, the ACT is not yet fully operational in South Africa, albeit the ACT has been tried in the Western Cape and Gauteng provinces. To date, the other seven provinces have not yet tried this practice.

Clubhouse models: Models of psychosocial rehabilitation established in the early 1980s, underscore the need for persons affected by Chronic Mental Illness (CMI) to move from parenthood to personhood, emphasising autonomy and self-help (Jung and Kim 2012). Clubhouse members make decisions regarding the extent to which they participate as well as the nature of such participation (Jung and Kim 2012). The clubhouse model stresses the importance

of parity between clubhouse staff and members; hence, clubhouse models are based on empowerment partnerships that allow members to develop meaningful interpersonal relationships that support employment, education, and housing opportunities. Clubhouses are peer-operated services managed collaboratively by staff and club members (Solomon 2004). A study conducted in Massachusetts suggests that long-term clubhouse membership is associated with a higher rate of employment and higher-paid jobs (McKay, Johnsen and Stein 2005).

A South African study by Maja et al. (2011) indicated a lack of awareness and poor understanding of disability by employers which contributes to the ineffective integration of people with disabilities (PWD) within the workplace, which could explain the low employment rate of PWD. Supported employment aims to facilitate the process of Return to Work (RTW) for MHCUs (Abbas and Soeker 2020). Evidence-based practice confirms supported employment as a preferred intervention strategy when facilitating RTW in the open labour market. It is, however, still a relatively new concept within South Africa with few available programmes and models (Van Niekerk et al. 2011). It is worth noting that internationally, there are supported strategies such as the Individual Placement and Support Strategy (IPS) which aims to enhance vocational outcomes and promote an individual's self-esteem and overall well-being (Bond and Drake 2012). Therefore, the clubhouse model is another supported employment strategy that aims to assist an individual to participate in competitive employment, reduce readmission to hospital and improve quality of life (McKay et al. 2018). In the South African context, the Model of Occupational Self-efficacy (MOOSE) has been adopted as a clubhouse model. MOOSE is enhancing work skills and facilitating the RTW for MHCUs. The MOOSE was developed in South Africa, and it is a client-centred evidence-based model demonstrating an 80 per cent success in RTW for MHCUs (Abbas and Soeker 2020). The MOOSE is regarded as an effective strategy for supporting employment within South Africa, by enabling MHCUs to enhance their work skills and facilitate a successful RTW process within the open market (Abbas and Soeker 2020). MOOSE is client-centred and therefore it can apply to social work in mental health. Moreover, it has similar tenets to social work principles such as adaptation of environmental factors and the presence of social support.

Case management, stepped care and collaborative care

Case management, stepped care and collaborative care are overlapping and interlinked approaches to the treatment of mental disorders. Increasingly, all the components are integrated, often referred to as stepped collaborative care, which includes a case management component (Gilbody et al. 2003). In developing countries such as South Africa, these approaches may offer innovative alternatives where there are limited or no referral resources.

Case Management

Case management (sometimes also referred to as care management) involves assigning responsibility for overseeing and coordinating the care of MHCUs to a particular member of the healthcare team (Gilbody et al. 2003). This is often someone responsible for providing a major aspect of the MHCU's care beyond the acute stage, for example, monitoring response to medication or providing counselling or psychotherapy (Gilbody et al. 2003). Gilbody et al. (2003) further point out that case management involves structured and systematic monitoring of the adherence to treatment and indicators of progress or relapses; follow-up in the case of treatment default; and liaison with other team members regarding treatment. The case manager may also facilitate access to resources such as health care for physical conditions, if necessary, or support from other sectors such as employment opportunities, grants or other material assistance (Lazarus and Freeman 2009). Case management is generally a central part of stepped care and collaborative care (Gilbody et al. 2003).

Stepped care

Stepped care has been developed as an approach to effective and cost-effective management and allocation of scarce resources. Needham (n.d.) in Lazarus and Freeman (2009) describes stepped care as involving the provision of low-intensity interventions to a significant proportion of MHCUs who derive significant benefit from these interventions; more intensive interventions (including referral for specialist care) are then restricted to MHCUs who have more severe disorders or who fail to improve. Successful stepped care is assumed to provide a filter that encourages appropriate care at the level of intensity required, with shorter waiting lists and easier access to more advanced care for those who need these services (Lazarus and Freeman 2009). Hence, case management is seen as essential for effective stepped care. Stepped care employs common-sense logic in circumstances of limited resources and where there is some evidence that it may improve MHCU outcomes.

Collaborative care

Collaborative care improves resource utilisation and provides more effective care for MHCUs. Bower et al. (2006: 484) describe it as a multifaceted intervention that includes case management and closer collaboration between primary care workers and mental health specialists. It enhances teamwork at the primary care level and may incorporate a stepped care approach, using interventions that expand beyond traditional methods. Collaborative care is shown to have some positive effects on outcomes such as depressive symptoms, medication adherence and MHCU satisfaction (Bower and Gilbody 2005).

Staff such as nurses, clinical social workers, or psychologists, who are based in primary care, are trained to provide evidence-based care coordination,

brief behavioural interventions and support treatments such as medications. In some implementations of collaborative care, this staff member also provides evidence-based, brief/structured psychotherapy (Patel et al. 2013). Therefore, social workers form part of the interdisciplinary team and have a critical role in these intervention strategies.

Spirituality plays a crucial role in mental health care, contributing to patients' well-being and treatment. Mizock, Millner, and Russinova (2012) note that spirituality and religion can enhance coping mechanisms, with practices like prayer, meditation, and worship helping MHCUs manage adversity. While religion was once excluded from psychotherapy (Plante 2007), recent literature highlights its benefits (Gottdiener 2006; Post and Wade 2009). Lukoff (2007) supports this, emphasising spirituality's role in holistic recovery. Walsh (2008) argues that spirituality aids in pain management and meaning-making. Starkowitz (2013) adds that spirituality is integral to African traditional medicine, aiming to resolve spiritual or environmental disharmony. Incorporating spirituality into counselling improves treatment outcomes, especially for those with mental disorders (Verghese 2008).

Interest in spirituality and social work has continued to experience growth both in training and practice over the last couple of years. Spirituality is a critical component of social work. Although the two have been detached from each other for the greater part of the twentieth century, they continue to find each other (Healy 2014; Holloway and Moss 2010). A plethora of literature suggests that there is an increasing relationship between spirituality and social work practice (Crisp 2017; Garcia-Irons 2018; Mabvurira and Nyanguru 2013).

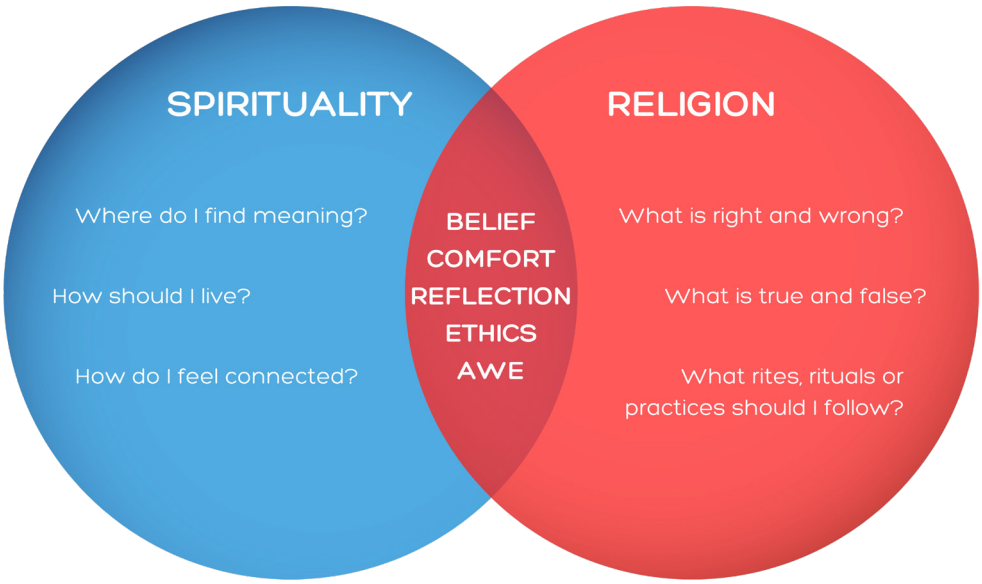

Figure 8.2: Relationship between religion and spirituality (Larsen 2011)

As far as spirituality is concerned, the question often asked is: where do I find

meaning, connection, and value? On the other hand, in religion, the question that is often asked is: what is true and right? The zone where the circles overlap depicts the individual experience which affects the way one thinks, feels, and behaves (Mafuriranwa 2018). The social work profession had its genesis on the bedrock of religion and spirituality (Chenoweth and McAuliffe 2017; Lindsay 2002; Mabvurira 2016). The interface between social work and religion dates to the 15th and 16th centuries when religion took leadership in alms giving, charity work and philanthropy (Chenoweth and McAuliffe 2017; Lindsay 2002). This resulted in the introduction of the Elizabethan Poor Laws of 1598, which were revised in 1601 and were further revised in 1874. Henceforth governments took over the control of social welfare to the present day through the introduction of a series of laws. At the end of the 19th century, social work became a profession and was now a recognised occupation. Studies confirm that at this time, there was a move away from a religious disposition to a modernist approach that is supported by scientific research and evidence-based social work (Dwyer 2010).

Metrics used for the diagnosis of a mental disorder

In the current era of managed care, direct contact time with MHCUs is often severely constrained and practitioners face a difficult task in dividing the minutes available among such varied tasks as problem identification, relationship development, intervention and guiding the client toward termination (National Association of Social Workers [NASW] 2003). In addition, as funding sources' requirements for accountability and quality control increase, practitioners must also complete initial assessments, monitor progress on an ongoing basis and evaluate outcomes (NASW 2003).

Brief measures, sometimes referred to as rapid assessment instruments or RAIs, are a particularly fast-growing subset (McMurtry and Rose 2004). RAIs are distinguished from other measures by their variety, ease of use, cross-disciplinary applicability, low cost and, above all, brevity (NASW 2004). Most include fewer than 50 items, some have fewer than 10 and all can be completed by most clients in a relatively brief time – often as little as one to five minutes (McMurtry and Rose 2004). This allows standardised measurement to be a brief part rather than a principal component of client contacts (McMurtry and Rose 2004). RAIs can be used for a variety of purposes, including screening, readiness for treatment, formal diagnosis, non-diagnostic assessment monitoring change over time and assessment of outcomes. These categories are not mutually exclusive, and a single instrument may span several of them (NASW 2003).

The strength of social work as a profession resides in its capacity to provide competent and ethical interventions in sensitive human situations that frequently occur in complex social environments (NASW 2003). Enhancing professional capacity to meet the challenges in the evolving landscape of mental health services remains the primary purpose of the Mental Health Specialty Practice Section (NASW 2003). Knowing how to find and appropriately use RAIs is an important skill for social workers in a variety of practice arenas.

(NASW 2003). For example, the use of RAIs in problem screening in multi-service settings can be of great value. Many people encounter an agency for a particular problem (for example, child maltreatment, substance abuse, domestic violence, or mental health concerns), but the early administration of a brief, multidimensional screening tool may identify underlying or ancillary problems that might otherwise be missed (McMurtry and Rose 2004). Such uses allow for more accurate assessments without requiring staff to be experts in all areas (NASW 2003). Social workers often rely on clinical judgment to make these determinations, but the quality of these judgments depends on variables such as clinician experience, contact time with clients and the quality of worker/client relationships (McMurtry and Rose 2004). Clinician judgment can also be affected by a lack of familiarity with MHCU problems or populations. RAIs are intended not to supplant clinician judgments, but to provide a further means of ensuring their validity (McMurtry and Rose 2004). The use of RAIs to assess needs, monitor change and evaluate outcomes is consistent with reliance on goal setting and mutual case planning for meeting these goals (NASW 2003). It is also in the best tradition of social work values that encourage client self-determination, empowerment and the working alliance between practitioner and client (McMurtry and Rose 2004). Instead, RAIs tend to focus on individual behaviours, characteristics, attitudes, or problems and on providing a quantitative score indicating the frequency, intensity, or duration thereof (NASW 2003). Many are deliberately designed for multi-disciplinary use, while others have been specially developed by social workers for use by other social workers. The types of RAI are presented below.

Self-administered RAIs, the most common type, are completed by clients in paper and pencil form or on a computer. The latter is becoming increasingly common for its ability to expedite scoring. It can be done through a stand-alone computer programme or by directing clients to a website where the form is located. Well-known examples of self-administered RAIs include the Beck Depression Inventory (BDI), Rosenberg Self-Esteem Scale and State-Trait Anxiety Inventory (STAI) (McMurtry and Rose 2004).

Screening instruments are used to assist in determining whether a clinically meaningful problem exists that may warrant further services or more extensive assessment. This 'case finding' function is one of the most common applications of RAIs and because of the extreme brevity of many screening measures, multiple instruments may be administered in a short amount of time to check for a variety of problems (McMurtry and Rose 2004).

Observer-rating forms are measures that practitioners, researchers, family members, teachers, hospital staff, or other onsite helping professionals complete about a particular client, based on their familiarity with the individual or on knowledge gained from observations. Examples include the Brief Psychiatric Rating Scale (BPRS), the Global Assessment Scale (GAS) and the Mini-Mental State Examination (MMSE). Practitioner-rating measures that must be preceded by a lengthy clinical interview cannot be properly defined as RAIs (McMurtry and Rose 2004).

Non-diagnostic assessment are instruments differ from screeners in that, though they may be very brief, they do not focus solely on case finding and can be more broadly used for treatment planning as well (McMurtry and Rose 2004). They also differ from diagnostic assessment instruments; though they may be designed to detect client problems that are of clinical concern, they do so without the intent of placing the problem in a formal diagnostic framework such as the DSM-5 (McMurtry and Rose 2004). Many measures developed by social work researchers fall into this group, including those in Walter Hudson's Clinical Measurement Package, such as the Generalised Contentment Scale (GCS) and Index of Self Esteem (ISE) (McMurtry and Rose 2004). Other instruments in this category are designed to measure problems or strengths in social and family relations. The Interpersonal Support Evaluation List (ISEL) is a frequently used measure of social support, for example, instruments such as the Family Environment Scale (FES) (McMurtry and Rose 2004). The Parenting Stress Index (PSI) and Conflict Tactics Scale (CTS) measure various aspects of family functioning (McMurtry and Rose 2004).

Other Metrics include the ADHERE model which identifies six considerations for practitioners assisting MHCUs in treatment adherence at its intersection with mental health and health conditions (McMurtry and Rose 2004).

The ADHERE Model is categorised below.

A: Assess knowledge and readiness

D: Dialogue about beliefs and attitudes.

H: Holistic Approach is important.

E: Empower client.

R: Reinforce strategies.

E: Evaluate progress.

Adapted from McMurtry and Rose (2004)

i. Assess client knowledge and readiness for treatment initiation

Assessment optimally resides in a relational environment of collaboration involving clients, significant others, social workers, and other members of the healthcare team (NASW 2003). Assessment involves exploration of client and family understanding of the recommended regimen and is facilitated using open-ended, non-confrontational questions, such as (McMurtry and Rose

2004):

- What have you heard about this treatment?
- What do you believe are your options? What do those closest to you believe are the options?
- Do you believe that this treatment is doable for you?
- What do you think may keep you from following treatment recommendations?

In assessing knowledge and readiness, it is important for the practitioner to elicit current perceptions of health status, beliefs about treatment benefits and disadvantages and to provide verbal and written information that is congruent with a client's knowledge and understanding. Attention to the use of linguistically and culturally appropriate terms and meanings, as well as explanations that consider the client's literacy level are critical in ensuring mutual understanding of regimen adherence and challenges (NASW 2003).

ii. Dialogue periodically about health beliefs and illness-related attitudes

Unanticipated barriers to follow-through may emerge over time (McMurtry and Rose 2004). Therefore, ongoing discussion is necessary to support adherence to a treatment regimen, especially when recommendations must be followed for an indefinite duration. Communication of empathy and unconditional positive regard for the client serves as the basis for discussing difficulties with adherence and lays an essential foundation for future discussion of treatment adherence (McMurtry and Rose 2004). Challenges to optimal adherence and non-adherent behaviour are relatively common and it may be helpful for the social worker to normalise adherence-related difficulties, purposefully assuring the client that the healthcare team does not equate adherence difficulties with being an uncooperative or 'bad' client (NASW 2003: 1). Carefully listening to the client's attitudes about living with a chronic illness is fundamental to dialogue and necessarily includes (McMurtry and Rose 2004):

- Attitudes about diagnosis, treatment, and quality of life.
- Past and current ways of coping with illness and other adverse life situations.
- Positive and negative experiences with providers and the healthcare system.

iii. Holistic approach is important

Based on the initial assessment and dialogue, the practitioner will have collected significant information about the client's strengths and needs (McMurtry and Rose 2004). The practitioner will also have a sense of whether the client's orientation is primarily individualistic or collectivist; this informs

decisions about whom to include in the treatment planning process (McMurtry and Rose 2004). Elicitation of the client's understanding of the illness is essential and optimally includes the client's health beliefs, cultural practices, environmental barriers and preferred learning and coping styles. Because a client may present with more than a single mental health concern, the social worker needs to take a holistic approach to addressing issues of drug use, physical health concerns and resource needs (NASW 2003).

There are several environmental barriers to engaging and sustaining the client's participation in mental health treatment. The client who abuses drugs, often as a self-treatment for a mental disorder, can find that the drugs exacerbate the symptoms of the mental disorder and may have a diminished capacity to manage a treatment plan (NASW 2003). Homelessness can make a client vulnerable and requires spending countless hours and physical and psychic energy planning for a place to sleep. Being homeless may force a client to move from one area to another and can prevent a therapist from being able to reach a client when needed. Financial status is also a barrier. Community mental health used to be a guaranteed resource for mentally ill persons who had no funds; however, this critical safety net is rapidly becoming inadequate as restrictions increase and functionally prevent access to unfunded patients. Environmental barriers also encompass fewer tangible issues, such as culture and relationship/familial history. With which culture might a client identify? In some cases, the client may freely disclose this. In other situations, due to shame or perceived bias, the MHCU may not speak of their culture, but their behaviours may still be reflective of cultural influences. (McMurtry and Rose 2004).

Cultural issues can be best understood by asking the client about their health beliefs and their understanding of their health and/or mental health situation (McMurtry and Rose 2004). It is the practitioner's role to listen and to try to understand how the MHCU's culture can positively and negatively influence adherence (NASW 2003). For truly holistic care, the social worker may need to have available resources for other services and needs and may strengthen their treatment plan by collaborating not only with the patient's perceived support systems but with other professionals and community programmes (McMurtry and Rose 2004).

iv. Empower the client to implement the action plan

Respect for the MHCU's choice is fundamental and the social worker optimally empowers the client to implement an action plan, regardless of whether a client decides to initiate treatments recommended by the healthcare team or to follow another alternative (NASW 2003). The MHCUs who choose to initiate a recommended regimen may find it helpful to identify cues, reminders and daily activities that serve as environmental reminders (McMurtry and Rose 2004). For example, one young mother is cued to take her medication as soon as her children leave for school. Equally important is the development of an

action plan considering unexpected events and/or changes in routines that potentially compromise adherence efforts (NASW 2003). Open discussion of client successes and concerns is potentially empowering and may be facilitated by dialogue prompted by questions such as:

- How are you coping with this plan?
- Help me to understand how this plan is working for you – what do you think is going well? What needs some attention?
- Give me an example of when this plan is difficult for you to follow. In the last three days, how many doses of medication did you miss? On average, how many doses are you able to take, as prescribed? Which medications/ doses cause the most difficulty for you?
- How satisfied are you with your current regimen?

v. Reinforce strategies

The importance of appropriate and ongoing client education is increasingly emphasised to ensure that the individual and members of his or her support system understand the multiple tasks of treatment adherence (McMurtry and Rose 2004). A review of the treatment plan and reinforcement of what is working for the MHCU are both essential components of this type of education (NASW 2003). For the mental health practitioner, reinforcing strategies helps the client to focus on the desired outcome and to relate the treatment process to a tangible goal. Discussing 'successes' when they happen (for example, following through with medications, keeping an appointment for a psychiatric consultation, and working with a collaborating agency to secure a resource) can be appropriately integrated into the therapeutic work (McMurtry and Rose 2004). In reviewing and reinforcing the client's role in ensuring adherence to a treatment plan, the social worker can also continually reassess the worth of the plan with the client. Regular reassessment is key to noting changes in the client's situation that might make the initial plan unworkable for the client (NASW 2003). Given the challenging and even chaotic lives of some clients, the social worker must be prepared to adjust the plan, accordingly, being flexible enough to recognise the impact of emerging barriers. It is important to note that problems with adherence may be a clinical issue or may reflect the inability or unwillingness of a client to engage in mental health treatment. Unfortunately, many clients with extensive cultural and/or environmental issues get pegged as being the problem, when in fact there may be legitimate reasons why the client is unable to adhere to a treatment plan.

vi. Evaluate progress

What is the difference between review and evaluation? Evaluation tends to look over time at the work one is doing with a client and/or family (McMurtry and Rose 2004). It is also an overall review of methodologies chosen,

interventions attempted and whether the client goals were met (McMurtry and Rose 2004). Review tends to be more micro practice, scanning for changes in the client's status and needs and adjusting along the way. The evaluation component is macro-focused, taking a retrospective examination of the progress made to date and looking carefully at issues such as consistency in practitioner methodology, observing for overall improvements in client functioning and looking for patterns in client behaviour based on interventions utilised (McMurtry and Rose 2004). Clinicians, as well as administrators, benefit from this global view, as it allows for a greater chance of reflection and removes the practitioner from becoming caught up in the session-to-session struggles the client may be presenting (McMurtry and Rose 2004). Evaluation should also extend to the broader array of resources the social worker relies on when using a holistic approach (McMurtry and Rose 2004). Considerations include (NASW 2003):

- Were the resources provided effective?
- Did the relationship between the provider(s) and the client (system) facilitate or impede progress?
- How do emerging changes in the service delivery system impact the client (system)?

In summary, helping clients in the critical health/mental health area of treatment adherence requires strong therapeutic skills, as well as an understanding of how factors in the client's social environment impact adherence behaviours. The person-in-environment perspective of social work practice optimally informs assessment and intervention. From this perspective, family, community, and cultural factors are considered with attention to how these factors either facilitate or disable treatment adherence. A clear understanding and thoughtful integration of ecological factors into intervention optimally, promote communication between the client, the client system, the practitioner and ultimately, the service delivery system. This perspective is not a new one but reinforces the unique and critical role of social work in mental health treatment. It should be noted that these metrics can be adapted in the South African context. The South African Council for Social Service Professions (SACSSP) (2008a) alludes to the ecometrics, and these have similar tenets to the discussed metrics. Therefore, social workers must be equipped with knowledge of how to use the metrics in practice and their applicability in the South African context.

Chapter 9
Recovery

Introduction

Recovery is an ongoing evolution through which individuals enhance their health and wellness and live to sustain self-directed lives (Substance Abuse and Mental Health Services Administration [SAMHSA] 2009). Recovery often begins as individuals collaborate with their natural supports and their providers to overcome stigma and identify their unique strengths, preferences, and support needs (Allegheny County Coalition 2012).

Recovery can be viewed as a manifestation of empowerment, functional ability and an improvement and maintenance of personal capacity in one or more of the major domains of life – work, housing, relationships, recreation – and by so doing, enabling the patient to '[live] a satisfying, hopeful and contributing life even with limitations caused by illness ... [and to develop] new meaning and purpose in one's life' (Anthony 1993: 15). Recovery research, which has shown that many people with severe mental disorders do recover, has been met with scepticism among professionals within the field of mental health, where severe mental disorders are considered as a chronic condition (Topor 2004). Slade and Longden (2015) point out that the pessimistic view of severe mental disorders as hopelessly chronic conditions is being contested by the results of several studies in recovery research. Furthermore, these authors indicate that results have shown that a significant number of MHCUs with severe mental disorders do recover and that the probability of doing so is relatively high.

Similarly, Anthony (1993: 1) argues that recovery occurs whether a mental disorder is seen as 'biological and/or psychosocial'. Furthermore, Topor and Sundström (2007) highlight that recovery in a social context means that people may still have symptoms and some contact with psychiatric services but are living normal social lives. Therefore, Topor (2004) states that the results contradict the view that severe mental disorders are chronic, incurable conditions. Recovery brings hope to MHCUs; they can function even if their symptoms persist. Indeed, this is an example of human transformation and human emancipation. The chapter will highlight the origins and history of recovery, conceptualisation of recovery, components of the process of recovery, how recovery is measured and approaches to recovery.

Conceptualisation of recovery

Recovery has been defined as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the

illness (Anthony 1993: 11). More so, Anthony states that recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. The concept of recovery emphasises a person's capacity to have hope and lead a meaningful life and suggests that treatment can be guided by attention to life goals and ambitions (Substance Abuse and Mental Health Services Administration [SAMHSA] 2012). Slade (2009) asserts that recovery is a word with two meanings: clinical and personal recovery. Similarly, Townsend and Glasser (2003: 85) explain that 'recovery is what the individual does; facilitating recovery is what the clinician does and supporting recovery is what the system and community does.' From these distinctions, philosophical tensions emerge between psychiatric medicine's focus on a person's recovery and the focus on the MHCU or their illness (Barker and Buchanan-Barker 2008). These tensions are explored by examining recovery through the following lenses of clinical recovery and personal recovery (Slade et al. 2008).

1. Clinical recovery reflects a definition of recovery that has emerged from scientific literature (Slade et al. 2008: 12; Slade 2009: 4). The medical model drives the clinical model. It posits that mental illness is a physical disease and recovery refers to the return to a former state of health. According to this model, mental illness is due to permanent chemical brain imbalances, which are present at birth (Ahern and Fisher 2001: 1).
2. Personal recovery reflects a definition that is individually defined and experienced. This model of recovery contrasts with the clinical model of recovery, based on a system of health promotion in which individuals actively define their needs and collaborate with others in the healing process (Schiff 2004: 23; Slade 2009: 4). It is a view shaped through the accounts of people with lived experiences of mental illness (Deegan 1996; Mead and Copeland 2000). Anthony (1993) points out that recovery is a familiar idea in physical illness and disability. For example, it is not unusual to regard a person with paraplegia as having recovered, even though the spinal cord has not.

McCranie (2011: 427) contends that recovery is a complex set of ideas and asserts that this phenomenon can be understood mostly as hope that individuals who suffer from serious mental health problems can reclaim their lives or create a new meaningful way of coping.

Origins of recovery

Roberts and Wolfson (2004) date the origins of recovery practice to the Tuke family who established The Retreat in York at the turn of the 18th century. William Tuke, a Quaker and a law reformer, set out to create a family-like healing and spiritual environment for members of the Society of Friends in York. The Tukes showed that moral or psychological forms of treatment in a work-oriented, peaceful and pleasant environment could replace physical restraint.

John Perceval, in *A patient's account of his psychosis,* 1830-1832 (Bateson 1974), gave an early autobiographical account concerning what helped and hindered in treatment and recovery from psychosis.

From the start, personal accounts, alongside more systematic analysis, have been important contributions to the literature on recovery. They highlight that putting values into practice (Woodbridge and Fulford 2004) is strongly influenced by what is personally meaningful and by being oriented around outcomes rather than inputs. More recently, the recovery approach has emerged from the writings of people who used services in the 1980s in the US and in the 1990s in the UK (Deegan 1988). Deegan compared her recovery from schizophrenia with the recovery of her friend who had been paralysed by an accident (1988). Both experienced anguish, despair, and hopelessness. Eventually, both learned to manage their difficulties and achieve meaningful goals. Deegan became a research psychologist, teacher and trainer and her friend qualified to work with other people with disabilities. A wide range of influential writers have greatly encouraged others with their accounts of mental illness and recovery, for example, mental health professionals such as Mike Shooter, the president of the Royal College of Psychiatrists (RCPsych) and Alistair Campbell, the British Prime Minister's (Tony Blair) former director of communications and strategy (Cantacuzino 2002; Roberts and Wolfson 2004).

Origin of the recovery movement in different countries

The origin of the recovery movement will be explored through key countries that were early adopters of recovery-oriented mental health services, including the United States, Canada, New Zealand, the United Kingdom, and Australia. China, India and Europe, which have recently embraced this approach, will also be discussed. The progress of recovery-oriented practices in South Africa will also be examined to assess how extensively they have been implemented in the country.

Recovery in the United States of America (USA)

The documented history of recovery for people living with mental illness is strongly influenced by the American perspective and literature on recovery (O'Hagan 2004). It is suggested that the recovery movement had its genesis in the United States (Meehan et al. 2008) and began to take form in the 1970s and 1980s when people with the experience of mental illness began speaking and writing about their experiences of recovery (Ahern and Fisher 2001; Carpenter 2002). This can be traced to the psychiatric survivor movement (Deegan 2003). People who did not have the lived experience of a mental disorder were excluded from consumer organisations, as consumers found their radical views on mental disorders were not shared by practitioners or the public (Schiff 2004).

Primarily, professionals, academics and other people living with mental disorders (Casey 2008) developed the frameworks of recovery in America in

a clinical setting. The vision of recovery was exported from America to other countries, notably Australia and New Zealand and consequently reinforced the dominance of psychiatric rehabilitation acknowledgement of the biomedical model (O'Hagan 2004). It is noted that America and New Zealand were the first countries to embed recovery principles in their health policies (Ramon et al. 2007).

Recovery in Canada

Canadian mental health policy and practice have developed under the influence of American practice. During the 1970s and 1980s, the Canadian Mental Health Association, supported by the Canadian government and the United States National Mental Health Association, met to discuss recovery practices in mental health care (Rochefort and Goering 1998). Discussions highlighted the need for greater support services for consumers and a community resource base for developing networks of care (Goodrick 1998). In the 1980s, programmes such as the Mental Patient's Association in Vancouver began operating drop-in centres and provided residences for mental health consumers to meet the need for increased support.

Housing was provided for psychiatric patients throughout Canada as an opportunity to 'escape hospitalisation and become responsible for their care,' demonstrating a trend toward self-help programmes in line with American practices (Goodrick 1998: 87). Stronger focus has been placed on putting the MHCUs in the role of the case manager, with initiatives in Canada offering more options for recovery, with larger support networks and consumer-created recovery programmes (Chamberlin 1990). Furthermore, there has been sustained funding allocated to the Mental Health and Addictions Programme to provide consumers with recovery-oriented mental health services (Berg 2006).

Recovery in New Zealand

Gawith and Abrams (2006) provide an account of the recovery movement in New Zealand. They documented that in the 1980s, some New Zealand psychiatric survivors were in contact with American, British and European organisations that were starting to question the values and philosophy behind psychiatry. The first user network for people living with mental illness appeared in the early 1990s in New Zealand. In New Zealand, policymakers were critical of the American conceptualisation of recovery, as it was seen to be driven by professionals rather than service users (O'Hagan 2003, 2004). Furthermore, American recovery literature was criticised for its lack of acknowledgement of important issues such as discrimination, human rights, cultural diversity, or the potential for communities to support recovery (O'Hagan 2003, 2004: 2; Roberts and Wolfson 2004). New Zealand is currently regarded as having one of the most coherent and progressive national recovery policies internationally, with advanced concepts of recovery and recovery-orientated services and practices

(Allott, Loganathan and Fulford 2003; Gawith and Abrams 2006; Schinkel and Dorrer 2007). The USA is a pioneer in recovery-oriented mental health practice; most countries have benchmarked the American practice.

Recovery in the United Kingdom

The recovery movement in the United Kingdom developed in the 1970s and 1980s. This movement was driven by the shift toward community-based care and the stories of ex-service users and mental health professionals and activists, all of whom had roots in the civil rights movements of the 1960s (Allott et al. 2002). Groups of professionals and consumers were formed in response to conditions in psychiatric wards, the closure of long-stay psychiatric services and the need for consumers to have a greater role in choices affecting their quality of life (Wallcraft and Bryant 2003). Recovery was first acknowledged in a UK policy document in 2001. Current policy directions include the vision for the transformation of mental health services to allow mental health care users to be active partners in their treatment, achieve their potential and be more socially competent and less socially isolated (Ramon et al. 2007; Schinkel and Dorrer 2007).

Recovery in Australia

The understanding of recovery in Australia is most heavily influenced by recovery literature from the USA, but also from Canada and New Zealand (Rickwood 2004; Slade, Amering and Oades 2008). It is suggested that the term 'recovery' has slowly been adopted in Australia since the late 1980s (Lakeman 2004; McGrath, Bouwman and Kalyanasundaram 2007). It has become popular in mental health discourse and influences policy directives and service delivery initiatives (Rickwood 2004: Slade et al. 2008). All Australian states and territories have initiatives underway related to recovery, although there is considerable variation evident in the level of knowledge, commitment and implementation (Rickwood 2004). In Australia, consumer groups have been the main drivers of the recovery movement (Ramon et al. 2007). In addition, the non-governmental sector in Australia has been promoting and applying the use of recovery from mental illness in its literature and many programme guidelines since the early 1990s (Ramon et al. 2007).

Recovery in China

Over the years, numerous studies focussing on recovery have emerged in Hong Kong. In 2005, Yip introduced the concept of strengths-based therapy, which serves as a recovery-oriented intervention for individuals grappling with addiction (Yip 2005). A series of articles published by Lam et al. (2010), Ng et al. (2011), and Ng et al. (2008) delved into the meaning of recovery, specifically for those recovering from schizophrenia and first-episode psychosis. These articles

drew insights from service users, medical students, and trainee psychiatrists, highlighting key themes such as the management of psychiatric symptoms, a sense of normalcy, decreased reliance on medication, and coping with the stigma associated with persistent mental illness. This body of work marks a significant advancement in understanding users' personal narratives about recovery.

Kwok (2009) became the first Hong Kong native to document her recovery journey from bipolar disorder in psychiatric literature, also sharing her story in her book. Following this, Chiu et al. (2010) conducted the first empirical study assessing the applicability of recovery concepts among Chinese individuals with schizophrenia spectrum disorders. Their findings suggest that SAMHSA's ten guiding principles, including resilience, respect, and empowerment, are relevant across cultures, highlighting that stigma is as important as symptom control in recovery. Expanding the conversation to workforce development, Mak, Lam and Yan (2010) conducted a staff survey within a community mental health NGO in Hong Kong, identifying the need for more staff training on recovery principles. The authors noted that while recovery concepts in Hong Kong share similarities with Western models, the local emphasis is more on symptom control and role reclamation. Recovery for Chinese service users is often viewed as an outcome ('Have I recovered?') rather than a process ('What is my recovery journey?'). Based on literature reviews and professional discussions, three strategies were proposed to shift Hong Kong's mental health services toward a recovery-oriented model, gaining support from a multi-disciplinary group of health professionals.

Recovery in India

India has recently experienced a paradigm shift in mental health services, moving towards human rights-based and recovery-oriented approaches that emphasise the importance of social determinants impacting mental health (Manisha and Sampa 2024). This shift challenges traditional frameworks focused primarily on diagnosis and medication, highlighting the significance of psychosocial recovery in helping individuals achieve personal goals such as education, employment, and independent living (Manisha and Sampa 2024). Despite these advances, many individuals with mental health issues face psychosocial disabilities and human rights violations due to inadequate support and care, prompting calls for expanded community-based mental health services that foster recovery and social reintegration (Manisha and Sampa 2024).

Currently, India's mental health service delivery model is largely centred around psychiatric institutions, which are often only accessible to those who actively seek help. The National Mental Health Survey (2015–2016) reported an 83 per cent treatment gap for mental disorders, indicating that one in six Indians requires mental health assistance. As a result, the focus remains on acute care rather than rehabilitation, despite the introduction of national initiatives like the National Mental Health Program (NMHP) and District Mental Health Program

(DMHP).

Psychiatric rehabilitation in India is gradually gaining traction, supported by hospital-based facilities, mental health NGOs, and community initiatives. Institutions like the National Institute of Mental Health and Neuro-Sciences (NIMHANS) and Crisis Intervention Partners (CIP) offer psychosocial rehabilitation services, though they often struggle to meet the high demand (Manisha and Sampa 2024). In recent years, medical colleges have begun to establish occupational and rehabilitation units. Some NGOs, such as the Schizophrenia Research Foundation (SCARF) and Banyan, have developed structured programmes that provide training in daily living skills and vocational activities, emphasising research, training, and community care. However, these efforts are still insufficient to address the treatment gap in rural areas and among socially disadvantaged groups (Thara and Patel 2010).

Recovery from mental disorders is a complex and multidimensional concept that varies among patients and caregivers (Manisha and Sampa 2024). While clinical recovery is important, functional recovery, defined by age-appropriate social and vocational functioning, is often prioritised. Individuals with lived experience emphasise the personal nature of recovery, highlighting the importance of spirituality, hope, and finding meaning in life (Manisha and Sampa 2024). To address these needs, effective rehabilitation models tailored to diverse settings and clinical populations must be prioritised.

Research should focus on understanding the entire rehabilitation pathway leading to recovery. Good mental health services must operate within legal frameworks that protect human rights and avoid coercion. Resource constraints should not be viewed as the main barrier to successful rehabilitation. Collaborative efforts among stakeholders, practitioners, families, and innovative technology-based services are crucial for supporting the recovery of individuals with mental illness (Manisha and Sampa 2024). Newly introduced services such as halfway houses, mental health mobile units (MMHU), and the District Mental Health Program (DMHP) should focus on continuous evaluation, training, and advocacy. This approach can enhance access to sustainable rehabilitation services, facilitating social participation, meaningful skill development, and employment opportunities, ultimately improving the quality of life and social support for individuals with mental disorder (Dalton-Locke et al. 2021).

Recovery in Europe

The RECOVER-E project aims to improve community-based, recovery-oriented care for individuals with severe mental disorders in Southern and Eastern Europe (Shields-Zeeman et al. 2020). Despite significant global progress in reforming mental health systems from institutional care to community-based services, many people in Europe still lack access to optimal care (Directorate-General for Health and Food Safety 2017). The project focuses on implementing and evaluating multi-disciplinary community mental health teams in five Central and Eastern European countries (Bulgaria, Croatia, North Macedonia, Montenegro,

and Romania), where hospital-based services exist for patients with severe mental disorders like depression, bipolar disorder, and schizophrenia (Shields-Zeeman et al. 2020).

The intervention involves introducing a new service delivery model that includes trained multi-disciplinary teams, incorporating a peer worker with lived experience of a severe mental disorder (Shields-Zeeman et al. 2020). The project utilises a hybrid implementation-effectiveness trial design with patient-level randomisation (n=180) to compare the new community-based care model with traditional hospital-based care. The effectiveness and implementation outcomes will be evaluated using a mix of research methods aligned with the RE-AIM framework (Shields-Zeeman et al. 2020).

By demonstrating the impact of an evidence-based service model, RECOVER-E aims to enhance the quality of care and outcomes for individuals with severe mental illness in middle-income countries, contributing to the growing evidence of the benefits of recovery-oriented and community-based service models in transitioning health systems (Shields-Zeeman et al. 2020).

Recovery in South Africa

An important and powerful force in both the design and function of mental health services has emerged in many parts of the world (Slade 2009). This force involves a new conceptualisation of the meaning of recovery. This has implications for how recovery is understood as a clinical term, but more importantly, it critically affects both how individuals who suffer from mental illness see themselves and are perceived by others, as well as how mental health services are designed (Parker 2012). In a country such as South Africa where services remain underdeveloped (Jacob et al. 2007), promoting these new understandings of recovery and working to develop a philosophy of recovery in mental health are critical steps in addressing the burden of mental disorders (Parker 2012). In South Africa, recovery as a concept has also been included in policy documents, such as the National Mental Health Policy Framework and Strategic Plan 2023-2030 (NMHPF) (Department of Health [South Africa] 2023) which states the support of service users and their carers to establish recovery in their communities as one of its objectives.

In addition, one of the NMHPF's values is recovery and it is amplified by the principle that services should be delivered in such a way as to support service users to be able to return to, or take on roles, in their community, as they choose. The objective, together with the value and principle linked to it, is in line with international conceptualisations of recovery and provides an imperative for public mental health services in South Africa to be recovery-oriented and a motivation for recovery programmes to be established. Some mental health recovery programmes have been developed and implemented in South Africa of late (Bila 2019; Brooke-Sumner 2016), albeit on a much smaller scale than internationally, to support individual service users' recovery and to foster the recovery-orientation of services. With the inclusion of recovery on

a policy level and the development of recovery programmes in South Africa, comes the need to find ways in which recovery can be measured in the South African context (De Wet 2021). This can be approached, as in other contexts, via two means, namely, by measuring the individual recovery of mental health service users and by measuring the recovery-orientation of systems, services, or providers (De Wet 2021). The following components of recovery are critical for the process of recovery.

Characteristics/components of the process of recovery

Mental health recovery is defined as a journey of healing and transformation that enables a person with mental health problems to live a meaningful life in a community of his or her choice while striving to achieve his or her potential (National Alliance on Mental Illness [NAMI] 2016: 1). The 10 fundamental components of mental recovery include the following principles (NAMI 2016; Substance Abuse and Mental Health Services Administration [SAMHSA] 2006):

1. **Self-direction:** Consumers lead, control, exercise choice over and determine their path of recovery by optimising autonomy, independence, and control of resources to achieve a self-determined life. The recovery process must be self-directed by the individual who defines his or her own life goals and designs a unique path towards those goals (SAMHSA 2006).
2. **Individualised and person-centred:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies, as well as his or her needs, preferences, experiences (including past trauma) and cultural background in all their diverse representations. Individuals also identify recovery as being an ongoing journey and a result, also as an overall paradigm for achieving wellness and optimal mental health (SAMHSA 2006).
3. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions – including the allocation of resources – that will affect their lives and are educated and supported in so doing. They can join with other consumers to speak for themselves collectively and effectively about their needs, wants, desires and aspirations. Through empowerment, an individual gains control of his or her destiny and influences the organisational and societal structures in his or her life (SAMHSA 2006).
4. **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addiction treatment, spirituality, creativity, social networks, community participation and family support as determined by the person. Families, providers, organisations, systems, communities, and society play crucial

roles in creating and maintaining meaningful opportunities for consumer access to these supports (SAMHSA 2006).

5. **Non-Linear:** Recovery is not a step-by-step process, but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognises that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery (SAMHSA 2006).
6. **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave hindered life roles behind and engage in new life roles (for example partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships (SAMHSA 2006).
7. **Peer support:** Mutual support – including the sharing of experiential knowledge and skills and social learning – plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community (SAMHSA 2006).
8. **Respect:** Community, systems and societal acceptance and appreciation of consumers – including protecting their rights and eliminating discrimination and stigma – are crucial in achieving recovery. Self-acceptance and regaining belief in oneself are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives (SAMHSA 2006).
9. **Responsibility:** Consumers have a personal responsibility for their self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their wellness (SAMHSA 2006).
10. **Hope:** Recovery provides the essential and motivating message of a better future – that people can and do overcome the barriers and obstacles that confront them. Hope is internalised but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focussing on their abilities to live, work, learn and fully participate in our society but also enriches the texture of community life (SAMHSA 2006).

Therefore, these components apply to recovery in the South African context as well as globally. These components make recovery a reality. Authors such as De Wet, Parker and Bila have made it a point that they bring forth these components of recovery in the South African context.

Five stages of recovery

The journey of recovery can prove to be arduous and daunting, particularly for individuals who have yet to address their mental health issues. Nevertheless, it is a path that can be navigated incrementally, aided by the guidance of professionals. Moreover, understanding the various stages of recovery serves not only to facilitate healing from mental health challenges but also to instil a sense of self-assurance in managing the complexities of life (Mental Health Foundation 2021).

Figure 9.1: The five stages of recovery (Georgetown Behavioural Hospital 2024)

Starting treatment: Various warning signs may indicate the necessity of seeking assistance for one's mental health. Whether it involves the exacerbation of symptoms, resorting to self-medication, or struggling to accomplish daily tasks due to mental health challenges, these indicators suggest it is time to embark upon the initial phase of recovery. Acknowledging the need for help may not always be straightforward; nonetheless, this inaugural stride holds immense significance in the broader journey of healing – and it is essential to recognise that you need not traverse this path alone. Specialised treatment facilities cater to individuals grappling with diverse mental health issues, offering tailored guidance and support. For instance, if one contends with co-occurring disorders entailing both a mental health condition and substance addiction, the outset of treatment may encompass a structured detoxification programme aimed at preparing the individual physically for the recovery process ahead (Georgetown Behavioural Hospital 2024).

Mental disorder education: Progressing through the stages of mental health recovery entails gaining comprehensive insights into one's specific condition, its prognosis, and the optimal treatment trajectory. Given the myriads of mental health disorders, each characterized by distinct symptoms and therapeutic interventions, it becomes imperative to understand the intricacies of one's

diagnosis. For instance, addressing anxiety necessitates a markedly different approach compared to managing a mood disorder such as bipolar disorder. Thus, in this phase of recovery, individuals delve deeper into their mental health diagnosis, equipping themselves with knowledge essential for navigating subsequent stages of treatment effectively (Georgetown Behavioural Hospital 2024).

Making a change: An indispensable facet of the recovery process involves effecting substantial changes in one's life. For numerous individuals, this entails establishing robust support networks and fostering a nurturing home environment conducive to healing and sustained progress. At times, this necessitates severing ties with toxic relationships. It may also entail modifying one's lifestyle, such as refraining from frequenting environments where past behaviours like substance abuse may be triggered. Ultimately, recovery manifests through the pursuit and implementation of constructive transformations (Mental Health Foundation 2021).

Finding new meaning: Engaging in novel hobbies, pursuits, responsibilities, and other fulfilling endeavours can reignite a sense of delight in life's simple pleasures. This facet of the recovery journey holds significance as it contributes to personal growth and facilitates integration into communities that align with one's values. Surrounding oneself with supportive individuals and allies can be transformative, underscoring the pivotal role of community and companionship in the recovery process (Jacob N. 2015).

Sticking with recovery: Finally, devising and adhering to a personalised recovery plan, even during the most challenging moments, constitutes an integral aspect of the recovery journey. Throughout treatment, individuals acquire invaluable coping skills to sustain their well-being. These may encompass cognitive behavioural therapy, dialectical behavioural therapy, group and family counselling, medication assessment and administration, trauma-focused therapy, discharge strategising, and an array of other therapeutic interventions (Metcalf 2019).

The stages of recovery for mental health are not just aimless milestones to reach. Instead, they encompass core values that an MHCU must work on to truly recover. These cover important subjects like self-care, determination, and persistence through all of life's challenges. However, it takes time, support, and dedication to get through each step in the recovery process. This is why mental health recovery centres are on standby to guide the MHCU toward all their treatment goals.

Recovery facilitators and obstacles

Research in several countries such as New Zealand, and England just to mention a few has identified some common themes regarding what promotes or prevents recovery (World Health Organization [WHO] 2019). The following tables list in detail key factors that people have identified as either facilitating or hindering recovery.

Table 9.1: Recovery facilitators

RECOVERING IDENTITY	RELATIONSHIPS
• Confidence • Hope and optimism • Self-acceptance, responsibility, belief, and esteem • Self-efficacy • Self-awareness • Growing beyond the label • Reclaiming power and self-determination • Belonging – cultural, social and community identity • Activism • Spirituality • Coping • Taking control	• Friendships • Supportive family relationships • Intimate relationships (i.e., partners) • Parenting • Peers • Pets • Service professional • Mutual trust and recognition • Hopeful relationships
Engagement and finding meaning and purpose	**Services and supports**
• Being valued • Engaging in meaningful roles • Volunteering, employment, career, and education • Learning about self and condition • Community and social engagement • Exercise and creativity • Other people's experiences	• Feeling informed and in control • Continuity and flexibility • Treatments and therapies • Security • Peer support • Relationships, attitudes, and power • Housing and community support • Financial security

Adapted from NHS Education for Scotland (NES) and the Scottish Recovery Network (2011).

Table 9.2: Recovery obstacles

Obstacles that hinder recovery

- Violence and abuse
- Stereotypes – False assumptions about people (for example, that they are violent) which can damage their confidence and prevent recovery.
- Stigma and discrimination – When people are excluded from communities or opportunities in life or are thought not to be worthy of support, this can hinder their recovery. Multiple forms of stigma and discrimination can intersect to shape inequality and impede recovery.
- Poverty – Not being able to meet one's personal and family needs. This can lead to emotional distress and can hinder recovery.

- Lack of independence and control – Services and individuals can sometimes disempower or create barriers for people, which may hinder their recovery.
- Lack of services and supports in the community – People may require a range of services and supports and should be able to access them to live a fulfilling life in the community (for example, social support, housing, employment services, educational opportunities, training for independent living, peer support, personal assistance etc.). Without these, people may continue to experience exclusion, which also harms their well-being and recovery.

Adapted from Cyr et al. (2016)

While promoting positive support for recovery is crucial, it is equally vital to address and remove any hindrances to the process. These recurring themes and factors should not overshadow the profound and individualised experiences individuals have lived through, nor should they diminish the significance of the meaning and purpose they attribute to their journey. Through exploring these experiences, individuals might unexpectedly uncover positive aspects that have arisen from negative circumstances, contributing to their recovery journey in meaningful ways.

The personal recovery tasks

Personal recovery is a concept that has emerged from the expertise of people with lived experiences of mental illness (Slade 2009). Personal recovery involves working toward better mental health, regardless of the presence of mental illness. People with mental illness who are in recovery are those who are actively engaged in moving away from floundering (through hope-supporting relationships) and languishing (by developing a positive identity), working toward struggling (through framing and self-managing the mental illness) and flourishing (by developing valued social roles) (Slade 2010). One understanding of recovery is that it emphasises the centrality of hope, identity, meaning and personal responsibility (Andersen, Oedes and Caputi 2003). Personal recovery is a multidimensional concept; it is a process that happens in various stages, at various times. 'There is no single way to measure it, but many different measures that estimate various aspects of it' (Anthony 1993: 8). It is about regaining a sense of self; it is about getting control over symptoms; it is not about the absence of symptoms; it is about the development of new meaning; it is not about who the person once was; it is about dealing with the many difficulties that the illness brings. Through several steps and at various stages, it may involve overcoming negative factors such as stigma and discrimination and not only the illness itself. Slade (2009: 4) indicates the tasks needed to be undertaken by people who are in recovery.

Table 9.3: Personal tasks of recovery

TASK	ACTIVITY	EXPLANATION
Recovery task 1	Developing a positive identity	Elements which are vitally important to one person may be far less significant to another, which underlines that only the person can decide what constitutes a personally valued identity.
Recovery task 2	Framing the 'mental disorder'	Involves developing a personally satisfactory meaning to frame the experience, which professionals would understand as mental illness. Involves making sense of the experience so that it can be put in a box: framed as a part of the person but not as the whole person.
Recovery task 3	Self-managing mental disorder	Framing the mental illness experience provides a context in which it becomes one of life's challenges and self-management is critical. The transition is from being clinically managed to taking personal responsibility through self-management.
Recovery task 4	Developing valued social roles	Involves the acquisition of previous, modified, or new valued social roles. This often involves social roles, which have nothing to do with mental illness. Valued social roles provide scaffolding for the emerging identity of the recovering person. Working with the person in their social context is vital, especially during times of crisis when support, usually received from friends, family and colleagues can become most strained.

Source: Slade (2009)

How recovery is measured

These measurements will help evaluate not only change and the impact of interventions but also contribute to a dynamic model of recovery itself and help to investigate mediating factors (Care Services Improvement Partnership [CSIP], Royal College of Psychiatrist [RCPsych] and Social Care Institute for Excellence [SCIE] 2007). The recovery measurements are as follows.

Recovery Assessment Scale (RAS): Giffort, Schmook, Woody, Vollendorf and Gervain (1995) suggest the administration of a scale to measure the concept of recovery for mental health consumers, originally developed as the Recovery Assessment Scale. The scale has 24 items under five sub-scales: personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others and no domination by symptoms.

Sample statements include: 'Fear doesn't stop me from living the way I want to be', 'I know when to ask for help', 'I have a desire to succeed, even when I don't care about myself, other people do' and 'coping with mental illness is the no longer focus of my life.' The RAS can be applicable in social work practice. This assertion is confirmed by Roestenburg et al. (2016: 187) that 'to facilitate the use of an appropriate clinical perspective in mental disorder intervention, social workers opt to use an evidence-based perspective that is supported by the active utilisation of measurement tools and structured clinical approaches that are broadly classified as an ecometric perspective on practice' (Hancock et al. 2020). The RAS is a self-rated measure of mental health recovery The RAS can be administered to any MHCU (Hancock et al. 2020).

Illness Management and Recovery Scales (IMR): Mueser, Gingerich, Salyers, McGuire, Reyes and Cunningham (2004) developed the Illness Management and Recovery (IMR) scales to measure outcomes targeted by the Illness Management and Recovery Programme. The IMR programme is an evidence-based practice designed to assist individuals with psychiatric disabilities in developing personal strategies to manage their mental illness and advance toward their goals. The IMR includes 15 Likert Scale items, with a 5-point response scale wherein response anchors vary depending upon the item.

The scales are not divided into domains. Rather, each item addresses a different aspect of illness, management, and recovery (Mueser et al. 2004). IMR is appropriate in the field of social work practice. Confirming this assertion, Roestenburg et al. (2016) state that in using an ecometric approach, a practitioner will typically conduct a thorough social assessment that includes the use of specific measures, scales, and procedures to accurately describe and assess mental health associated with social circumstances and determine the most suitable interventions. Therefore, the IMR can be equated to the ecometric approach within the South African context.

Approaches of recovery

There are numerous theories of recovery; the following theories are focused on: recovery model, tidal model, and wellness recovery action plan (WRAP). These theories resonate well with the tenets of this book, namely person-first language, and empowerment of MHCUs, amongst others.

Recovery model: The mental health recovery model is a treatment concept in which a service environment is designed in such a way that mental health care users have primary control over decisions about their care (Jacob K.S. 2015). This contrasts with most traditional models of service delivery when consumers are instructed what to do or simply have things done for them with minimal if any, consultation and taking into consideration their opinions (Jacob K.S. 2015). The recovery model is based on the concepts of strengths and empowerment, indicating that if individuals with mental illnesses have greater control and choice in their treatment, they will be able to take increased control and initiative in their lives (National Association of Social Workers [NASW] 2008).

A key point of the model is that it is not the role of service providers to make decisions for consumers, but that they have a responsibility toward providing education, focussing on the possible outcomes that may result from various decisions (NASW 2008). Many staff members first react with concern when they hear that mental health MHCUs should make decisions about their care. 'What if someone decides they do not want to take prescribed medication?' is perhaps the most common and worrisome concern.

Legally, however, no adult can be forced to take medication or undergo certain treatments unless a court order or legal guardian is directing them to do so (Mental Health Act [No 17 of 2002] (Department of Health [South Africa] 2002). The recovery model does not advocate anything different. The reality of practice, though, is that MHCUs (particularly those with more chronic and debilitating disorders) are usually instructed as to what treatments and medications to take, with minimal effort on the part of practitioners to involve MHCUs in making their own decisions. The recovery model states that a programme's philosophy should acknowledge and encourage mental health care users' involvement and decision-making. Most MHCUs do ultimately ask for and take clinicians' treatment recommendations, but they need to know that they have both the right and the responsibility to make their own decisions (NASW 2008). Social workers should continue serving, supporting, and encouraging MHCUs (NASW 2008).

However, social workers must understand and accept that helping MHCUs make their own choices – good or bad – will ultimately be in the best interests of their recovery and independence, even if social workers believe that a particular action is a bad idea. As professionals, social workers need to learn to take a supportive role, rather than one as a decision-maker (NASW 2008). This may take a change in mindset for many clinicians, but they must make that change (Rammler 2005). On the other hand, there are constraints around the extent to which social workers can help someone who prefers to follow his or her path to recovery. The recovery model does not call for social workers to do anything unrealistic that would hinder the recovery of the MHCU, or that would involve treating one MHCU more favourably than another. The model calls for social workers to support MHCUs' decisions, within reason, to the best of their abilities (NASW 2008).

Tidal model: All human experience is defined by the fluid nature of human experience (Tidal Model 2016). The tidal model borrows from chaos theory in recognising that all change, growth, or development occurs through small, often barely visible, changes that follow patterns that are, paradoxically, consistent in their unpredictability (Barker and Buchan-Barker 2008). The fluid nature of life itself provides the basis for the core metaphor of the tidal model – water (Tidal Model 2016). People are in a constant state of flux as they negotiate their relationships with an infinite number of influences, some of which appear to come from the world outside and others that appear to spring from 'within' (Barker and Buchan-Baker 2008: 93). Most of this activity is imperceptible in the way, for example, that we mature or simply grow older. Only when we compare

'snapshots' taken at wide intervals, do we detect the ongoing changes. These snapshots confirm that change is the only constant; one that is largely silent and unnoticeable, but present, as change flows invisibly through our human experience (Barker and Buchanan-Barker 2008).

The Tidal Model of mental health care is founded on four key principles. First, it emphasises the importance of the natural community, viewing individuals as living on an "ocean of experience." Psychiatric crises are seen as threats that can disrupt this journey, and mental health care aims to help individuals reconnect with their life experiences (Barker and Buchanan-Barker 2005). Second, it recognises that change is a constant and often unconscious process, encouraging individuals to become aware of small changes that can significantly impact their lives (Barker and Buchanan-Barker 2005). Third, empowerment is central to the caring process, with professional helpers guiding individuals to take charge of their lives and experiences (Barker and Buchanan-Barker 2005). Finally, the therapeutic relationship is viewed as a temporary collaboration that involves caring for individuals rather than merely caring about them. While people may strive for control over their lives, the reality is that uncertainty is inevitable. Thus, the Tidal Model teaches individuals to 'swim with the tide or build a boat' (Barker and Buchanan-Barker 2004), placing the person at the centre of its theoretical framework.

The Tidal Model emphasises values surrounding human interaction during distress, guiding how we support others in their times of need based on the principle of mutual respect (Barker and Buchanan-Barker 2007). As the model gains global recognition across diverse settings, there is a growing emphasis on reaffirming these foundational values. It is increasingly acknowledged that both the 'helper' – be it a professional, friend, or peer – and the individual in distress must be equally committed to the change process, fostering a collaborative bond that facilitates progress (Barker and Buchanan-Barker 2007).

Wellness recovery action plan: the wellness recovery action plan (WRAP) is a self-management and recovery system designed to maintain wellness, decrease symptoms, increase personal responsibility, and improve quality of life (Copeland 2002). It teaches people how to keep themselves well; to be able to identify and monitor symptoms; and to use safe, personal skills, support, and strategies to relieve their symptoms. It involves people listing their maintenance activities, personal triggers, early warning signs and an intensive crisis plan (Copeland 2002). These theories are critical as they provide an understanding of the phenomenon. They provide a lens through which social workers can understand the concept more clearly. Looking at the South African mental health landscape, some of these theories will seem unachievable. Mental health is neglected in the country. More so, social workers have a critical role to play however, in most of the clinics social workers are seconded by DSD and are not employed permanently. Recovery is hindered by the frequent non-availability of patients' prescribed psychiatric medicines at community psychiatric clinics. The role of social workers at these clinics is to educate family members on symptom monitoring to alert the psychiatric nurses on impending relapses; most of these

mental health care facilities do not have permanently employed social workers but instead contract social workers from NGOs to render the sessional services at these facilities. However, WRAP might not be applicable in the South African context, albeit this is ideal as our mental health policy is aligned with recovery-oriented mental health practice.

Chapter 10
Recovery-oriented mental health practice

Introduction

Recovery-oriented practice describes an approach to mental health care that encompasses principles of self-determination and individualised care (Davidson 2008). Moreover, Davidson (2008) asserts that the mental health care users' movement has been instrumental in drawing the attention of mental health providers, researchers and policymakers toward the concept of recovery from mental disorders. Service users advocate that mental health services should be recovery-oriented (Acuff 2000; Curtis 2001). This notion has been incorporated internationally into mental health policy (Allott, Loganathan and Fulford 2000; Jacobson 2003). To achieve this, programmes based on a service's user-oriented model of recovery need to be developed and a recovery measure based on such a consumer model is required to enable further research into the processes of recovery (Andresen, Caputi and Oades 2006). Recovery orientation forges a clear direction as to how mental health services, community mental health sector organisations and related sectors should provide care and treatment for people living with mental disorders. This is evident in policies at international and national levels, with many countries seeking to develop services that work within a recovery-orientation paradigm (Commonwealth of Australia 2003, 2013; Health Scotland 2008; Mental Health Commission of Canada [MHCC] 2009; Mental Health Commission of New Zealand 2008). Supporting the personal recovery of people experiencing mental disorders has become an objective for mental health in several western countries which have made the incorporation of recovery-oriented practice as part of mental health policies (Delaney 2012; Glick, Sharfstein and Schwartz 2011). Moving towards recovery-oriented practice in mental health services is considered by many to be a paradigm shift away from a one-dimensional biomedical approach to mental health treatment where a professional is an expert treating the MHCU as a passive receiver. Instead of focussing on medical symptom relief, recovery-oriented practices aim to promote the individual's well-being and resources to gain a meaningful and satisfactory life by promoting and supporting hope, personal goals, social inclusion, and supportive relationships in collaboration where the individual becomes an expert (Borg, Karlsson and Stenhammer 2013).

The principles of recovery-oriented mental health services

The interrelated principles of recovery-oriented mental health services are outlined in a review conducted by Subandi et al. (2023), which examined guidelines from five different countries to develop a protocol for implementation in Yogyakarta, Indonesia. While the specific principles may vary

slightly between countries, they generally encompass core concepts such as empowerment, self-determination, person-centred care, hope, holistic wellness, and social inclusion. These principles emphasise the importance of individuals' autonomy and active participation in their recovery journey, recognising their unique strengths, preferences, and goals (Frost et al. 2017). Additionally, the principles underscore the need for services to foster hope, resilience, and a sense of belonging, while also addressing social determinants of health and promoting community integration. By aligning with these interrelated principles, mental health services can better support individuals in their recovery and promote overall well-being.

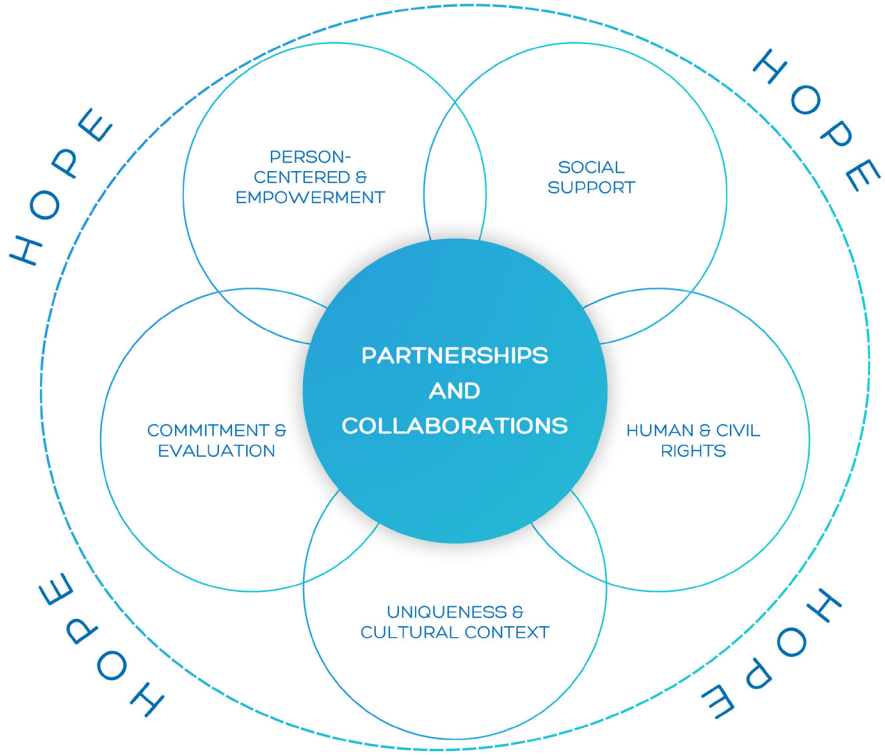

Figure 10.1: Interrelated principles of recovery-oriented mental health practice (Subandi et al. 2023)

The principles of recovery-oriented mental health services, as identified in Subandi et al.'s (2023) review, are closely aligned with those highlighted in previous studies. Hope emerges as a central principle, defined within the context of mental health recovery as a future-oriented expectation to achieve personal goals and meaningful relationships, despite the potential setbacks and complexities inherent in the journey. Hope serves as a guiding principle for both consumers and mental health professionals, with practical implications for fostering resilience and facilitating positive outcomes (Thongsalab, Yunibhand and Uthis 2023). Building and maintaining hope involves various strategies, including regaining authority through self-empowerment, creating welcoming

and accepting environments, and providing peer support (Subandi et al. 2023). Additionally, the use of positive language and culturally specific terminology contributes to cultivating hope and promoting recovery. Other key principles include organisational commitment, recognition of human and civil rights, person-centred and empowerment-focused care, and acknowledgement of consumer uniqueness and cultural characteristics (Thongsalab et al. 2023). However, implementing these principles presents challenges at multiple levels, including definitional clarity, stigma reduction, resource allocation, and policy implementation. Collaborative efforts involving diverse stakeholders and implementation strategies tailored to local contexts are essential for successfully integrating recovery-oriented principles into mental health services. While this review provides valuable insights into recovery-oriented practices, future studies should address limitations such as language barriers and the comprehensiveness of guideline coverage (Subandi et al. 2023).

Recovery-oriented practice

Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their recovery and well-being and to define their goals, wishes and aspirations (Commonwealth of Australia 2013). Additionally, Slade (2009) states that recovery-oriented practice is the practice in which health professionals, including social workers, support an individual's process of recovery. Moreover, the development of recovery-oriented practice builds on research evidence of what people experiencing mental disorders point to as supporting factors in recovery (Borg et al. 2013). However, it is described as a highly subjective non-linear process involving setbacks and progress, with some common factors, such as connectedness with other people and the community; hope and optimism about the future; a positive sense of identity; meaning in life in terms of mental illness experiences and social roles and goals; and empowerment. which have been identified and described by Borg et al. (2013). In synthesising reports and models of personal recovery, Leamy et al. (2011) present a conceptual framework given the acronym CHIME consists of 5 components which make up the recovery process – Connectedness, Hope and optimism, Identity, Meaning, purpose and Empowerment.

Spaniol et al. (2002) assert that effective medication and symptom management strategies and access to mental health services are deemed essential to an individual's recovery. Borg and Davidson (2008) highlight that social context (that is, personal relationships) and elements such as living conditions, work, education, financial situation, and community are emphasised as being crucial in the process. Moreover, capabilities for recovery-oriented practice and service delivery encompass underlying core principles, values, knowledge, attitudes and behaviours, skills, and abilities. Individuals, teams, and organisations need these capabilities to support people with mental health issues to live a meaningful and contributing life in their community of choice.

Attaining and strengthening these capabilities is an ongoing process that takes time and commitment from leaders, professionals, staff, and volunteers in mental health service provision (Spaniol et al. 2002).

Recovery-oriented mental health practice is understood as encapsulating mental health care (Commonwealth of Australia 2013):

- Embraces the possibility of recovery and well-being created by the inherent strength and capacity of all people who experience mental health issues;
- maximises self-determination and self-management of mental health and well-being and involves person-first, person-centred, strengths-based, and evidence-informed treatment, rehabilitation, and support;
- acknowledges the diversity of people's values and is responsive to people's gender, age and developmental stage, culture, and families, as well as people's unique strengths, circumstances, needs, preferences and beliefs;
- addresses a range of factors, including social determinants, that impact the well-being and social inclusion of people experiencing mental health issues and their families, including housing, education, employment, income geography, relationships, social connectedness, personal safety, trauma, stigma, discrimination, and socio-economic hardship;
- helps families or support people to understand their family member's experiences and recovery processes and how they can assist in their recovery, while also helping them with their own needs for counselling, therapy, education, training, guidance, support services, peer support and advocacy (Victorian Department of Health 2011a; Slade 2009; O'Hagan and the New Zealand Mental Health Commission 2001; Queensland Health 2005); and
- understands that people who have lived experience of unresolved trauma struggle to feel safe and consider the possibility of unresolved trauma in all service settings and incorporate the core principles of trauma-informed care into service provision (Commonwealth of Australia 2013).

Farkas et al. (2005) describe four core values associated with recovery-oriented services: 1) person orientation, 2) person involvement, 3) self-determination/choice and 4) personal growth. These values require that mental health professionals acknowledge and engage with people experiencing a mental disorder as whole persons with strengths, talents and interests, as well as limitations, that they engage in equal collaboration and recognise the individual's right to full partnership in all aspects of their recovery including deciding, planning and evaluating services to support their recovery, that they focus on the individual's right to make personal decisions and choices about aspects such as personal goals and preferred services and that they promote hope in focussing on the potential of growth inherent in all individuals regardless of their current struggles (Farkas 2007; Farkas et al. 2005).

Characteristics of recovery-oriented mental health care

It is acknowledged that the lived experiences of mental illness must be synthesised with professional experience to determine how recovery-oriented services can be best provided (Glover 2005). Themes identified in the literature as principles that should underpin recovery orientation in services include person-centred care in mental health prioritises individuals' preferences, choices, and life goals, ensuring their rights and responsibilities are balanced (Farkas et al. 2005; Walker 2006). This approach involves collaborative treatment planning based on personal choice and trust (Mead and Copeland 2000; Young, Green, and Estroff 2008). Key elements include promoting self-determination, treating individuals as equals (Mead and Copeland 2000; Farkas et al. 2005), and understanding their whole-life context, including health and substance use (Western Australia Department of Health 2004). Recovery-oriented services should focus on individuals' strengths, foster hope, and support community integration (Farkas et al. 2005; O'Connell et al. 2005). Staff should embody recovery principles, emphasising empathy over diagnosis (Mental Health Foundation of New Zealand 2008; Mead and Copeland 2000). Additionally, services must adhere to national standards (Western Australia Department of Health 2004), be informed by lived experiences (Glover 2005) and evidence-based practices (Deegan 2003) and promote participation in service planning while challenging stigma and protecting human rights (Jacobson and Greenley 2001; O'Connell et al. 2005). Balancing personal growth with risk and fostering connections among individuals experiencing psychiatric symptoms are crucial for effective recovery-oriented programmes (Young et al. 2008; Davidson 2008).

Recovery-oriented service delivery

Recovery-oriented mental health services provide evidence-informed treatment, therapy, rehabilitation, and psychosocial support that aims to achieve the best outcomes for people's mental health, physical health and well-being (Victorian Department of Health 2011a). Service delivery is centred on and adapts to people's needs and aspirations rather than people having to adapt to the requirements and priorities of services (Frost et al. 2017). Recovery-oriented services accept all people and offer them respect and safety (Commonwealth 2013). Recovery is a vision and commitment shared at all levels of an organisation (Commonwealth 2013). A diverse, appropriately supported, and resourced workforce that includes people with lived experience sustains the vision. It includes peer-run programmes and services (Victorian Department of Health 2011b).

In advocating for the social inclusion and human rights of people with mental health issues and in seeking to reduce stigma and discrimination, recovery-oriented services work in partnership with consumer organisations and a

broad cross-section of services and community groups. A recovery-oriented mental health service operates within legislative and budgetary frameworks (New Zealand Mental Health Commission 2001) by leveraging its expertise and resources alongside the experiences of individuals with lived mental health issues. Such services empower individuals to take responsibility for their mental health and well-being, encouraging them to reclaim active roles in their lives. They promote the recognition of strengths, resilience, and the inherent capacity for a fulfilling and meaningful life. Additionally, these services foster acceptance and inclusion within local communities, enabling meaningful interactions between individuals with mental health issues, their families, and the community. Furthermore, they acknowledge the potential presence of unresolved trauma as a contributing factor to mental distress among those accessing the service.

Janse van Rensburg (2012) asserts that the adoption and integration of a recovery framework should include the following essential steps: The promotion of recovery awareness in all aspects of services, such that personal recovery outcomes become the universal goal according to which service provision is measured; the introduction of active measures to combat discrimination against individuals with psychosocial disabilities within mental health care services and on a societal level; the introduction of progressive programmes in all services to establish and further develop consumer involvement in service feedback, planning and delivery; introduce steps to improve accessibility to the wide range of treatment and support services required for recovery; and the strengthening of primary-level and community-based mental health services to improve prevention, rehabilitation and restoration of social roles (Janse van Rensburg 2012).

Self-determination is the foundation of service delivery (Roberts 2000). People working toward benefitting those with mental distress believe in their self-determination (Bentall 2004). They enhance self-determination by fostering hope, offering a choice of responses, and ensuring a quick return to active citizenship. They foster the leadership of service users in their recovery and at a collective level through their advocacy and workforce roles (Bentall 2004). Families retain hope for their family members. They are supported and educated to enhance the recovery of a family member as well as the recovery of the family unit from the stresses associated with mental distress. All families have access to family peer support and recovery education (Ministry of Health in New Zealand 2008). People in the wider community understand that people suffering from mental distress are not especially prone to violence and usually retain their competence and that services cannot prevent all tragedies. They see major mental distress as a fully human experience and think discrimination against people with mental distress is wrong. Community members, without the blinkers of fear and discrimination, are valuable stakeholders in the planning, delivery, and evaluation of responses (New Zealand Mental Health Commission 2003). The language people use reflects the purpose, values, and assumptions that services are built on, especially the roles of service users

as active agents in their recovery, the broad understandings of mental distress and the anticipation of recovery (Stuart 2016). The new language values are both subjective and objective. It emphasises internal autonomy over external authority. In the context of respectful relationships with service users, workers feel uncomfortable describing them with terms such as 'non-compliant', 'lacking insight', 'inappropriate' or 'manipulative' (Onken et al. 2007).

Recovery-oriented social work practice in mental health

Social work has made significant contributions to the recovery movement, and, in turn, the movement has reinvigorated our professional position in mental health (Khoury and del Barrio 2015).

Historically and currently, social work has been a major provider of mental health services, by some estimates delivering half of the professional services provided to individuals with psychiatric conditions. The profession has strong theoretical and historical ties to mental health recovery-oriented frameworks and shares many of the same essential values, ethics, and practice perspectives (Khoury and del Barrio 2015). The National Association of Social Workers (NASW) (2008) and Gregorian (2005) drew attention to the fact that social workers should be considered and included in plans for healthcare reform as they contribute to the outcomes. In a country as diverse and unequal as South Africa, one would expect that the role of social workers in addressing the population's needs would have been more explicit, given the importance of their role in the nation's transformation and the 2030 agenda for sustainable development to 'leave no one behind', according to the United Nations Sustainable Development Group (2016). Unfortunately, acknowledgement and inclusion of the role of social workers are absent in most of South Africa's policies and reforms. This lack of acknowledgement of social work in health care in transformation suggests the possibility of only limited awareness and understanding of the role and contribution of social work in health care. It raises the possibility that devoid of social work consultation and acknowledgement, health care reform may be ineffective.

Social workers' training in direct practice, systems change, and policy practice can influence and enhance the recovery of individuals with lived experience of psychiatric diagnoses on both micro and macro levels (Khoury and del Barrio 2015). Social workers are well-versed in how to effectively and collaboratively advocate for rights and protections that must be afforded to their clients (NASW 2021). In the South African context, the South African Federation for Mental Health (SAFMH) strengthens existing advocacy groups, supporting the establishment of new ones where such groups are still lacking, identifying individuals with leadership potential, and developing them into leaders for the mental health movement around which ongoing advocacy and awareness activities can be built. Given the need for continued systemic change, there is an opportunity and ethical imperative for social workers to collaborate with the MHCUs in that effort (Khoury and del Barrio 2015).

Several themes encapsulate the recovery-oriented perspective for social workers (Council on Social Work Education [CSWE] 2016). Recovery-informed practice is aligned with the ethical standards of the social work profession and the core values of self-determination, empowerment, and social justice (Kourgiantakis, Hussain and Ashcroft 2020). Recovery-oriented social workers use the world of the person with lived experience of psychiatric diagnoses as the lens through which they operate and believe that individuals can and do recover from psychiatric conditions; this is the foundation on which recovery-oriented practice is built (Kourgiantakis et al. 2020). Research has shown that having at least one person who believes in the individual with psychiatric diagnoses encourages his or her recovery; combats the effects of stigma, discrimination, and shame; and is critical to the individual's recovery. Social workers supporting individuals with psychiatric conditions should at minimum be their stalwart champions (Khoury and del Barrio 2015).

Recovery-oriented social workers seek to amplify the voices of individuals with lived experiences of psychiatric diagnoses (CSWE 2016). They engage in treatment that emphasises goal-directed outcomes, is directed by their clients and includes clients' families and significant others with their client's permission (CSWE 2016). The more meaningful options presented to the client, along with the evidence that supports these interventions, the better informed the individual will be when evaluating possibilities and weighing the consequences of his or her decisions (Karpetis 2018). Additionally, an expectation of life beyond the mental health system through community and social inclusion and emphasis on natural community support instead of formalised services or supports and recommending peer support networks and services, are part of a recovery perspective (Khoury and del Barrio 2015). Self-advocacy can be a better strategy that will amplify the voices of the MHCUs. This is also confirmed by Lee (2022) who asserts that self-advocacy is the ability to communicate what your needs are. In support of the theme of self-advocacy, the SAFMH highlighted the importance of storytelling and the need to amplify the voices of MHCUs in the fight against continued stigma and discrimination when it comes to psychosocial disability (PD). Research shows that when persons with mental illness, including those with PD, share their stories, it can have a positive impact on how the rest of society perceives them (American Psychiatric Association 2020). SAFMH's campaign hoped to have harnessed the stories and provided a platform for different voices to be heard and acknowledged. To become a recovery-oriented social worker, it is essential to recognise the critical role of social work training in facilitating recovery for individuals with psychiatric diagnoses, addressing both micro and macro levels (Council on Social Work Education 2011). Social workers leverage their expertise to advocate for clients' rights, promoting collaboration and empowerment. Their focus on activism, social justice, and civil and human rights distinguishes social work from other behavioural health fields. Given the ongoing need for systemic change, social workers are ethically obligated to engage in partnerships with clients, actively participating in efforts to drive systemic transformation.

A recovery-oriented social worker (CSWE 2011) addresses institutional bias in diagnosis by critically examining disparities across different groups and promotes cultural humility by respecting the knowledge of individuals with lived experiences. They support the integration of meaningful cultural and spiritual practices in recovery (AHP 2011), and explore the effects of stigma and labelling (CSWE 2011). Advocacy for recovery-oriented practices and social justice is essential, in confronting oppression, stigma, and discrimination. Social workers focus on empowering clients to set personal goals, assessing for trauma, co-occurring disorders, and strengths, and using evidence-based interventions like family psychoeducation and peer support. They assist clients in expanding social networks, facilitating self-directed care, and ensuring clients are central decision-makers in their recovery. Additionally, social workers promote nonpharmacological treatments, wellness strategies, and develop comprehensive recovery plans across life domains, while helping clients access resources and overcome barriers.

This section illustrates the application of recovery-oriented practices within supported employment, providing insight into how individuals with mental health challenges are empowered to take control of their lives, drawing upon the principles of recovery-oriented mental health care. It demonstrates the practical implementation of such practices. Self-advocacy emerges as a pivotal aspect highlighted in this discussion, underscoring the importance of individuals advocating for themselves. Furthermore, the narratives of individuals with mental health challenges are amplified, showcasing their resilience in overcoming obstacles to accessing resources and achieving their objectives. In this context, recovery-oriented social workers play a crucial role in ensuring equitable treatment for individuals with mental health challenges and upholding their human rights.

The synergy of social work values and recovery-oriented principles

There are significant similarities between the core values of social work and some of the central tenets of the recovery model. Taking them one by one as categorised by Corrigan et al. (2005):

- **Self-determination** – is one of the most important aspects of recovery. People who exercise self-determination play an active role in their recovery process. This also includes self-responsibility. In this case, the locus of control exists within the person. This fits well with the strength's perspective, a theory both at the base of the recovery paradigm and social work practice.
- **Social Justice (Stigma)** – in this core value, the major cause of social injustice has been the historic and ongoing stigmatisation of persons with serious mental illness. Much has been written about ways in which people can work to reduce stigma. This value, applied to recovery,

encourages advocacy, education of others and a mutual process with all the constituent groups.

- **Importance of Human Relationships (dignity and worth)** – equating this value with recovery from serious mental illness speaks to having non-stigmatised, mutually respectful relationships with people where growth is the goal. The focus is on reconnecting or simply connecting with various communities and individuals to alleviate the loneliness and disaffiliation that persons with serious mental illness experience. While social justice involves working for change both macro and micro, valuing human relationships is expressed more frequently through one-to-one relationships between workers and clients/consumers/survivors.
- **Service** – is where biases in our profession become evident. Unfortunately, desirable clients and people with serious mental illness remain quite near the bottom of the pecking order. From social work education through our progression of jobs, working with persons with serious mental illness is not desirable. Those clinicians who chose to work with this population are often painted with a similar brush. Our core values include service to those most in need, yet we often need to be reminded of that when the opportunity for an internship, a first job, or a career to work with serious mental illness presents itself.
- **Competence** – it is puzzling as to why those who are in most need of expert care wind up with people who have the least amount of expertise as caregivers. We often refer to those who work with this population as case managers, not social workers, or clinical social workers. In keeping with the de-professionalisation of social work, case managers often have minimal amounts of training, though there are exceptions to this. Without adequate salaries, in addition to the difficulty of working in this area, it is hard to attract and keep competent professional social workers. Competence can also be seen from another perspective. We practice with knowledge and appreciation of the population with which we are working. If we believe (even on a subconscious level) that people with serious mental illness are not going to get better, why should we learn about them? If the goal is maintenance, then anyone can do it.

Traditional mental health versus recovery-oriented approach

Traditional mental health services typically adhere to a medical model approach, focussing primarily on diagnosing and treating mental illnesses through medication and therapy prescribed by healthcare professionals (Biringer et al. 2016). These services often prioritise symptom management and stabilisation, with limited involvement of the individual in their treatment decisions. In contrast, recovery-based mental health services adopt a holistic wellness approach, emphasising empowerment, individualised support, and the active participation of individuals in their recovery journey (Biringer et al. 2016).

Rather than solely focussing on symptom reduction, recovery-based services aim to help individuals achieve meaningful life goals, such as employment and social relationships, while building resilience and coping skills (Biringer et al. 2016). Additionally, recovery-based services view relapse as a natural part of the recovery process and emphasise learning from setbacks (Biringer et al. 2016). They also recognise the importance of social support networks and aim to reduce stigma by promoting a strengths-based approach that highlights individuals' abilities and potential for recovery (Biringer et al. 2016). Overall, recovery-based mental health services represent a shift towards a person-centred, strengths-based approach that prioritises autonomy, resilience, and community integration in supporting individuals with mental health challenges.

Traditional services and recovery-based services are best seen as two ends of a continuum. Most services in 2008 were somewhere between the two. The citizens and the recovery-oriented mental health staff recognise the importance of social, economic, political, psychological, spiritual, and biological contributors to mental distress and loss of well-being. Mental disorder is seen primarily as a way of being, with associated personal and social barriers to living well, as well as a fully human experience from which value and meaning can be derived (Roberts 2000).

Table 10.1: Overview of traditional mental health versus recovery-oriented practice

		TRADITIONAL SERVICES	RECOVERY-ORIENTED SERVICES
Beliefs	CONTINUUM		
	View of madness	- Pathology - No meaning	- Crisis of being - Fully human experience
	Philosophy	- Treatment - Paternalism	- Recovery - Self-determination
	Language	- Medical - Objective - "They"	- Personal - Subjective - "We"
Consumers	**Service**	Passive recipients	Active agents and leaders
	Users		
	Families	Unsupported and grieving	Supported and positive
	Workforce	- Mainly medical/clinical - Expert authorities	- Diverse backgrounds - Collaborators
	Communities	Fearful and discriminatory	Accepted and inclusive
Service	**Service types**	Drugs and hospitals	- A broad range of therapies; support; recovery - Education and Advocacy
	Service cultures	- Authoritarian - Segregation from society	- Participatory - Inclusion in society
	Service settings	Hospitals and clinics	- Community and home-based crisis and other services - Online services
Outcomes	**Social networks**	Service community	Natural community
	Housing	- Hospitals - Residential services	Own home
	Employment	- Pre-vocational services - Sheltered workshops - Unemployment	- Real work for real pay - A valued contribution to society

Source: Destination Recovery, Mental Health Foundation of New Zealand (2008: 49)

In South African indigenous or tribal healing practices, the internal means of discipline are intricately linked with ensuring the safe and just treatment of MHCUs (Sorsdahl, et al. 2009). These practices, deeply rooted in cultural and spiritual traditions, are passed down through generations and upheld by the teachings of wise elders and healers. Discipline within these traditions is maintained through mechanisms such as ostracism, word-of-mouth criticism, and ceremonial rebuke by elders, all aimed at preserving adherence to cultural norms and ethical standards. Unlike Western healthcare systems, which rely on externally imposed codes of ethics, indigenous healing operates within its own cultural and spiritual framework, viewed as a sacred process rather than a regulated profession. Consequently, it is regarded as an individual freedom and not subject to outside regulation. While indigenous healing may not require external codes of ethics, there is recognition of shared ethical principles across healing traditions. Therefore, identifying and articulating these shared ethical concepts can strengthen the voice of healing professions, promoting a more unified and potent manifestation of healing energies. However, in contexts where indigenous healing practices are adapted within Western frameworks, such as Western shamanism or Western sangomas, it may be pertinent to develop a code of ethics tailored to the specific cultural and professional context, ensuring the safe and just treatment of MHCUs within those settings.

The collaboration between official/formal mental health services and indigenous/traditional healing practices varies depending on the context and region. In some instances, there are efforts to integrate traditional healing methods into formal mental health services, recognising the value of cultural practices in promoting well-being among indigenous communities. This integration may involve partnerships between Western-trained mental health professionals and traditional healers, joint training programmes, or referrals between the two systems. However, the extent of collaboration between formal and traditional mental health services can vary significantly. In some cases, there may be barriers to collaboration, such as differences in approaches, language barriers, or lack of understanding and respect for traditional healing practices by formal mental health professionals. Additionally, funding constraints and institutional policies may also hinder collaboration efforts (Starkowitz 2013).

Regarding the application of formal codes of ethics and standards of practice, it's essential to recognise that traditional healing practices often operate within their own cultural and spiritual frameworks, guided by their ethical principles and norms. While formal codes of ethics and standards of practice are important within Western mental health systems, they may not always directly apply to traditional healing practices. However, efforts can be made to ensure that collaboration between formal and traditional mental health services is conducted ethically and respectfully, with a mutual understanding of roles, practices, and ethical considerations. This may involve developing guidelines or protocols for collaboration that respect the autonomy and cultural integrity of traditional healing practices while also upholding the ethical standards of formal mental health services (Sorsdahl et al. 2009). Overall, fostering meaningful

collaboration between formal and traditional mental health services requires sensitivity, respect, and a willingness to bridge cultural and professional divides.

Traditional healing modalities and the recovery-oriented approach exhibit both similarities and differences. Both paradigms emphasise a holistic perspective on health, acknowledging the interconnectedness of physical, emotional, mental, and spiritual well-being (Sorsdahl et al. 2009). However, traditional healing modalities are deeply entrenched in the cultural and spiritual traditions of specific communities, passed down through generations, while the recovery-oriented approach is more adaptable to diverse cultural backgrounds. Both approaches prioritise the empowerment and self-determination of individuals in their healing journey, though traditional healing often draws on cultural resources and practices unique to each community. Treatment in traditional healing may involve herbal remedies, rituals, and ceremonies, while the recovery-oriented approach focuses on supporting individuals in achieving personal goals beyond symptom management. Integration with formal mental health services varies, with traditional healing often operating independently within cultural frameworks, while the recovery-oriented approach is typically integrated within formal mental health services. Ethical considerations differ, with traditional healing often guided by internal means of discipline and cultural norms, whereas the recovery-oriented approach adheres to formal codes of ethics within mental health professions. In summary, while both modalities share goals of promoting well-being and empowerment, their approaches to mental health and healing are shaped by distinct cultural, historical, and institutional contexts.

Incorporating traditional healing modalities into recovery-oriented practices enriches mental health care with diverse cultural perspectives and holistic wellness approaches. Rooted in cultural and spiritual traditions, traditional healing offers valuable insights into the interconnectedness of mind, body, and spirit, aligning closely with the holistic principles of recovery-oriented care. These practices prioritise empowerment and self-determination, drawing upon cultural resources and community support systems to facilitate healing journeys. While differing from Western approaches in techniques and ethical frameworks, both share the goal of promoting well-being and resilience. Integrating traditional healing into recovery-oriented practices fosters cultural competence, respects diverse traditions, and enhances support for individuals seeking holistic pathways to recovery (Sorsdahl et al. 2009).

Application of recovery-oriented principles in practice

Shepherd (2007) suggests that there are recovery-orientation questions that staff can ask people who come for mental health services, which can also be used for evaluation including:

- Did I promote the person's involvement in their care planning?
- Did I promote their sense of personal control (negotiate over treatment

and medication options)?
- Did I promote 'hope' (maintain high expectations, a sense that key life goals can be achieved, despite the reality of severe mental health difficulties)?
- Did I help the person develop methods of self-management (for example, give links to useful information sites about mental health problems, treatment, medication and its side effects, self-help materials, local self-help and support groups and explore and support personal coping strategies)?
- Did I help the person with employment options?
- Did I demonstrate a belief that they can work if they want to?
- Did I show a willingness to listen to the problems?
- Do they perceive getting back to work and did I advise them as to how this can be achieved?
- Did I ensure that they have stable and safe accommodation of a reasonable standard that they are happy with?
- Did I help them access mainstream community activities (education, leisure, sports, church)?
- Am I aware of their existing social networks and want to build on them?
- Did I talk to them about how to best deal with problems of stigma and social inclusion?

Evidence-based practice (EBP) and recovery-oriented mental health services

During the past decade, confidence in scientific research, with its objective observations and measures, has increased considerably in the mental health arena (Frese et al. 2001). In recent years, this increased confidence in scientific treatment methods for mental illnesses has given rise to a movement that calls for the more widespread adoption of treatment approaches that are scientifically grounded (Frese et al. 2001). This movement has been developing under the rubric of evidence-based practices (Frese et al. 2001). Under this concept, the call for greater reliance on scientific evidence is being extended to treatment approaches that are supported by psychological and sociological evidence as well as by the findings of biological research (Frese et al. 2001).

Evidence-based practices (EBPs) are defined by the Institute of Medicine as 'the integration of best-researched evidence and clinical expertise with MHCU values' (Institute of Medicine [US] Committee on Quality of Health Care in America 2001). In a series of articles on EBPs, the Journal of Psychiatric Services has identified a core set of interventions that improve outcomes for persons with serious mental illness (SMI). They include assertive community treatment (ACT), family psychoeducation, medication for specific conditions, supportive employment, and integrated treatment for co-occurring substance use disorders (Drake, Mueser and Torrey 2000; see also Chapter Eight). Drake et al. (2001: 393) assert that 'mental health services should not focus

exclusively on traditional outcomes such as compliance with treatment and relapse or rehospitalisation prevention but should be broadened to include helping people to attain such consumer-oriented outcomes as independence, employment, satisfying relationships and good quality of life.' They claim that evidence-based practices 'do not provide the answers for all persons with mental illness, all outcomes, or all settings.'

Evidence-based practices (EBPs) are interventions for which there is consistent scientific evidence, showing that they improve MHCU outcomes (Drake et al. 2001). For example, research shows that using antipsychotic medications within a specific dosage range and providing education and skills training for family caregivers over several months, prevents or delays relapse in MHCUs (Drake et al. 2001). Moreover, these authors point out that the requirements for scientific evidence used by different groups sometimes vary, but in general, the highest standard is several randomised clinical trials comparing the practice to alternative practices or no intervention. Drake et al. (2001) indicate that various practice guidelines developed in the 1990s by the agency – then known as the Agency for Health Care Policy and Research – exemplify this approach by using three levels of evidence:

- Level A: refers to good research-based evidence, with some expert opinion.
- Level B: indicates fair research-based evidence, with substantial expert opinion to support a recommendation.
- Level C: denotes a recommendation, based primarily on expert opinion, with minimal research-based evidence.

Bond, William and Evans (2000) assert that although the term evidence-based practice is sometimes used to refer to guidelines that are not based on research, true evidence-based practices are grounded in consistent research evidence that is sufficiently specific to permit the assessment of the quality of the practices rendered as well as the outcomes. The crux of the matter is that precisely because evidence-based practices are grounded in the qualifications imposed by current science, they are standardised, replicable, effective and a switch to research-based interventions with known effectiveness that can dramatically improve outcomes in large practice systems, for example, the overall rate of employment of persons with severe mental illness (Drake et al. 2001). Additionally, the authors assert that the central strategy in defining evidence-based practices is to be straightforward about the limits of the evidence. The provision of evidence-based practices, even under constrained conditions, would be an improvement and would move stakeholders toward awareness of the potential of other evidence-based practices (Torrey et al. 2001). For example, research indicates that assertive community treatment does not consistently improve vocational outcomes and that supported employment must be a well-integrated component of the intervention to achieve high rates of competitive employment (Bond, Becker and Drake 2001). Thus, providing assertive community treatment should increase pressure to implement

supported employment (Torrey et al. 2005; see also Chapter Nine).

Evidence-based practices (EBPs) play a crucial role in informing and enhancing recovery-oriented services within the mental health care landscape (Drake et al. 2001). While EBPs and recovery-oriented approaches are distinct frameworks, they are not mutually exclusive; rather, they can complement each other to provide comprehensive and effective care. EBPs, rooted in empirical research and clinical evidence, offer standardised interventions that are effective in treating mental health conditions. These interventions often focus on symptom reduction and stabilisation, which aligns with some aspects of recovery-oriented care. However, recovery-oriented services go beyond symptom management to emphasise empowerment, self-determination, and holistic well-being (Torrey et al. 2001). Therefore, integrating EBPs into recovery-oriented services can offer a balance between evidence-based treatment and person-centred care, ensuring that individuals receive the most appropriate and effective interventions while also addressing their broader recovery goals. This synergy between EBPs and recovery-oriented approaches enhances the quality and effectiveness of mental health care, ultimately promoting the well-being and recovery of individuals experiencing mental health challenges (Bond et al. 2001).

Evidence-based practices (EBPs) are highly relevant to this chapter as they form a cornerstone of modern mental health care, providing empirically validated interventions that have demonstrated effectiveness in treating various mental health conditions. Within the context of this chapter, which likely discusses mental health care and interventions, EBPs offer a framework for understanding and implementing evidence-based treatment approaches (Drake et al. 2001). While recovery-oriented services prioritise empowerment, self-determination, and holistic well-being, EBPs contribute to the overall quality of care by offering standardised interventions that address symptom reduction and stabilisation. Thus, discussing EBPs within this chapter provides insight into the integration of evidence-based treatment approaches with recovery-oriented principles, highlighting the importance of evidence-based practice in ensuring individuals receive appropriate and effective care tailored to their needs (Bond et al. 2000).

Chapter 11
Implementation of recovery-orientated social work practice in mental health care

Introduction

Social work is a crucial profession in the field of mental health globally and the profession has values that are associated with a recovery paradigm. Nevertheless, there are gaps in understanding of how social workers are applying the recovery paradigm in practice (Kourgiantakis et al. 2020). The World Health Organization (WHO) (2013) identifies social work as a key profession in mental health across 149 countries. An American survey found that social workers' most common specialty practice area is mental health and most social workers engage with individuals and families with mental health concerns even when working outside of this specific field (Kourgiantakis et al. 2020). Irrespective of their practice domain, most social workers support clients with mental disorders (96 per cent) and addiction concerns (87 per cent) (Whitaker, Weismiller and Clark 2006). The recovery paradigm is strongly associated with social work values and conceptual frameworks promoting empowerment, partnership and choice informed by ecosystems theory and a strength-based model (Carpenter 2002; Davidson and White 2007).

Despite social work's unique alignment with the recovery paradigm, researchers argue that social work has not had a strong voice in challenging and critiquing the dominant biomedical model (Hyde, Bowles and Pawar 2015; Khoury, Rodriguez and del Barrio 2015). There are gaps in understanding the extent to which social workers are applying recovery guiding principles in practice (Khoury et al. 2015; Loumpa 2012). Researchers have identified several impediments to implementation, including the lack of a universal definition of recovery-oriented care and a paucity of evidence-based research to inform practice (Hyde et al. 2015; Williams, Almeida and Knyahnytska 2015). The organisational context may also influence implementation by pressuring social workers to adhere to institutional policies and procedures that may be incongruent with recovery principles (Hyde et al. 2015).

Williams et al. (2015) contend that recovery does not sufficiently deal with sociopolitical issues related to power and control over mental healthcare. Social work's core value of social justice can make valuable contributions to advancing how recovery is implemented in mental healthcare systems; however, social work has also been critiqued for its conformity to dominant structural systems that are not recovery-oriented and perpetuate stigma and discrimination (Williams et al. 2015). Considering the important role of social workers internationally, we need a greater understanding of how social workers are conceptualising and implementing recovery in mental health (Substance Abuse

and Mental Health Services Administration [SAMHSA] 2012). Moreover, research has shown that recovery-oriented practice is ambiguous, and it is important for clinicians to learn to operationalise this concept and guidelines needed that are context-specific (Le Boutillier, Leamy and Bird 2011). There is a lack of guidelines for the clinical application of recovery-oriented care and attempts to operationalise this has been through the lens of organisational priorities (Le Boutillier, Chevalier and Lawrence 2015).

Implementing recovery-oriented mental health practice

The development and implementation of recovery-oriented mental health policies and services are current themes in the ongoing process of mental health reform in many countries (Shera and Ramon 2013). Examples of how recovery-oriented practice has been implemented, focussing on two countries: the United Kingdom (UK) and Canada are discussed further.

Implementation of recovery-oriented mental health practice in the United Kingdom (UK)

The new meaning of recovery appeared in the national policy arena of the UK in 2001 – yet another import from the US – and was initially championed by service users, several of whom feel that it has since been taken over by professionals in terms of claiming the credit for leading and developing this approach without following its key principle – namely the need to ensure that service users are in control of their own lives (Wallcraft 2005). Wallcraft further explains that without the involvement of professionals in the process of implementation, recovery cannot become embedded in the UK's mental health services. Furthermore, formal decisions were being taken collaboratively through the system of the care programme approach (CPA), which requires a written plan, periodically reviewed by care coordinators. While consultant psychiatrists chaired the meetings, care coordination was carried out by a variety of other professionals (nurses, occupational therapists, social workers) (Wallcraft 2005).

ReFocus is a five-year project that began in 2009 and is aimed at enhancing the evidence base of recovery-oriented practices (Leamy et al. 2011). It has created recovery-evaluation tools to accompany the introduction of recovery practice to an urban and a more rural-based mental health trust. The project was funded by the National Institute of Health Research (NIHR) in the UK and led by Professor Mike Slade at the Institute of Psychiatry. This project has developed its own set of measures and an intervention manual that uses a randomly controlled trial sample (Slade, Bird and Le Boutillier 2010), the largest sample of a UK recovery study. Castillo (2010) conducted a major research project in Colchester, England exploring the meaning of recovery and evaluating the contribution of The Haven model to recovery. Qualitative data was collected from 60 service users and six carers, through some repeated focus groups and individual interviews (Castillo 2010). Quantitative data was collected for the

Department of Health, which co-funded the project. The findings demonstrate a hierarchy of conditions that should be met before reaching the pinnacle of the pyramid termed 'transitional recovery'. These include being safe and developing trust in others, feeling cared for, accepting boundaries, community belonging, and developing 188 abilities, hopes, ambitions and achievements. The positive stories of people who have implemented recovery engender hope that the bottleneck can be changed through a cultural change in the organisations in which staff is working (Ramon 2011) and through a fundamental change in the basic training each professional receives (Anderson and Holmshaw 2012). Parallel to working with service users, mainly by other service users who have already applied the recovery approach to their lives and with like-minded service providers, it is necessary to change the internalised negative self-identity (Bovink 2012; Deegan 1993; Glover 2012). A considerable effort to enhance mental health service users' involvement in auditing, planning and research has been made by the National Health Service in the UK. This development has been, in part, due to ongoing pressure from the UK service users' movement, which has argued for a long time that no decisions about them should be taken without them.

While this is an achievement, too few are actively engaged in these activities, and consultation fatigue is often expressed (Bovink 2012). The concept of shared decision-making (SDM) has become the most recent UK policy keyword in mental health (National Institute for Health and Care Excellence [NICE] 2009; Department of Health [United Kingdom] 2011). SDM is indeed rooted in the recovery and strengths approaches, which argue that people with mental illness can participate in decision-making and in making relevant decisions about their own lives. However, SDM, in the context of treating the experiential knowledge of service users as worthy of systematically being considered in clinical decisions, hardly exists in everyday mental health practice, especially concerning psychiatric medication. The latter is an aspect worthy of consideration and not only because of the centrality of medication as a mental health intervention. It has been known that 50 per cent of MHCUs do not take their medication regularly (Nose, Barbui and Tansella 2003) and do not share this decision with their prescriber. Nose et al. (2003) are of the view that people voluntarily decide to stop taking medication but are afraid to share this information with the professionals they are working with. Furthermore, there is evidence that these are considered decisions not simply taken spontaneously (Roe et al. 2009; Malpass et al. 2009). There is limited knowledge about existing alternatives to medication. Likewise, approaching medication as one option within a range of what Deegan has called 'personal medicine,' namely the strategies people should sustain their well-being (Deegan, Rapp and Holter 2008: 603), is not practised.

Implementation of recovery-oriented mental health practice in Canada

Many efforts to reform mental health services in Canada have been undertaken over the past several decades (Shera and Ramon 2013). Additionally, Shera and Ramon (2013: 18) have identified some central themes in these initiatives:

- Correcting the imbalance between institutional and community-based care.
- Moving toward a more comprehensive array of services which include treatment, rehabilitation, prevention and the promotion of mental health.
- Devolving governance of mental health services at regional and local levels to increase responsiveness.
- The recognition that mental health care should not be limited to formal mental health supports.
- The involvement of MHCUs and their families as partners in the planning, delivery and evaluation of mental health services.

Shera and Ramon (2013) assert that these themes continue to be central to both provincial and national efforts at reform. In Canada, the Canadian Mental Health Association has been very influential in implementing its policy document.

In terms of the implementation of this transformed delivery system, the committee strongly endorsed the shifting of resources from the institutional sector to the community. But in recognition of the time that this will take, they recommended a Mental Health Transition Fund to cover the transition costs and make a major investment in community-based services (Shera and Ramon 2013). The commission's Knowledge Exchange Centre (KEC) was designed to improve the lives of people living with mental illness by creating ways for Canadians to access information, share knowledge and exchange ideas about mental health. This is divided into three major activities:

- **Sharing** – facilitates access to information through interactive publications and the provision of searchable databases and protocols that can be used to identify best practices in mental health.
- **Collaboration** – a commitment to collaborate with leading individuals, organisations and users to bring expertise together and foster knowledge, exchange networks, communities of practice and inter-agency alliances.
- **Support** – which will develop individual and organisational capacity to engage in knowledge exchange by using toolkits, offering workshops and implementing knowledge activation initiatives (Shera and Ramon 2013).

The **At Home project** is based on the Housing First model, which assumes that a place to live is critical to focus on other personal issues. This initiative received $180 million in federal funding and is being implemented in five

cities across Canada, intended to provide evidence regarding how to best help people who are mentally ill and homeless. More than 2,000 homeless persons have been involved in this project. A final evaluation of the project was made available in 2013 (Shera and Ramon 2013). The Peer project intends to enhance the utilisation of peer support (O'Hagan et al. 2010) through the creation and application of national standards of practice. It involves using peer-based education strategies to encourage a change in societal attitudes toward mental illnesses, specifically targeting youth in schools and adults in workplaces. The expectation is to develop evidence-informed standards that will enhance the credibility of peer-based services. The commission's most ambitious project is the Partners for Mental Health initiative, which is a grassroots advocacy movement, committed to repositioning mental health on the national agenda. It uses a web-based social media approach to create an online community that will advocate for major changes in the policies, programmes and supports around mental health. The target is to mobilise a million people to advocate for the transformation of the mental health system (Canadian Mental Health Association 2003).

A leading example of a consumer/survivor initiative (CSI) organisation is the **Krasman Centre**, which promotes itself as a place to be label-free and offers hassle-free recovery-oriented programmes (Shera and Ramon 2013). It offers peer-based programming, wellness and recovery support, family support, a telephone support line (WARM line), arts-based therapeutic programmes, self-help groups, a drop-in centre (with computers, a meeting room, laundry and shower facilities for the homeless) and WRAP programmes. Moreover, Shera and Ramon (2013) point out that there has been an increasing demand for peer-support workers and to help meet this need, the centre has developed the Peer Recovery for Employment and Resilience programme.

The programme is designed to support individuals' recovery and to prepare them to enter the peer, recovery, mental health, or social service workforce (Shera and Ramon 2013). **The Dream Team**, a group of consumers/survivors, has been involved in telling their stories of coping and recovery over several years. They obtained a grant from the Wellesley Institute to test their perceived assumption of the value of supportive housing by conducting a community-based research process that brought residents, housing providers and neighbours together. This study found that supportive housing does not hurt property values or increase crime but that supportive housing residents make important contributions to the strengths of their neighbourhoods, and they add to the economy and vibrancy of the area.

There is no doubt that the consumer/survivor movement has been a major force in promoting recovery-oriented mental health reform in Canada (De Wolff 2008). Another initiative, **Mental Health First Aid**, has trained more than 50,000 individual Canadians to respond to mental health emergencies. They are taught to recognise the signs and symptoms of mental health problems, provide initial help, and guide toward appropriate professional help. Many of these trainees have become instructors (train the trainer model) (Shera and Ramon 2013).

There are differences in the implementation of recovery-oriented mental practice in these two countries. In the UK, recovery-oriented mental health practice was initiated by the users, many of whom felt that it has since been taken over by professionals in terms of claiming the credit for leading and developing this approach without following its key principles, namely the need to ensure that service users are in control of their own lives. Most of the projects have not incorporated a strengths-based approach and still focus on deficit-based treatment. On the other hand, in Canada, recovery-oriented mental health practice is service-user-led and there is a collaboration between the stakeholders.

Canada has adopted the Friendship Bench concept since 2015. The Friendship Bench uses a task-sharing approach to alleviate a situation by training lay health workers to recognise mental illness using a locally validated assessment tool and offering evidence-based problem-solving therapy (Mental Health Innovation Network n.d.). These health workers are based in primary care clinics and are in regular contact with clients. A bench is placed within the clinic premises, where clients can speak with the health workers about their problems (Chibanda et al. 2015). This is called a 'Friendship Bench' (Chibanda et al. 2015). Clients are also offered to take part in the income-generation component of the Friendship Bench, the peer support group Circle Kubatana Tose, where they are taught to make bags out of recycled plastic and learn to share their stories with others in a safe environment (Chibanda et al. 2015). The bright yellow bench was donated by the initiative's co-founder Sam Fiorella, whose son Lucas died from suicide in 2014, after suffering in silence (CTV News 2022). 'By encouraging kids to say "hello" to each other and to make it OK to not be OK, we've seen a 20 per cent increase in the number of kids asking for help after we've put this programme into a school,' said Fiorella (CTV News 2022, para 3). With suicide as the second leading cause of death for Canadians aged 15 to 34, the bench initiative seeks to reduce the statistic by serving as a visual reminder for students to sit, take a minute, and talk openly and honestly about their mental health (CTV News 2022).

More than 60 benches have been installed across 50 Canadian schools in seven provinces. Besides encouraging conversation, the Friendship Bench aims to educate students about the causes of mental disorders and connect them to on-campus and in-community support. Each bench has a plaque directing students to the initiative's website, which provides links to mental health support services (CTV News 2022).

Figure 11.1: A Friendship Bench (Source: The Friendship Bench 2021)

Implementation of recovery-oriented mental health practice in Africa

The implementation of recovery-oriented mental health practices in Africa was examined. The only available resource was a scoping review conducted in 2022 by Keopile Mongie, Manyedi and Phiri-Moloko from the Faculty of Health Sciences in Gaborone, Botswana, and the School of Nursing Science at North-West University, Faculty of Health Sciences, Mafikeng, South Africa (Keopile Mongie et al. 2022). Moreover, Keopile Mongie et al. (2022) assert that the exploration of recovery-oriented programmes in the management of mental illness within Africa yielded no findings in the literature review conducted. Predominantly, studies on this subject originate from regions such as the USA, Australia, the UK, Brazil and Europe. The research indicates a predominance of a singular approach to recovery, with many programmes being shaped by the personal narratives of individuals and advocacy movements emerging from successfully recovered clients in affluent communities (Lavallee and Poole 2010; Slade, Amering and Farkas 2014). Moreover, the concept of recovery itself has been predominantly associated with Western societies and their more advanced mental health methodologies, as noted by Lavallee and Poole (2010). Thus, there is a critical need to recognise the perspectives of indigenous peoples and develop culturally specific recovery programmes or frameworks for them to be truly effective.

The adoption of a recovery-oriented approach to mental health care is observed primarily in high-income countries such as the United States of America, New Zealand, Australia, Canada and the United Kingdom (Glover 2012). Notably, a seminal report in 2014 by multinational pro-recovery researchers underscored the necessity for culturally tailored recovery programmes that are sensitive to the unique resources and service contexts of diverse communities (Slade et al. 2014). Despite some countries in Africa

undergoing deinstitutionalisation, most African nations still lack comprehensive mental health policies, and the principles of recovery are not effectively implemented (Maiga and Eaton 2014). Furthermore, there remains a significant lack of awareness and understanding regarding recovery-oriented mental health services (Bila 2019).

Sub-Saharan Africa persists as one of the most economically disadvantaged regions globally, marked by a substantial deficit in mental health resources (Maiga and Eaton 2014). The absence of comprehensive policies suggests a lower prioritisation of mental health issues and management across Africa, hindering the adoption of modern treatment modalities like recovery-oriented mental healthcare (Chorwe-Sungani et al. 2015). Botswana, classified as a middle-income country within sub-Saharan Africa, currently relies predominantly on a biomedical approach, primarily utilising psychotropic drugs for the care of individuals with mental illnesses (World Population Review 2024). Given the scarcity of psychiatrists, nurses play a central role in mental healthcare provision, a common trend in many African nations and globally (Hinga 2021). In Botswana, there exist approximately 0.29 psychiatrists per 100,000 people, making it challenging for psychiatrists to promptly attend to all patients (Maphisa 2018). Consequently, initial patient care at mental health facilities is typically administered by psychiatric mental health nurses or general nurses. These nurses serve as the backbone of mental health services in Botswana. Despite this, there is currently no established policy, guideline, or programme specifically addressing principles of recovery-oriented mental healthcare. Botswana operates with a single referral mental hospital in the southern region and four psychiatric units affiliated with general hospitals (Maphisa 2018).

The information gathered is predominantly from the nursing perspective, with no data obtained regarding the role of social work in recovery-oriented mental health practice in Africa. This highlights a significant gap in practice within the African context. However, it is worth noting that in South Africa, a study conducted by Bila (2019) explores the perspectives of social workers regarding recovery-oriented mental health practice. This study underscores the existence of a notable gap across Africa in terms of understanding and implementing recovery-oriented mental health practices from the social work perspective.

Implementation of recovery-oriented mental health practice in South Africa

Mental health is vital for overall well-being, and recovery is globally recognised as crucial in mental health care (De Wet and Pretorius 2021). In high-income countries, efforts have expanded to promote individual awareness and engagement in their recovery, prompting changes in mental health services towards a recovery-oriented approach. Consequently, there's a growing emphasis on measuring individual recovery for personal, professional and funding reasons (De Wet 2021). Despite challenges and limited resources, South Africa is beginning to explore recovery and its measurement within its unique

context.

Recently, South Africa has incorporated the concept of recovery into policy documents like the National Mental Health Policy Framework and Strategic Plan 2013-2020 (NMHPF) (Department of Health [South Africa] 2013). This policy emphasises supporting service users and their caregivers in establishing recovery within their communities. It aligns with international perspectives on recovery, emphasising the importance of public mental health services being recovery-oriented. While South Africa has developed some mental health recovery programmes, they remain smaller in scale compared to international efforts (Bila 2019; Brooke-Sumner 2016; The Spring Foundation n.d.a). With this policy inclusion and programme development, the need arises to measure recovery within the South African context. This involves measuring individual service users' recovery, which is the focus of this study, driven by the need for a contextually appropriate measure in the public mental health field in South Africa.

In South Africa, the context for service user recovery is marked by poverty, limited development, insufficient funding and primarily institution-based public mental health services (Jacob N. 2015; Parker 2012; Sunkel 2014). These challenges hinder the effective delivery of services. Considering these constraints and the fact that international recovery frameworks were designed for contexts with greater resources, they may not be suitable for South Africa. In advancing recovery in South African contexts, it's crucial to acknowledge the limitations of directly applying individualistic recovery frameworks from developed settings. Emphasising individual responsibility may not align with the collective focus often observed in South African communities (Leamy et al. 2011; Price-Robertson et al. 2017). Tse and Ng (2014) stress the importance of mental health services considering cultural complexities and encouraging community involvement.

Stevens (2018) highlights the need to integrate contextual influences into mental health and recovery frameworks, echoing Frantz Fanon's perspective. Jacobson and Farah (2012) propose a culturally sensitive recovery model that considers the nested relationships of service users within their environments, emphasising the visibility of social determinants of health. This underscores the importance of understanding recovery from various cultural perspectives and within specific contexts, such as the Western Cape province of South Africa, rather than solely through individual experiences.

Recovery-oriented programmes in South Africa are limited in number. While mental health and addiction recovery often fall under the purview of the same organisations, such as SAMHSA in the USA, distinguishing between them is crucial due to differing definitions and challenges in translation to practice (Brekke et al. 2018; Corrigan et al. 2019). In South Africa, some private healthcare programmes claim to focus on both addiction and mental health recovery, though it is unclear if they truly embody a recovery-oriented approach or simply serve as treatment centres (for example, Twin Rivers Rehab) (Twin Rivers Addiction Recovery Centre 2024). Similarly, other private healthcare

programmes in South Africa purportedly target mental health for example, Papillon Recovery Centre and Palm Tree Clinic (Papillon Recovery Centre 2024; Palm Tree Clinic 2024), yet their alignment with recovery principles remains ambiguous based on available information.

In South Africa's public mental health sector, there are limited dedicated mental health recovery programmes. Existing psychosocial programmes, focused on vocational and social skill development, mainly consist of residential care facilities or day centre services provided through public psychiatric hospitals or primary care clinics (C. Sunkel, personal communication, March 7, 2014). While these programmes play a crucial role in supporting service users, they do not align with the principles of personal recovery as outlined in the literature (Anthony 1993; Deegan 1988), nor are they necessarily delivered with a formal recovery-oriented approach by staff. Only a few mental health recovery programmes have been established in recent years in South Africa, albeit on a much smaller scale compared to international efforts, to assist individual service users in their recovery journey and promote a recovery-oriented approach to services (C. Sunkel, personal communication, March 7, 2014; The Spring Foundation n.d.b).

The Spring Foundation, located in the Western Cape Province of South Africa, stands out as one of the rare programmes truly embodying Jacobson and Greenley's (2001) recovery-oriented framework (De Wet et al. 2019; The Spring Foundation n.d.a). Established in 2011, it aims to foster recovery by promoting hope through re-connection (The Spring Foundation n.d.a). The foundation operates various recovery-oriented initiatives, including a market garden, youth projects, a wheelchair clinic and an identity document project, all focused on reconnecting service users with hope (De Wet et al. 2019; The Spring Foundation n.d.a). The desire to measure service users' recovery and assess programme impact further drove the initiation of this study, reflecting the foundation's commitment to enhancing outcomes.

Of course, the information presented reflects a psychological viewpoint. Notably, the exploration of recovery-oriented mental health practice from the social work perspective, as outlined by Bila (2019), underscores a gap identified in current practice.

Challenges in implementing recovery-oriented mental health practice

Different challenges can impede the implementation of recovery-oriented mental health in practice. For example, stigma, both societal and professional, is one of the most persistent barriers to a more humane, recovery-oriented system of care for persons with mental illness (Shera and Ramon 2013). Rusch, Angermeyer and Corrigan (2005) argue that understanding both public stigma and self-stigma is critical in identifying strategies to reduce stigmatisation. Moreover, these authors point out that mental health professionals also need to question their own potentially stigmatising attitudes toward people with mental

illness. Rusch et al. (2005) identified three core strategies: protest, education and contact.

Adams, Daniels and Compagni (2009), in their comparative analysis of seven countries (Australia, Canada, England, Italy, New Zealand, Scotland and the United States of America), identified anti-stigma campaigns as a top priority with a primary focus on the media, young people and the workforce. They also emphasise the importance of partnerships with user groups in these efforts and the need to view these initiatives as long-term commitments. Political challenges are complex and ever-changing. Mental health (unfortunately not well understood as a key dimension of health) has historically not been high on the priority lists of politicians or of citizens they represent (Shera and Ramon 2013). That mental health is not prioritised is also the case in South Africa. Energy is occasionally focused on this area after tragic events such as suicides or maltreatment, but interest soon subsides (Shera and Ramon 2013).

In SA, that has happened in the case of Life Esidimeni Hospital (Hodal and Hammond 2018) for Mental Health, where MHCUs were transferred to unlicensed non-profit organisations in the community when the hospital closed in 2016. The government responded when tragically 144 MHCUs passed away while in the care of these non-profit organisations. Shera and Ramon (2013) further state that the political landscape is dominated by political parties that are often in office for a much shorter period than that needed to implement long-term reform in their mental health systems. This also contributes to the problem of many excellent reviews of mental health policies and services being shelved rather than informing public policy. Policy challenges involve two key components: the development of policy and the implementation of policy (Shera and Ramon 2013). Policy emerges from processes of research, stakeholder dialogue and interest group pressures. It is also significantly influenced by the availability of funds (Shera and Ramon 2013). In these times of fiscal austerity in many countries, decision-makers are increasingly looking to other jurisdictions to find out what works. In the context of Australian government policymaking, Banks (2009: 33) argues 'that it is as important that we have a rigorous, evidence-based approach to public policy today as at any time in our history.' Banks also identify public sentiment, which is demanding a more transparent, cost-effective approach to policy-making that promotes better use of taxpayer money.

There are, however, many areas in which clear evidence is lacking and interventions from elsewhere often need significant modification to be appropriate for different contexts (Mulvale, Abelson and Goering 2007). A good deal of government policymaking is driven by ideology and no evidence. This characteristic and the process of negotiating changes to obtain approval often undercut the potential of the policy's impact (Mulvale et al. 2007). Policy implementation is often an even more problematic area (Thornicroft et al. 2010). Translation of policies into well-designed programmes with adequate resources, support and monitoring, is the exception rather than common practice. There are, however, some best practice models, for example, in implementing an

evidence-informed practice that is transferable to promoting recovery-oriented mental health at both organisational and service system levels (Dill and Shera 2012).

Resource allocations for mental health programmes are critical, as is the selection of areas for investment within this broad programme area (Thornicroft et al. 2010). Payment systems influence MHCU selection, quality, availability of medication and outcomes in MHCU-centred ways (Thornicroft and Tansella 2004). In the last few decades, many countries have diverted money away from institutions toward the community, but many would argue that the investment in community-based services has been insufficient to meet the need. Knapp et al. (2006) identified the economic barriers to improving the availability, accessibility, efficiency and equity of mental health care in low- and middle-income countries. Many programmes are under-resourced and have little chance of achieving the intended outcomes. Professionals working in human services also need a more advanced level of economic literacy to be able to advocate for more cost-effective programmes for users. Organisational change, particularly in larger organisations, can be a daunting task. In the current climate, these changes are initiated with few, if any, new resources and often as part of a cut-back or merger strategy (Benton and Austin 2010). Key questions to be addressed in implementing a vision of recovery within organisations are:

- Does the organisation have the financial and human resources needed to implement a recovery approach?
- Does the culture of the organisation support recovery through clear vision and goals, staff cohesiveness, autonomy and openness to change?
- What is the capacity of staff to acquire, assess and implement a recovery approach to practice? Is there an inclusive process of involvement and cohesive leadership both in the development and implementation phases of the organisational change effort? Several mental health organisations in Canada have attempted to implement recovery-oriented services and have identified both their successes and the challenges encountered in these efforts (Casey 2008: 1; Malachowski 2009: 49; Shepherd, Boardman and Burns 2010: 1).

The Implementing Recovery – Organisational Change Project in England (Shepherd et al. 2011: 1–5) has identified several key organisational challenges that are observable in many countries. They include:

- Changing the nature of day-to-day interactions and the quality of experience.
- Delivering comprehensive, user-led education and training programmes.
- Establishing a recovery education centre to drive these programmes.
- Ensuring organisational commitment, creating a culture and leadership.
- Increasing personalisation and choice.
- Transforming the workforce (training and deployment of peer

professionals).
- Changing the way, we approach risk assessment and management.
- Redefining user involvement to achieve a true working partnership.
- Supporting staff in their recovery journey.
- Increasing opportunities for building a life beyond illness. One of the most difficult issues in achieving a recovery-oriented approach will be confronted in the process of convincing professionals to practise in a significantly different way (Davidson et al. 2009: 33–61).

Davidson et al. (2009) pose the following questions:

- Will professionals and mental health organisations willingly integrate services in the best interest of MHCUs?
- Can professionals work in a more MHCU-centred, empowering fashion?
- Will MHCUs have a legitimate role in the planning and delivery of services?

On the other hand, MHCUs have been clear about what they need to deal with their illness and survive in the community (Davidson et al. 2009; Nelson, Lord and Ochocka 2001). Regrettably, many MHCUs are sceptical about whether mental health professionals and systems of care will significantly shift their attitudes and practices to achieve the goals of recovery. Perhaps continuing pressure to combine recovery principles and evidence-based practices (Torrey et al. 2005) and a significant restructuring of the educational programmes of mental health professionals (Council on Social Work Education [CSWE] 2011), will contribute toward gradual progress. The community capacity-building challenge appears to demonstrate most clearly the differences between a mental health service system view of recovery and a person-centred community-based approach to recovery. Those who are caught up in the service system paradigm often fail to see the broad range of normative resources that are available in communities for those who are experiencing mental illness. This also requires humility in understanding the limited role that formal mental health services play in the process of recovery. Many excellent resources have articulated the importance of communities such as Carling's (1995) work on community integration; Nelson et al.'s (2001) development of an empowerment-community integration paradigm and the Canadian Mental Health Association's Framework for Support (Trainor, Pape and Pomeroy 2004). These challenges are like those experienced by developing countries. Without the political will, policies, resources and buy-in by the professionals, the community and mental health care users cannot take a leading role and without resources, the implementation of recovery-oriented services will be impossible.

Lessons for recovery-oriented mental health practice for social workers in South Africa

The examples highlighted above offer valuable insights into the application of recovery-oriented mental health practice, particularly within the context of developing countries like South Africa. They serve as practical guidelines, shedding light on how recovery orientation can be effectively integrated into mental health services. While these examples demonstrate successes, they also reveal the challenges inherent in implementing recovery-oriented approaches in practice. By drawing lessons from these experiences, South Africa can establish a framework for the development of recovery-oriented mental health practice, setting a benchmark for future initiatives in the field.

Lessons for social work practice in South Africa can be drawn from the challenges and successes highlighted in the country's exploration of recovery-oriented mental health care. Firstly, it's crucial to recognise and address the unique challenges faced by individuals and communities in South Africa, including poverty, limited development and institution-based mental health services. Secondly, cultural perspectives play a significant role in shaping recovery-oriented approaches, emphasising the need for cultural sensitivity and adaptation in service delivery. Thirdly, there is a need for clarity and alignment of recovery-oriented programmes with recovery principles, particularly in both private and public healthcare sectors, to ensure effectiveness and accountability. Furthermore, social workers should strive to fully integrate personal recovery principles into existing psychosocial programmes to better support mental health care users. Finally, the example of The Spring Foundation underscores the potential impact of recovery-oriented frameworks in rekindling hope among service users, highlighting the importance of integrating such approaches into social work practice. Overall, there is a need for further exploration and integration of social work principles into recovery-oriented initiatives in South Africa to enhance mental health outcomes for individuals and communities.

Chapter 12
Recovery-oriented social work intervention programme in a South African context

Introduction

Social work plays a pivotal role within the expansive domain of mental health, with its principles closely aligned with a recovery-oriented paradigm (Kourgiantakis et al. 2020). Community-based recovery practices encompass a spectrum of opportunities and engagements tailored for individuals within their societal milieu (Davidson, Tondora and Ridgway 2021; Ramon 2018; Glover 2005; Tew 2013). Central to the concept of recovery orientation is the pursuit of equity, ensuring that individuals grappling with mental health challenges have equitable access to opportunities, choices, and rights akin to the broader populace (Kourgiantakis et al. 2020). Integral to the journey of recovery is the reclamation of autonomy and the fulfilment of citizenship, wherein individuals are esteemed members of society with access to fundamental resources such as housing, education, employment, community engagements, and physical healthcare (Davidson et al. 2021). However, achieving such inclusion often necessitates tailored support tailored to individual needs (Drake, Deegan and Rapp 2010; Karlsson and Borg 2017; Repper and Perkins 2003). The conceptual frameworks of social recovery and recovery capital provide valuable organisational structures for facilitating community integration (Ramon 2018). The genesis of social recovery can be traced back to Warner, who characterised it as the attainment of economic and residential independence with minimal social disruption (Warner 1994).

Currently, social recovery is concerned with people's ability to lead meaningful and contributing lives as active citizens while experiencing mental health problems (Ramon 2018). Social recovery focuses on community living and people's resources and opportunities as opposed to a diagnosis, deviance, and service framework (Kourgiantakis et al. 2020). Enabling people to participate fully in life means access and availability of resources and opportunities in the community. The concept of recovery capital provides a contextual way of mapping people's existing strengths and resources and brings a focus on what needs to be done (Tew 2013). Tew describes five types of capital relevant for recovery and community inclusion: economic (money at one's disposal), social (resources in one's social network), identity (relations with significant others), personal or mental capital (coping and ways of seeing oneself) and relationship capital (the quality of close relationships) (Tew 2013). Thus, recovery capital challenges understandings of mental distress and recovery that individualise personal pathology and personal responsibility, suggesting the need for recovery-oriented practices to be attentive to personal, practical, relational, and social contexts.

Practice standards for recovery-oriented care

Davidson's (2009) practice standards for recovery-oriented care have been applied within the South African context, where no specific standards exist. These standards offer practical guidance for practitioners and agencies committed to recovery-oriented care. They prioritise the participation of people in recovery and their loved ones throughout the care process, emphasising their input and inclusion in staff roles. Access and engagement are facilitated by reducing barriers and building trust over time, while continuity of care ensures ongoing support across different stages. Strengths-based assessments focus on individuals' capabilities, recognising them as experts in their recovery. Individual recovery planning is personalised, promoting community inclusion and respecting the 'dignity of risk'. Practitioners are encouraged to shift from managing cases to acting as recovery guides, collaborating with individuals on their journey. Asset-based community development is used to map and mobilise local resources, fostering inclusion. Finally, the standards address systemic and societal barriers, such as stigma and access to services, to create a supportive environment for recovery (Davidson et al. 2009).

Case study

The case study adapted from a study conducted by Thomas and Rioga (2013), serves to illustrate the practical application of the practice standards. Its purpose is to demonstrate how these standards can be effectively implemented in real-world scenarios, providing a clear framework for their integration into professional practice.

> Mzamani is a 48-year-old man diagnosed with schizophrenia and substance dependence. He lives in the community in a 24-hour supervised hostel. He has lived in this accommodation for nearly five years. Recently, he asked his allocated care coordinator Mental Health Practitioner (MHP) for a possible move to a flat. Mzamani has an extensive history of contact with mental health services which started at the age of 16. Contact with his family is limited to frequent visits by his mother and occasional telephone calls from a childhood friend who lives many miles away from Mzamani`s hostel. Mzamani is on anti-psychotic oral medication, specifically olanzapine, but now on a weekly anti-psychotic depot injection, fluphenazine decanoate, because of problems with medication adherence. The injection is usually administered every Wednesday morning by his care co-ordinator at a clinic. Mzamani hears voices, which he describes as tormenting. He also experiences periods of severe paranoia that include beliefs that people around him are planning to kill him. He thus spends most of his time alone in his hostel room, sometimes listening to music. He has expressed feelings of hopelessness and

helplessness to his MHP during some periods of severe experiences of paranoia, for example, in his words, 'My neighbours are aggressively following me, they want to kill me.' Mzamani has never worked and his hygiene is generally considered to be poor. Mzamani`s MHP and treatment team usually experience feelings of hopelessness as he continues to misuse substances and frequently fails to attend his therapeutic activities despite encouragement to do so. However, a change in treatment philosophy, and the adoption of a recovery-orientated approach by the MHP and treatment team, have resulted in improvement in Mzamani`s adherence to his therapeutic programme.

A.

Primacy of participation involving MHCUs and their families in all aspects of care delivery is crucial. In South Africa, this includes inviting MHCUs to share their stories, developing peer-operated services, and having MHCUs act as peer supporters and provide staff training based on their lived experiences. MHCUs should participate on organisational boards and advisory committees, contributing to their treatment plans. For instance, Mzamani, after becoming actively involved in his care, took ownership of his condition and adhered to treatment. Job opportunities for MHCUs within mental health organisations should also be created, with inclusive policies giving them control and choice in their care. In MDT panels, MHCUs can take responsibility for their care, amplifying their voices. Regular feedback on care changes should be provided to MHCUs and their families, with their input being considered. In Mzamani's case, adopting a recovery approach led to positive changes. When MHCUs and their families are dissatisfied, grievance procedures should be in place. Public and private institutions should be knowledgeable about engaging MHCUs in daily operations, hosting events and advocacy activities to raise awareness and reduce stigma around mental health. When MHCUs are encouraged to participate, their responses can be empowering. Mzamani reflected, *'At first, I wondered what I could contribute, but I realised my voice mattered. People listened. I no longer had to hide who I was, even the unwell part of me. My experiences as a client gave me ideas for change. Initially, my programme wasn't a good fit, so I didn't attend. Now, things are better, and my recovery is progressing.'*

B.

Promoting access and engagement involves taking services to clients rather than waiting for them to come forward. In rural areas, mobile clinics could include recovery-oriented mental health services. Services must be designed around MHCUs' specific needs, preferences, and characteristics. Providing quick access to a range of supports, including motivational strategies, is crucial.

For Mzamani, employment and housing are key aspects of recovery, as he has been unemployed and living in a hostel for five years. Substance abuse is also a challenge, requiring early intervention from mental health professionals and addiction specialists.

In South Africa, where MHCUs are often homeless and marginalised, engagement is critical. Mass mobilisation raises awareness and encourages people to take part in social, economic, and personal development. MHCUs share experiences of persistent support, being met on their terms, and receiving help with important aspects of their lives, such as family and employment. This tailored engagement fosters trust and long-term recovery.

C.

Ensuring continuity of care involves shifting the focus from merely getting Mental Health Care Users (MHCUs) into treatment to embedding the recovery process within their natural environment. Many MHCUs, like Mzamani, often drop out of treatment because services are only available during weekdays, leaving them without support on weekends. Recovery-oriented mental health practices advocate for services that are accessible with minimal barriers, emphasising outreach and pre-treatment recovery support, such as friendship benches.

In Mzamani's case, introspection revealed that his lack of adherence to treatment stemmed from multiple factors, including his long stay in a hostel and substance abuse issues. He expressed a desire to find employment and move to a flat, highlighting the importance of job opportunities in his recovery journey. Within a responsive continuum of care, MHCUs can choose services that match their needs and preferences in collaboration with their recovery team. The recovery management model considers the MHCU's stage of change, focussing on building strengths and recovery capital. Family and support systems are critical for recovery, shifting the goal from relapse prevention to promoting sustained recovery.

For Mzamani and others, a full range of support services, including community-based resources like safe housing and recovery centres, is essential. MHCUs are viewed as capable of managing their illness, and recovery-oriented services prioritise interventions that support this goal. Advocacy efforts extend beyond institutional policies to the broader community, aiming to reduce stigma, educate the public, and develop community resources.

Feedback from MHCUs on continuity of care:

'They were there for me without expecting anything in return.'

'MHP respected my efforts, and even though I made slow progress, they stuck with me. I've been clean for 18 months now, and they still check in every day.'

'I wasn't kicked out for setbacks, and my case manager reminded me of my progress, motivating me to continue.'

'They helped me balance recovery and rebuilding my life, including getting a job, paying off debts, and improving my marriage, all without relying on substances.'

D. Employing a strengths-based assessment

A strengths-based assessment focuses on the belief that individuals are experts in their own recovery journeys, emphasising their insights gained from overcoming challenges. This collaborative process involves sharing written assessments with individuals and asking impactful questions such as, 'What happened?' and 'What have you found helpful in the past?' Practitioners utilise self-assessment tools to gauge satisfaction across various life areas, allowing for the identification of diverse goals and tailored support. Rather than viewing perceived deficits through a negative lens, practitioners interpret them within a 'strength and resilience' framework. For instance, instead of labelling someone who takes their medication irregularly as 'noncompliant', they may be recognised for employing alternative coping strategies, such as exercise and relaxation. This assessment also considers strengths and resources within the individual's family, natural support networks, and community, reinforcing the understanding that recovery is a collective journey rather than a solitary one. Individuals are encouraged to draw on their past successes when identifying strategies for their recovery plans. Gathering information through in-depth discussions and soliciting input from families fosters trust and enriches the assessment process. Although each case is unique, assessments are documented promptly to guide recovery planning. The use of modular approaches in service delivery allows practitioners to collect specific information within designated timeframes, enhancing the assessment's relevance. By avoiding stigmatising diagnostic labels, practitioners focus on describing functional strengths and limitations, emphasising that acknowledging limitations is a constructive step in recovery. Person-first language is employed to ensure respect and avoid depersonalisation, acknowledging that a disability does not define an individual's identity. For example, in the story of Mzamani, an individual struggling with mental health issues initially viewed his situation as insurmountable. Through the strengths-based assessment process, Mzamani was encouraged to reflect on his strengths, past successes, and support systems. This collaborative approach helped him realise that his illness was just one aspect of his life, allowing him to engage with his recovery actively. Mzamani discovered that he could draw strength from friends, family, and counsellors, which transformed his outlook on life. As he explored his capabilities and set meaningful goals, he embraced a new perspective, highlighting the importance of recognising personal strengths in the recovery journey. Ultimately, the strengths-based assessment fosters a respectful, empowering environment where individuals can pursue their life goals despite ongoing challenges, leading to a more fulfilling recovery experience.

E. Offering individualised recovery planning

Individualised recovery planning is centred on the core principles of person-centred planning, which emphasise active participation and collaboration between individuals and practitioners. Adhering to the ethos of 'nothing about us, without us', practitioners partner with individuals in all planning meetings, allowing them to have control over the timing, location, and attendees of these discussions. This approach ensures that individuals can invite supportive persons, such as advocates or peer-support workers, and that meetings are scheduled to accommodate their recovery activities, such as employment. Pre-meeting support is provided to ensure individuals are prepared to engage fully as equals in the planning process.

The language used in recovery plans is made understandable for all participants, and any necessary technical terms are explained clearly. This collaborative process offers a flexible range of options that individuals can choose from, ensuring that goals reflect their unique interests, preferences, and strengths. In cases involving children and youth, family goals are considered, with youth increasingly leading the process as they mature. If preferred supports are unavailable, the recovery team collaborates with the individual to develop alternatives, focussing on actionable next steps with clear timelines. This empowers individuals to take responsibility for their part in making the plan work, regardless of their disability status.

A variety of interventions and contributors to the care process are acknowledged and respected. Practitioners emphasise the importance of existing relationships and support systems, making efforts to include natural supports who provide critical input. Recovery planning emphasises pathways to meaningful community engagement, documenting areas such as physical health, relationships, employment, spirituality, and social participation. The planning process also recognises the need for individuals to pursue activities that contribute to their recovery, even if they have not achieved clinical stability.

The principles of dignity of risk and the right to fail guide practitioners in their approach. Before resorting to coercive measures, they explore collaborative ways to engage individuals, presenting a range of options while respecting their choices. Administrative leadership demonstrates a commitment to both outcomes and process evaluation, with a focus on quality-of-life dimensions rather than solely clinical stability.

In the story of Mzamani, an individual navigating mental health challenges, he experienced a transformative journey through personalised recovery planning. Initially overwhelmed by his circumstances, Mzamani engaged with practitioners who followed the person-centred planning model. He was encouraged to invite his pastor – a significant figure in his life – into the planning meetings. This support made a profound difference, as the pastor provided insights and encouragement that resonated with Mzamani's personal goals.

Mzamani's recovery plan focused not only on managing symptoms but also on reclaiming his life. He expressed a desire to rebuild his relationship

with his daughter, which served as a powerful motivation for his recovery. Despite scepticism from some about this goal, Mzamani and his support team collaboratively developed strategies to handle the associated stress, ensuring that he had a robust plan in place. The journey was challenging, with moments of stress and doubt, but Mzamani felt empowered by the support of his team. Today, waking up to his daughter's smiling face each morning brings joy and meaning to his life, reinforcing the idea that individualised recovery planning can lead to profound personal transformation.

F.

The cornerstone of effective mental health care lies in the relationship between practitioners and individuals in recovery. This relationship fosters hope and faith in the possibility of improvement, even when the individual struggles to believe in themselves. Practitioners embody this belief, envisioning a future beyond the label of 'mental patient' by aligning with the person's desires and values while communicating positive expectations. They assess each individual's stage in the recovery process, recognising that different aspects of recovery may progress at varying rates – for example, one might actively engage in recovery from substance abuse while still grappling with mental health issues. Interventions aim to enhance autonomy, competence, purpose, and connections to others, while respecting the individual's right to make mistakes as part of their learning journey. Adverse experiences can provide meaningful lessons that propel recovery forward, and the 'dignity of risk' framework supports proactive planning, including relapse-prevention strategies. Each intervention is tailored to the individual's unique context, acknowledging influences such as personal history, family dynamics, and interests that shape their identity. Practitioners combat stigma by viewing individuals within the context of their daily lives and actively leveraging personal experiences to highlight the importance of social roles.

Stories from individuals in recovery reinforce this approach. One participant expressed profound gratitude for a practitioner who instilled hope, stating, 'She believed in me, even when I didn't believe in myself. Hope was the biggest gift she could have given me ... and it saved my life.' Another shared a transformative experience when asked, 'So, how can I best be of help' – realising the importance of taking charge of their recovery. A third story highlighted the practical support offered by a practitioner, who provided clothing for a child starting kindergarten, emphasising that meeting basic needs can significantly impact one's recovery journey. Lastly, an individual reflected on their fears about returning to a hospital but found comfort in collaboratively creating a plan with their case manager to ensure safety and stability during potential crises. These narratives illustrate the powerful role of practitioners as recovery guides, demonstrating how genuine belief, support, and collaboration can facilitate meaningful recovery journeys.

Incorporating the story of Mzamani, who faced significant barriers in his

recovery journey, adds depth to the narrative. Mzamani's experience illustrates how practitioners can leverage shared cultural understandings and community resources to empower individuals in recovery. His path to regaining stability involved both personal and community engagement, as practitioners worked with him to build resilience by emphasising his strengths and connecting him with local support networks. Mzamani's journey reinforces the idea that recovery is not merely an individual endeavour but a communal process that thrives on mutual support and understanding.

G.

Focused community mapping and development play a crucial role in reshaping the perceptions of individuals in recovery and other marginalised groups, viewing them primarily as citizens rather than clients. This shift emphasises their unique gifts, strengths, skills, interests, and resources that they contribute to community life. Through active participation in civic, social, recreational, vocational, religious, and educational activities, individuals in recovery experience renewed empowerment and social connectedness. To facilitate this engagement, opportunities for employment, education, and community involvement are regularly identified and compiled into asset maps, capacity inventories, and community resource guides. These resources are made accessible during initial agency orientations and are continuously updated as community knowledge expands.

The creation of asset maps and capacity inventories is a collaborative effort among community stakeholders, reflecting a diverse range of gifts, strengths, skills, knowledge, and resources present within the community. Importantly, this approach is not limited to traditional social and human services but encompasses the full spectrum of community assets. Community development is driven by a creative, capacity-focused vision shared by stakeholders, steering clear of deficit-oriented models that rely solely on needs assessments. Mzamani's story exemplifies the transformative power of community mapping and development in reshaping lives and fostering a sense of belonging. Initially facing challenges in his recovery, Mzamani felt marginalised and disconnected from his community. However, through the support of community mapping initiatives, he began to see himself not just as a client but as a valued citizen with unique strengths and contributions.

Engaging with local resources helped Mzamani discover a range of activities that reignited his passions and interests. He was encouraged to participate in civic and recreational opportunities that facilitated social connections and personal growth. For instance, he found a volunteer position at a nearby community garden, where he could contribute his gardening skills while connecting with others who shared similar interests. This role not only allowed him to give back but also provided him with a renewed sense of purpose and fulfilment.

Moreover, Mzamani's involvement in community events and workshops

opened doors to new friendships and professional opportunities. He became actively engaged in planning community activities, which further solidified his ties to the neighbourhood and helped him gain confidence in his abilities. As he became more integrated into the community, Mzamani discovered local resources for mental health support and wellness activities that encouraged a healthier lifestyle, both physically and mentally.

Through these experiences, Mzamani's recovery journey transformed from one of isolation to one of empowerment and active participation. He reflected on how important it was for him to find a place where he felt accepted, stating, 'The community mapping efforts helped me see that I have something valuable to contribute. I realised I'm not just a person in recovery; I'm part of something bigger.' His story highlights how community mapping and development can facilitate recovery by focussing on individual strengths, fostering social connections, and promoting a sense of belonging, ultimately leading to a more fulfilling and enriched life.

H. Identifying and addressing barriers to recovery and treatment

To effectively address barriers to recovery, there must be a commitment to embracing recovery-oriented care and moving away from illness-based paradigms. This requires that stakeholders recognise recovery-oriented system change as a civil rights issue, advocating for essential freedoms like self-determination and community inclusion for individuals diagnosed with mental illnesses. Key systemic changes include shifting focus from 'medical necessity' to 'human need', prioritising strengths-based interventions over deficit-oriented approaches, and emphasising personally defined quality of life. A fundamental power shift is also necessary to prioritise personal autonomy and self-determination over expert knowledge. Challenges such as competing agency priorities and unclear exit criteria for individuals in care must be addressed. Funding structures should adapt to support innovative, community-based recovery-oriented services. Training and staff development are critical for increasing practitioners' competencies in this area. Addressing societal barriers, including stigma and lack of basic resources, is essential. Collaboration with community organisations can foster welcoming environments for recovery. Effective communication and engagement with individuals experiencing mental illness are vital to ensure their voices are heard and to facilitate their recovery journey.

Mzamani's journey toward recovery highlights the importance of addressing both external and internal barriers to treatment in the context of mental health care. Initially, Mzamani found himself overwhelmed not just by his mental illness but also by the challenges of reintegrating into society post-hospitalisation. The fear of losing his job and benefits loomed large, and he faced significant hurdles when requesting accommodations from his employer for medical appointments. However, with the guidance of his therapist, who helped him understand the complexities of his benefits and how to communicate

effectively with his employer, Mzamani began to reclaim his life. This empowerment was pivotal; he successfully returned to work and even earned the 'Employee of the Month' award within a year. His story exemplifies the critical need for a recovery-oriented approach that prioritises personal agency and self-determination over a solely medical model. Furthermore, Mzamani's experiences shed light on systemic barriers, such as a lack of personalised treatment plans that reflect individuals' needs and goals. After working with a new clinician who valued his input, he found himself more engaged in his treatment, feeling that his voice mattered in the planning process. This shift not only fostered a sense of ownership over his recovery but also encouraged him to pursue social opportunities beyond traditional support groups. He began playing basketball in a city league, significantly expanding his social interactions and fostering a sense of belonging. With the support of his case manager, Mzamani navigated his fears of discharge and developed a robust support system that included trusted individuals he could turn to in times of need. His evolving perspective on recovery – transcending the role of being a passive recipient of care to becoming an active participant in his journey – illustrates the transformative power of recovery-oriented practices. Mzamani's story serves as a poignant reminder that systemic changes in mental health care, driven by the principles of recovery, can create pathways for individuals to reclaim their lives, promote community inclusion, and embrace self-determination.

Application of CHIME framework

The CHIME (connectedness, hope, and optimism about the future, identity, meaning in life, and empowerment) framework for personal recovery was first synthesised by Leamy et al. (2011). Currently, one of the most accepted theoretical frameworks to understand personal recovery is CHIME, a compilation of five interrelated recovery processes, namely Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment (Leamy et al. 2011; Slade et al. 2012). It is the most comprehensive depiction of the recovery process to date (Brijnath 2015). This framework is versatile and has been used in studies as wide-ranging as those on cultural diversity and depression (Brijnath 2015); CHIME was developed through a systematic review and narrative synthesis of the existing literature on personal recovery frameworks and definitions. Art therapy for mental health recovery (Stickley, Wright and Slade 2018). Hope and optimism refer to a belief in recovery, the motivation to change, having hope-inspiring relationships, thinking positively and valuing success, and having dreams and aspirations (Stickley et al. 2018). Identity encompasses the dimension of identity, rebuilding or redefining a positive sense of identity and overcoming stigma (Leamy et al. 2011). Dimensions of identity have been further explained by the research team as the view that an individual can have multiple identities pertaining not only to their medical diagnosis but also including the aspects of culture, ethnicity, and sexual identity (Bird et al. 2014).

This conceptual framework of personal recovery has already proved to be a useful research utility, providing a taxonomy for categorising different intervention strategies. Further evidence reviews have been conducted into different areas of the CHIME framework, for example, Hope (Schrank et al. 2012), Strengths (Schrank et al. 2012), and Connectedness, Identity and Empowerment (Tew, Ramon and Slade 2012). Individual interventions can also be positioned within the framework, concerning their intended outcomes. For example, studies of peer support (Kaplan et al. 2011) or meaningful activities (Howard et al. 2010) can be categorised alongside interventions addressing Connectedness or Meaning and Purpose respectively. Reviews of recovery measures have also made use of the framework within their analysis (Williams et al. 2012).

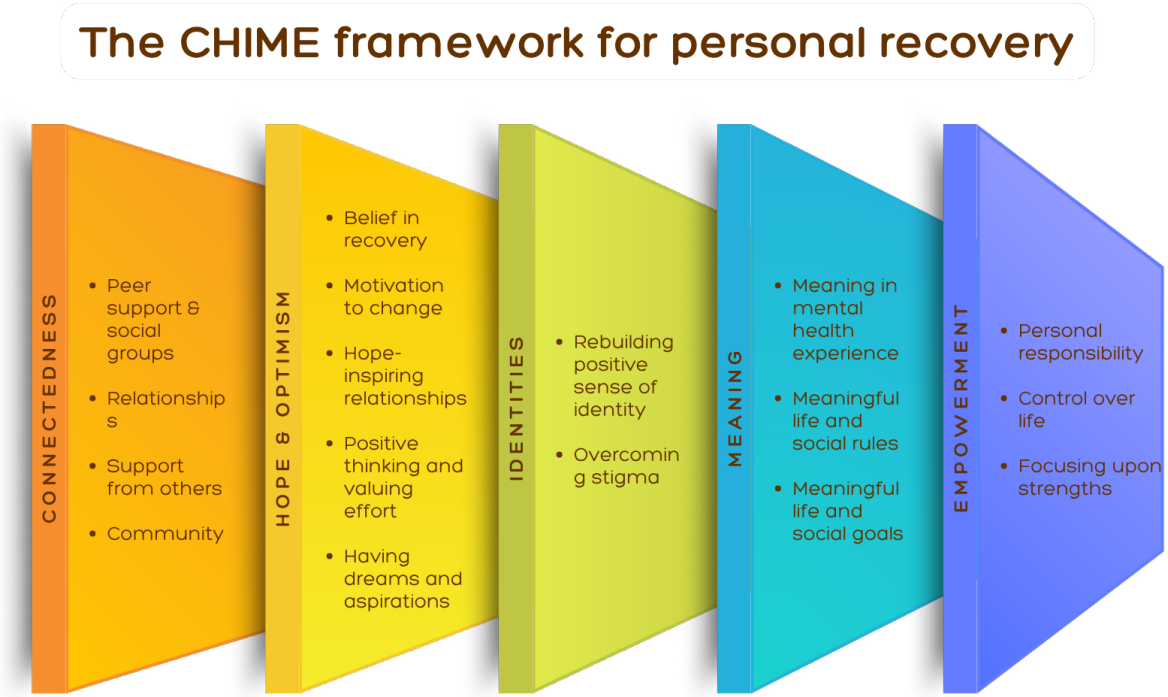

Figure 12.1: The CIME Framework (Source: Leamy et al. [2011])

Emerging from the United Nations General Assembly Human Rights Council (2019) the World Health Organization Quality Rights framework (WHOQRF) aims to guide the standards for quality of care in mental health services. The WHOQRF is inclusive of the CHIME framework of recovery (World Health Organization 2019). However, it has also sought to address some of the limitations and criticisms of the CHIME framework. The WHOQRF incorporates a human rights approach, promotes the peer workforce, seeks to be inclusive of cultural diversity, focuses on the social determinants of health, promotes empowerment and includes understandings of trauma (World Health Organization 2019). In the WHOQRF recovery-oriented practice model, practitioners and organisations are encouraged to empower consumers by

building on strengths to support them in their unique recovery journey (World Health Organization 2019). Recovery-oriented practice in the WHOQRF (World Health Organization 2019: 14) model starts with the question, 'What can we work on together to make your life better?' This leads to the key tenets of WHOQRF recovery-oriented practice:

- Focussing on strengths and assets;
- Inspiring hope;
- Understanding the values and preferences of the person;
- Working alongside the person;
- Maintaining boundaries;
- Being aware of potential barriers that may hinder the person's recovery journey, including power imbalances within services;
- Supporting the person in positive risk-taking; and
- Connecting the person to the community, including peers and family members
  (World Health Organization 2019)

The Collaborative Recovery Model

The Collaborative Recovery Model (CRM) (Oades et al. 2005) was established to enable evidence-based recovery-oriented practice with people with mental health conditions. Designed for use in the community mental health and psychosocial rehabilitation settings, the model offers an integrative framework of evidence-based modular competencies that is inclusive of lived experience perspectives (Oades et al. 2005). The guiding principles of CRM are:

- Recovery as an individual process. This includes:
  - » finding hope,
  - » redefining identity,
  - » finding meaning in life, taking responsibility, and
  - » acknowledging recovery is a personal journey – and that its experience is unique to the individual.
- Collaboration and autonomy support.

An effective working alliance supports the recovery process and supports autonomy through a 'self-determination theory approach' of working from the MHCU's perspective, providing choice and acting with transparency (Oades et al. 2005: 279). The Model's components are:

- change enhancement;
- Identification of collaborative needs;
- collaborative goal setting and striving; and
- collaborative task assignment and monitoring (Oades et al. 2005).

Evidence indicates CRM can support the implementation of recovery-oriented policy and knowledge into community mental health practice and is viewed by consumers and staff as valuable in supporting recovery (Wolstencroft, Deane and Jones 2018).

Social and relational recovery

People with psychosocial disability are often marginalised and socially excluded (Lloyd et al. 2006). Additionally, they can become isolated and feel disconnected due to diminished connections with family, friends, colleagues and other community relationships. People may lose previously active roles in the wider community and have limited engagement with a broader range of people beyond those working in mental health roles. There is growing recognition of the crucial role that social factors play in the development of mental health conditions and the recovery journey (Tew, Ramon and Slade 2012). Reconnecting, reengaging and repairing relationships and connections with others, including workers, forms part of many people's recovery journey and is thus an element of recovery-oriented practice. Relational recovery 'is a way of conceiving recovery based on the idea that human beings are interdependent creatures; that people's lives and experiences cannot be separated from the social contexts in which they are embedded' (Price-Robertson, Obradovic and Morgan 2017: 2). For Tew et al. (2012), recovery incorporates the idea of being on a journey, of creating a worthwhile and fulfilling life with or without continuing experiences of symptoms Connecting to meaningful activities and communities, as well as establishing connections to people, are all elements of recovery and a part of recovery-oriented practice. It has been argued that experiences such as hope, identity, meaningfulness and empowerment emerge at the intersections between people, their relationships and environments; they are best seen as interactional processes rather than states possessed by any one individual (Price-Robertson et al. 2017).

Interpersonal relationships

Topor, Bøe and Larsen (2018) argue that recovery occurs through interactional processes in relationships, including the relationship between a worker and consumer. Consequently, workers in everyday encounters and daily practice can make important contributions to peoples' recovery journey, especially in terms of social and relational recovery (Topor et al. 2018). An effective part of the recovery-oriented practice that also encompasses the understanding that recovery is a social process, are 'small things' or micro-affirmations (Topor et al. 2018: 1212). 'Micro-affirmations' is a term coined and defined by Rowe (2008: 46) as 'apparently small acts, which are often ephemeral and hard-to-see, events that are public and private, often unconscious but very effective, which occur wherever people wish to help others to succeed ... [they] are tiny acts of opening doors to opportunity, gestures of inclusion and caring and graceful acts

of listening.' This term and others such as small things and small acts are used in the literature to describe the phenomenon (Topor et al. 2018). Common elements of the terms used are the relational aspects and that, despite being 'small' or 'tiny', they can play an important role (Topor et al. 2018). As Costin (2017: 122) states, 'These gestures, no matter how insignificant they might seem, carry infinite weight in a person's sense of wellness and recovery.'

When characterising what small things are, context is important as they are deemed 'small' in contrast to other 'big things' that occur in everyday life relations and situations (Topor et al. 2018). They are not the big things such as diagnoses or interventions, they are the little things of great importance, that are often taken for granted, which can happen between consumer and worker. Small things or micro-affirmations can take the form of words, gestures and actions, affirming a common human ground between the social workers and MHCUs (Topor et al. 2018). Small things in the form of words can look like every day small talk and communication that does not solely focus on diagnoses or intervention (Gudde et al. 2013; Topor et al. 2018). Workers sharing experiences from their own lives with consumers, which is often referred to as 'self-disclosure' in a therapeutic setting, can also be considered a small thing (Topor et al. 2018: 1212). Workers using simple, welcoming words, as well as being silent together with consumers when appropriate, are other examples of small things that according to consumers are beneficial to the construction of helpful relationships with workers (Topor et al. 2018). These small things as well as the tone used, can convey that a consumers' words are being heard and listened to (Topor et al. 2018). As Topor et al. (2018) highlight, being listened to and heard has both a literal and metaphorical meaning. Gestures are another form of small things and comprise bodily expressions, body language and physical presence (Topor et al. 2018).

It can be highly beneficial for the relationship between the worker and consumer and consequently the recovery journey to use appropriate eye contact and smiling (Topor et al. 2018). Small things can also be in the form of 'non gestures' which can include a professional not answering a phone call when interacting with a consumer (Topor et al. 2018). These 'non-gestures' can convey to a consumer that they are the focus and priority, and full attention is being given to them (Topor et al. 2018). Small things can also be actions. These actions are defined as 'more extensive behaviours than gestures, often implying a specific goal and stretched over time' (Topor et al. 2018: 1215). A characteristic of these actions that make them 'small things' is that they tend to be normal or ordinary actions done by a professional but done outside of professional working hours or going beyond the basic requirements of the role (Topor et al. 2018). Simple actions such as being timely, available, or sharing a coffee and conversation that is not saturated in diagnoses talk can be highly valuable (Topor et al. 2018).

The function of these small things can be the breakdown of the power dynamics that can reinforce the differences between professionals and consumers (Topor et al. 2018). These small things can also remind and reinforce

for consumers that they are more than simply a diagnosis or a consumer and consumers can experience 'being like others' (Topor et al. 2018: 1216). These simple practices can make important contributions to consumers' recovery journeys, especially in the social and relational domains (Topor et al. 2018; Topor et al. 2011).

Family and MHCUs

As well as working to develop and improve relations between worker and consumer there can be a need to support the consumer to improve and re-establish existing relationships with families. The importance of rebuilding or developing family relations is noted as a crucial element of recovery. Consideration and sensitivity should be taken as family relationships can be complex, have varying compositions, informed by the consumer's culture and preferences. The estrangement may be by choice of the MHCUs for example, family violence) or the family group is chosen rather than by birth. Mental health conditions do not only influence a person but also their families and other people involved in their support and care (Pernice-Duca 2010). Price-Robertson et al. (2016) outline six key strategies for promoting relational recovery and practice considerations:

- Understand that recovery occurs in a family context;
- focus on strengthening parent-child relationships;
- support families to identify what recovery means for them;
- acknowledge and build on family strengths, while recognising vulnerabilities;
- assist family members to better understand and communicate about, mental health conditions; and
- link families into their communities and other resources.

Price-Robertson et al. (2016) did not seek to provide a 'how-to guide' for workers, but rather a resource that can be used to orient their work and practice to be supportive of family recovery. The importance and benefit of information and education about mental health and mental health conditions for the individual and their families, in addition to family consultation and participation, have been identified as supporting the recovery journey (Pernice-Duca 2010). Pernice-Duca (2010) also highlights a focus on increasing positive and satisfying family contact as well as creating space and opportunities for reciprocity.

Social inclusion and community participation

As well as working on existing relationships with workers and family, there can be a need for support that enables people to establish new relationships with those in the community (Tew et al. 2012). Social inclusion, a crucial element of recovery, can stem from being a part of social networks, establishing connections and engaging in meaningful social and occupational activities

within the broader community (Tew et al. 2012). Research undertaken by Kaplan et al. (2012) indicates that community participation can facilitate recovery.

There are multiple domains where community participation can be promoted and supported to enable a person to develop and maintain social and relational connectedness. As Lloyd et al. (2006: 3) argue, it is important 'to consider setting specific targets for employment, housing, education, or engagement in social activities. The promotion of social inclusion should be incorporated into every service user's care plan.' The domains Lloyd et al. (2006) suggest are also reflected in the community participation domains outlined by Salzer and Baron (2016). There is evidence to indicate benefits associated with focussing on these domains for people with psychosocial disability (Salzer and Baron 2016). Recovery-oriented practice involves supports that address a range of domains, such as those listed below, all of which impact on the well-being and recovery of those individuals with mental disorders:

- **Housing:** affordable and sustainable housing is needed to actively address social recovery for people, so they can connect and participate in the community. Recovery-oriented practice addressing factors such as housing has an impact on people's well-being and influences the opportunity for enhanced community participation (Australian Government Department of Health 2013).
- **Employment:** having employment can positively impact on people's social networks and therefore can contribute to recovery (Webber and Fendt-Newlin 2017). Interventions such as supported employment have been shown to have the strongest evidence of effectiveness (Webber and Fendt-Newlin 2017). Webber and Fendt-Newlin (2017) argue that recovery colleges are similar in this manner, as they provide opportunities for consumers to take up new roles, including as educators and staff (see below education).
- **Education:** Sommer et al. (2021) have suggested that being engaged with peers, such as involvement in recovery colleges, can support people in their recovery through regaining social connections. Other social groups that give people access to peer support and others with lived experience can be invaluable as they too can support social interactions. These are opportunities to interact and engage with people with shared experiences. There is the potential for finding role models and inspiration, which can lead to a sense of belonging. These group situations can also be a safe space to learn, develop, and practice social skills. Getting assistance in developing and rebuilding social skills is a valued support in terms of recovery (Brophy et al. 2015).
- **Spiritual/religious:** being able to participate in activities and exploration of spirituality and religion can be important in terms of connecting with the wider community (Salzer and Baron 2016). Addressing and providing space for the spiritual and religious needs of people with psychosocial disability can be important for recovery (Fox and Videmsek 2019).

- **Physical activity/leisure/recreation:** recovery-oriented practice involves support for consumers in identifying interests and activities that can address and enable social inclusion (Salzer and Baron 2016).

The lived experience workforce

The lived experience workforce, also commonly referred to as the peer workforce, is an emerging professional discipline within the Australian mental health system. Peer workers have been employed and are increasingly utilised in Victoria since 1996 (Victoria Mental Illness Awareness Council 2019). The lived experience workforce embodies recovery-oriented practice that is grounded in empathy, mutuality, and hope. Lived experience workers act in a professional capacity while drawing on their expertise, knowledge, and training to engage in roles such as clinical and non-clinical work, support work, peer support, consultancy, care coordination, advocacy, research, education, and management. The lived experience of mental health challenges and personal recovery is at the centre of recovery-oriented practice and is the defining feature of peer-based roles. Lived experience professionals are increasingly valued. As Mission Australia (2018: 4) states: 'People who have experienced life adversity and have subsequently developed distinctive capabilities required to overcome the difficulties faced, are uniquely placed to provide services to others facing similar life adversities.'

The lived experience (peer) workers often hold professional qualifications in addition to their own lived experience of mental health conditions and recovery. As a result, lived experience workers have unique learnings, attributes, and capabilities. There is significant evidence to support the impact of lived experience work in facilitating the recovery of MHCUs. As Davidson et al. (2012) describe, peer support work has been shown to increase consumers' sense of hope, control, and autonomy. The lived experience work values include mutuality, voluntary engagement, self-determination, hope, responsibility, and empowerment (Western Australian Association for Mental Health 2014). Lived experience work includes:

- being values-based and authentically lived experience informed;
- taking a person-centred, strengths-based, and relational approach;
- enacting recovery principles;
- conveying, inspiring, and illustrating hope;
- helping the person navigate access to services;
- being trauma-informed;
- being responsive and flexible;
- utilising positive and safe self-disclosure and shared experience;
- supporting empowerment; and
- fostering a culture of 'communication based on shared experience and equality'.

(Schweizer et al. 2018: 47).

Lived experience roles included educating other workers, supporting cultural change in organisations, leadership and improving the recovery-oriented practice of clinicians (Chisholm and Petrakis 2020). Schweizer et al. (2018) explored the impact and sustainability of lived experience worker roles and reported that organisational support, including well-being, management, and effective human resource strategies was critical. Notably, this is an existing priority area in Australian mental health policy. As the Fifth National Mental Health and Suicide Prevention Plan (Australian Government Department of Health 2017: 4) states, [currently] 'the peer workforce is sporadically utilised and poorly supported.' Another area of development for the lived experience workforce is the support and inclusion of people with lived experience in management roles (Mission Australia 2018).

Training for the lived experience workforce

Training for peer support workers (that is, individuals who are providing direct practice support to a person with mental health conditions) typically involves the completion of Certificate IV in Mental Health Peer Work (Myskills 2020). This training has been available through the 'Free TAFE for priority courses' initiative in Victoria (State Government of Victoria 2021) but can otherwise be difficult to access and less affordable. Intentional Peer Support is another foundational training curriculum that aims to train and support peer support workers through a framework embedded in trauma-informed practice, mutuality, connection, and hope (Intentional Peer Support n.d.). This training has become increasingly favoured by the lived experience workforce (Intentional Peer Support n.d.).

Other training opportunities can have barriers to access. For example, training opportunities may vary from organisation to organisation. Also, regional peer workers may have fewer training opportunities than their city-based counterparts. It is important that people in lived experience identified roles also have access to peer networks and peer supervision. Many of the competencies taught to peer support workers would also benefit people who do not identify as having lived experience but are open to new ways of supporting people in a mental health setting. This has the potential to enhance recovery-oriented practice through greater sharing of lived experience expertise, but these opportunities are rarely available.

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