“The Makings of Madness:

How is the 'problem' of mental health represented in South African health policy?”

by

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Declaration

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Abstract

This study critically analyses the problem representations found within South African mental health policy documents. It provides insight as to how mental health is problematised in South African public policy. The study makes explicit the embedded assumptions within the policy, and reveals the context in which mental health is conceptualised. The policy documents used for analysis are: The *White Paper for the Transformation of the Health System in South Africa of 1997*; the *National Mental Health Care Act 17 of 2002*; the *National Child and Adolescent Mental Health Policy Guidelines of 2003*; and the *National Mental Health Policy Strategic Framework for 2013-2020*. Carol Bacchi's 'What's the problem represented to be?' (WPR) approach is used as the analytical tool with which to identify the dominant problem representations of mental health. Problem representations are referred to by Bacchi as the explicit and implicit statement of a 'problem' in any policy. This analytical tool is based upon Foucauldian, post-structuralist principles that centre around the construction of meaning through discourse and social practices. These principles direct the study in the process of analysing how mental health is shaped by discourse and interventions. The thesis considers the various conceptualisations of mental health that frame the context in which mental health is understood. The conceptualisation of mental health will greatly influence how it is framed and managed in policy. A review of the research already conducted on South African public policy shows that the focus of the literature is invariably centred around the implementation of the policies and the resulting service delivery gaps. The literature does not examine how mental health is conceptualised and constructed in mental health policy, revealing a gap in the research that this study fills. The critical analysis of the four policy documents reveals five dominant problem representations, namely: the separation of mental health services from general health services; poor intersectoral collaboration in mental health care services; the disconnect between communities and mental health care services; the link between poverty and mental health problems; and the rights of those with mental health problems being infringed upon. The dominant problem representations are expressed both explicitly and implicitly. The identification of the dominant problem representations reveals the assumptions that underpin how mental health is problematised. The study emphasises the understanding of mental health as a socio-economic problem, providing solutions centred around poverty alleviation and economic development.

Opsomming

Hierdie studie ontleed die probleemvoorstellings wat gevind word binne die Suid-Afrikaanse beleidsdokumente oor geestesgesondheid. Hierin word insig verskaf in die manier waarop geestesgesondheid geproblematiseer word in Suid-Afrikaanse openbare beleidsdokumente. Die studie lig die ingeslote aannames binne die beleidsdokumente uit, en onthul die konteks waarin geestesgesondheid begryp word. Die beleidsdokumente wat gebruik word vir ontleding is as volg: *The White Paper for the Transformation of the Health System in South Africa of 1997; the National Mental Health Care Act of 2002; the National Child and Adolescent Mental Health Policy Guidelines of 2003; and the National Mental Health Policy Framework for 2013-2020.* Carol Bacchi se benadering, '*What's the problem represented to be?'* (WPR), is die analitiese instrument wat gebruik is om die oorheersende probleemvoorstellings van geestesgesondheid te ontleed. Probleemvoorstellings word deur Bacchi beskryf as die eksplisiete en implisiete voorstelling van 'n probleem in enige beleid. Hierdie analise instrument is gebaseer op Foucault se poststrukturalisme beginsels wat betekenis deur redevoering en sosiale gewoontes saamstel. Hierdie beginsels rig die studie in die proses van ontleding in hoe geestesgesondheid deur redevoering en ingrypings gevorm word. Die tesis oorweeg die verskeie voorstellings van geestesgesondheid wat die raamwerk verskaf vir die konteks waarby geestesgesondheid verstaan word. Die voorstelling van geestesgesondheid beïnvloed in 'n hoë mate hoe die beleid bestuur en beraam word. 'n Oorsig van die beleide wat reeds op Suid-Afrikaanse beleidsdokumente gedoen is het daarop aangedui dat die brandpunt van die literatuur gesentreer is op die uivoering van die beleide asook die uitlopende probleme in dienslewering. Die literatuur ondersoek nie hoe geestesgesondheid voorgestel en saamgestel is in die beleid nie, en sodoende word 'n leemte uitgelig in die navorsing wat hierdie studie vul. Die kritiese analise van die vier beleidsdokumente openbaar vyf oorheersende probleemvoorstellings, naamlik: die skeiding van geestesgesondheidsdienste en algemene gesondheidsdienste; die swak intersektorale samewerking in die sorg van geestesgesondheidsdienste; die ontbinding tussen gemeenskappe en geestesgesondheidsdienste; die verband tussen armoede en geestesgesondheidsprobleme; en die regte wat oortree word van hulle wie geestesgesondheidsprobleme het. Die dominante probleemvoorstellings word eksplisiet en implisiet uitgedruk. Die identifisering van die oorheersende probleem openbaar die vooropgestelde idees wat die probleme in geestesgesondheid ondersteun. Hierdie studie beklemtoon die verstandhouding van geestesgesondheid as 'n sosio-ekonomiese probleem, en verskaf oplossings rondom die verligting van armoede asook die ontwikkeling van die ekonomie.

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List of Acronyms

ANC	African National Congress
APA	American Psychiatric Association
ADHD	Attention Deficit and Hyperactivity Disorder
AIDS	Acquired Immunodeficiency Syndrome
CBO	Community Based Organisations
CMD	Common Mental Disorders
DoH	Department of Health
DSM – 5	Diagnostic and Statistical Manual of Mental Disorders
EMRS	Emergency Medical Rescue Services
GNI	Gross National Income
HIC	High Income Countries
HIV	Human Immunodeficiency Virus
ICD – 10	The International Statistical Classification of Diseases and Health Related Problems
NGO	Non-governmental Organisations
NHI	National Health Insurance
No.	Number
PHC	Primary Health Care
PLWMHP	People Living with Mental Health Problems
PTSD	Post-Traumatic Stress Disorder
LMIC	Lower to Middle Income Countries
SADAG	The South African Depression and Anxiety Group
SAHPRA	The South African Health Products Regulatory Authority
SAPS	South African Police Services
RDP	Reconstruction and Development Programme
TB	*Mycobacterium* Tuberculosis
UNICEF	United Nations International Children's Emergency Fund
UHC	Universal Health Coverage
WHO	World Health Organization
WPR	What’s the Problem Represented to be?

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Chapter 1: Introduction

1.1. Background and Rationale

Mental health has long been the orphan of the South African health care system. The Life Esidimeni tragedy brought to the forefront the crisis of mismanaged resources, gross negligence, and inadequate workforce that has come to exemplify mental health care services or lack thereof, in South Africa.

It is estimated that as many as one in five people in South Africa will or does suffer from some mental health problem in their lives; more than 17 million people in South Africa are reported to be dealing with common mental health problems; and three out of four adults that present with a 12-month psychiatric disorder receive no treatment (Williams *et al*, 2008). Despite mental health being the third highest burden of disease in South Africa (after HIV/AIDS and other infectious disease), the Department of Health (DoH) spends only 5% of its budget on mental health related issues (Docrat *et al.*, 2019:706; Seloana, 2018). Indeed, there is no discrete budget for mental health, and with the dominance of the HIV/AIDS pandemic, mental health is left whatever can be spared. Of the finances and resources that are provided, there is little evidence that they are distributed adequately or used efficiently. This is partly due to the decentralisation of mental health services, where provinces are responsible for their population's needs. As a result, there are great disparities between provinces regarding their specific budgets, staffing, rehabilitation and integration projects, referrals, follow up, or even basic reports given to the national board (Lund, Kleintjes, Kakuma, *et al.*, 2010: 401). Furthermore, South Africa's mental health workforce is woefully inadequate, with only 0.3 psychiatrists, 0.3 psychologists, and 0.4 social workers respectively per 100 000 population (Lund & Flisher, 2002:1).

The state is responsible for health care in South Africa, with the official obligation to strategically spearhead health care provision (Coovadia, Jewkes, Barron, *et al.*, 2009:829). The majority of the (uninsured) population rely on state-managed health facilities. This responsibility to provide and manage mental health care is outlined in Section 27 of the

Constitution of the Republic of South Africa (Constitution of the Republic of South Africa, 1996), as well as in the *National Health Act 61 of 2004* (National Health Act, 2004:2).

There are several trends in South African mental health care that should be noted, one of which is the general shift in health care towards primary health care principles (as seen in the White Paper for the Transformation of the Health System, 1997:84). Primary health care principles refer to a mode of care that addresses the broader determinants of health through intersectoral policy, empowers users, and meets people's health needs throughout their lifetime. This is a thoroughly holistic conception of health, which understands 'health' as general well-being, rather than simply an absence of infirmity (WHO, 2020).

Another trend seen in South African mental health care is deinstitutionalisation, the movement of mental health care away from mental hospitals to community-based settings (Taylor Salisbury, Killaspy & King, 2016:2). South African health policy states that mental health care should be deinstitutionalised and fully integrated into the general health services: '[e]very organ of State responsible for health services must co-ordinate the implementation of its policies and measures in a manner that promotes the provision of community-based care, treatment, and rehabilitation on services' (National Mental Health Care Act, 2002:7). In practical terms, this means moving patients away from psychiatric hospitals and wards, towards PHC facilities, community-based organisations (CBOs), and non-state organisations for care. The process of integrating mental health care services has become an increasing popular approach in improving uncoordinated and fragmented services (Lamontagne, 2013:8). It increases the accessibility of services, particularly disadvantaged communities (Janse Van Rensburg, 2018:6).

Integration in South African is applied through a task-shifting approach. Task-shifting is the process where specific tasks are assigned to health workers or laymen with less training and qualifications so as to ease bottlenecks in service delivery (WHO, 2008:7). This is especially useful in a context where specialised mental health practitioners are limited, such as South Africa. Mental Health Review Boards are set up to access and monitor the referral process and assess the suitability of these organisations. However, as illustrated by the investigations after the Life Esidimeni tragedy, there is evidence to suggest that these assessments are not fully performed or reported (Makgoba, 2017).

These policies also authorised the decentralisation of mental health care where services are to be provided at a provincial level, due to the inter-related and inter-dependent relationship between the national and provincial levels of government. This significantly complicates analysis as each province may interpret and implement the policy differently in their unique environments. There is also the practical complication that minimal data has been collected from the provinces regarding their patients and treatments (Lund, Kleintjes, *et al.*, 2010:393).

As a result of the limited care provided or perhaps due to stigma or cultural considerations, many South Africans have turned to non-medical avenues for their mental health needs. Mental health problems are often understood as a spiritual matter for pastors and traditional healers to deal with (Sorsdahl, Stein, Grimsrud, *et al.*, 2009:434). The DoH partners with non-state actors such as religious and spiritual leaders to provide mental health care through the afore mentioned task-shifting approach. The government also partners with communities in an attempt to provide mental health care more in line with local needs. Wherever possible, the policies state that an individual should be treated as close to their community as possible (National Mental Health Policy Framework, 2013:19).

1.2. Themes identified in the literature

A cursory review of the literature indicates that there are four major conversations in the world of South African mental health care research, namely those that deal with the:

1. The emphasis on human rights[1]
   - The discussion on mental health care policy alignment to human rights standard.
2. The focus on prioritised care of high-risk demographics[2]
   - The identification and suggested care of demographics deemed ‘high-risk’ for mental health problems
3. Decentralisation of mental health services to provinces[3]
   - Examining the shift of care from a centralised, institutionalised service to a provincially led service.

[1] For example, see Burns, 2011; Docrat *et al.*, 2019; Lund *et al.*, 2008
[2] For example, see Mokitimi, Tomlinson, Baron, *et al.*, 2018; Kleintjes *et al.*, 2010
[3] For example, see Omar *et al.*, 2010; Lund, Kleintjes, *et al.*, 2010

4. Integration of mental health care to primary health care facilities[4]
    - Describes the incorporation of mental health services into primary health care services.

1.3. Research Problem

The failure of mental health policy at an implementation stage has been covered by a multitude of scholars[5], their research proving that the inadequate public mental health care services are a result of poor procedural execution, scarce resources, and limited access.

However, expansive analysis on the conceptualisation of mental health in national policy is limited. In the various policies and documents, mental health is presented as a single issue; a simple problem that can be rationally solved through collective decision making. There is an underlying assumption that mental health is a pre-existing, readily identifiable problem which can be easily solved by policy makers.

The fact that there is no clear definition within the policies of what mental health is, gives some indication that ‘the problem' is not so simple. Mental health is a slippery term heavily reliant on context. For example, the basic foundation of our understanding of mental health and its subsequent criteria and potential 'solutions' are based on predominantly high income, western psychiatric theory. This presents unique complications when applying these diagnoses and 'solutions' in a low to middle income country (LMIC). Without interrogating the distinctive frame of reference used in policy, what is understood as mental health will be entirely too simplistic and one dimensional, as will the policies surrounding it.

The manner in which mental health is framed and represented has implications for how policy makers respond to it. Any 'problem' that is represented as a single-framed issue could result in worrying implications. Singularly worrying is the single framed 'problem' of mental health. As shall be demonstrated in this study, mental health is multi-determined and multi-causal, and cannot be attributed alone to clear biological, economic, social, or religious markers.

[4] For example, see Petersen, 2000; Petersen *et al.*, 2012; Schneider *et al.*, 2016
[5] For example, see Burns, 2008; Petersen & Lund, 2011; Lund, Petersen, Kleintjes, *et al.*, 2012

This thesis will identify how selected national policy documents represent the 'problem' of mental health and what presuppositions or assumptions underlie this representation. It will interrogate how mental health is framed conceptually. The central aim of the study is to interrogate representations offered by policy makers on the 'problem' of health.

1.4. Research Question(s)

This study is guided by one primary question and two secondary research questions.

Primary question:

What is the 'problem' of mental health in South African national health care policy represented to be?

Secondary Questions:

1. What are the assumptions underpinning these representations?
2. How is mental health conceptualised?

1.5. Theoretical and Conceptual Framework

As a basis for problematising how mental health is represented in policy, this study will utilise the framework based on Carol Bacchi's (2009:2) analytical tool, 'What's the Problem Represented to be?' or the WPR approach.

Conventional policy analysis tools, such as 'problem solution' approaches, depict the policy process as ‘rational, balanced, objective, and orderly’ (Goodwin, 2012:25). However, many commentators have pointed out that the ambiguous nature of the policy process renders these portraits questionable (Bletas & Beasley, 2012; Colebatch, 2006, Newman, 2001, Yeatman, 1998). These post-structuralists and post-modernists argue for a shift in focus from the instrumental dimensions of policy analysis, to questioning conceptual frameworks. Instead of being seen as finding a solution to an existing problem, policy processes are understood in

terms of framing[6] and reframing the problem (Colebatch, 2006:14).

Situated within this Foucauldian, post-structuralist school of thought is Bacchi's framework. The WPR approach is a tool with which to facilitate critical interrogation of public policy (Bacchi, 1999:13). It starts from the premise that a proposed solution reveals what one believes is problematic or needs to change. By revealing 'solutions', policy proposals implicitly represent what is considered to be the 'problem', also known as the problem representation (Bacchi, 2009: xviii). Bacchi's approach therefore shifts from presumed problematic conditions, to question how the 'problems' are given shape and meaning within policy (Bacchi, 2016:2).

The approach can be condensed into six guiding questions designed by Bacchi (2009:2):

1. What's the problem (e.g.: domestic violence, abortion, poverty, etc.) represented to be in a specific policy?
2. What presumptions or assumptions underlie this representation of the 'problem'?
3. How did this representation of the 'problem' come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the problem be thought about differently?
5. What effects are produced by this representation of the 'problem'?
6. How/where has this representation of the 'problem' been produced, disseminated, and defended? How could it be questioned, disrupted, and replaced?

This framework helps to disentangle the complex policy arena and allows policy makers and analysts to better decipher and contextualise different forms of evidence within the various political, theoretical, and ideological perspectives. The starting point is a close analysis of government documents within their specific socio-political contexts. Using the raw material of policy statements, media representations, and theoretical analyses, the WPR approach seeks to identify and critique the 'solutions' proposed. It is through analysing the presented 'solutions', that one can note the competing interpretations or discourses in political issues. The focus on discourse, defined here as' languages, concepts, and categories employed to frame an issue' (Bacchi, 1999:2), indicates the influence that Foucauldian theory has on the WPR approach.

[6] 'Framing' here being defined by Kingdon ((2003:59) as 'how an issue is defined which can in turn influence how the issue is viewed (non-issue, problem, crisis, etc.), who is considered responsible and the cause and possible solutions'.

Foucault trail-blazed the problematisation of discourses, stating that 'all those discursive practices that introduce something into the play of true and false and constitute it as an object for moral reflection, scientific analysis, or political analysis' (Foucault, 1984:257).

Within the post-structuralist and postmodernist policy theory are various scholars whose theories operate in the same paradigm as Bacchi's and would have adequately sufficed as the theoretical backbone of this study (Shapiro, 1988; Smith, Hunter, Blackman, *et al.*, 2009). However, Bacchi's framework stands out, moving beyond questioning the values in policies or the linguistic and semantic framings, to questioning 'the deep-seated ontological and epistemological premises' (Bacchi, 2016:11). As a result of its elegant simplicity, its versatility, and its continued relevance in the policy analysis field, this analytical tool was chosen for this study.

This analytical tool was initially developed to investigate how gender was represented in policies. After noting its practicality in a broader setting, Bacchi then applied to it the post-positivist field in critiquing policy analysis theories and applications in certain case studies, before finally applying it as a method of analysing governance. Part of the appeal for many scholars using the WPR approach (Yanow & Schwartz-Shea, 2015; Connell, 2012; Gunter, 2011), is its unique adaptability to analyse any policy field, offering a range of questions that are seldom asked in policy analysis. As a result, the WPR approach has been used in a wide variety of fields, including gender theory, health policy, education, international relations, and environmental studies.

A practical example of how the approach can be used in policy analysis is seen in Osborne *et al* (2013). The review analyses an income management initiative for certain 'dysfunctional communities,' where welfare income is directed away from certain goods such as cigarettes, alcohol, etc (Osborne, Baum & Brown, 2013). A WPR approach would question the understanding of the 'problem,' which seeks to correct the behaviour of the individuals and their income habits, rather than shifting focus to the broader context, questioning how these individuals are shaped by and fit in within their socio-political environment. This particular initiative reveals a simplistic understanding of poverty, which would in turn result in a simplistic response unsuited for the environment contextually.

While Bacchi's model has been used to critique health policy (Bacchi, 2016), mental health

subject framing in Hong Kong and New South Wales (Cui, Lancaster & Newman, 2019), and the representation of mental health in court (Spivakovsky & Seear, 2017), there is limited use of the model for mental health care policy in a LMIC context. This study will thus offer an alternative perspective on South African mental health policy, problematising policy by applying Bacchi's six questions to government documents.

Bacchi's model allows for a multi-focal analysis of how mental health is represented in policy, enabling this study to take into account the complexities that make up particular policy 'problems'. As far as the majority of the literature evaluating mental health policy in South Africa is concerned, policy is understood from a stagist, positivist framework. Due to the multi-causal nature of mental health, a simplistic understanding of what it is and how to 'solve' it, will lead to simplistic, limited, and possibly detrimental policies. In using Bacchi's framework, this study will offer a unique analysis of South African mental health policy, unpacking the framings and assumptions of the 'problem' made by policy makers, with the aim of critically assessing the substantive content of the policies.

1.6. Methodology

The WPR approach prescribes the analysis of secondary sources and grey literature in order that the analyst can critically reflect on the substantive content of policy initiatives in health policy (Bacchi, 2016:1). As a result, this study will predominantly be a desktop study in method. For the most part, it relies on non-numerical data from secondary and tertiary sources, making it a qualitative study according to the definition of Burnham *et al* (2008:40).

Initial document analysis took place before the analyst applied Bacchi's (2009) WPR approach, so as to establish which mental health care policy documents were to be used for analysis with Bacchi's tool. This process is described as the 'analytical procedure which entails finding, selecting, appraising, and synthesising data contained in documents' (Bowen, 2009:28). This is the foundation of Bacchi's approach. All data was obtained from the national documents, as opposed to formal interviews. No formal interviews were conducted to extract data.

The collection of data is interpreted through Bacchi's WPR method as outlined above, using two of the six questions to problematise the mental health care policy. The two questions that

form the methodology are: ‘What’s the ‘problem’ represented to be in a specific policy?’ and ‘What presuppositions or assumptions underlie this representation of the ‘problem?’ (Bacchi, 1999:2). This study only dealt with these two questions out of the six in Bacchi’s analytical tool as its aim was to identify the problem representation in mental health care policy. The other questions posed by the WPR approach are intended to provide analysis on the silences and effects of the problem representation, and are thus superfluous to this study.

The policy documents analysed in this study will be restricted to those produced by the DoH. The reason documents released from provincial departments of health were not analysed was due to the fact that out of the nine provinces, one produced a stand-alone mental health policy. The four documents chosen to analyse are: The *White Paper for the Transformation of the Health System in South Africa of 1997;* the *National Mental Health Care Act of 2002;* the *National Child and Adolescent Mental Health Policy Guidelines of 2003;* and the *National Mental Health Policy Framework for 2013-2020.* This will reveal the problem representations of mental health in South African public policy over a period of time.

The disadvantage of using secondary sources is that the data collected may not be entirely appropriate, simply because it has been collected to answer a different research question or objective, rather than one’s own study (Denscombe, 2010:233). However, the advantages of largely using secondary sources far outweigh the disadvantages, as secondary data collection allows for an ease of 'accessibility, convenience, and reduced costs in time, money, and inconvenience to participants’ (Vartanian, 2011:16). Additionally, the analytical tool chosen for this study encourages the use of secondary sources such as policy documents that make up what is labelled as ‘prescriptive texts’, that will be the focus of analysis (Bacchi, 2009:34).

1.7. Ethical considerations

After being granted ethical clearance, this study followed the guidelines and procedures set out by the Stellenbosch University's Research Ethics Committee (REC) for Humanities.

1.8. Conclusion

Chapter 1 introduces the topic and outline the history, theory, case study, and methodology.

Chapter 2 provides background on the various different conceptions of mental health in South Africa through reviewing literature on the many ways mental health is understood and managed.

Chapter 3 details the major policies, legislation, and practices that affect mental health care in South Africa. It then discusses the scholarship on mental health policy in South Africa.

Chapter 4 presents a review on Bacchi's analytical tool, the 'WPR approach' and grounds it within poststructuralist theory, with particular reference to Foucault's philosophical underpinnings. This approach is contrasted with other policy analysis theories. It then details how the analytical tool will be used in this study.

Chapter 5 practically applies the WPR approach to explore the various ways mental health is represented in South African policy. It then explores the assumptions and frames of reference underpinning the representations, as well as examining how mental health is conceptualised in mental health care policy.

Chapter 6 produces a summary of the findings and gives an answer to the research problems and subsequent questions. It then details the limitations of the study and offers recommendation for further research

Chapter 2: Review of Literature Surrounding Mental Health

2.1. Introduction

This chapter will provide an overview of the literature regarding the conceptions of mental health in South Africa. This will provide context and background necessary to solve the research questions of how mental health is represented in policy, the assumptions and conceptualisation that underly these representations. This will be achieved through outlining the various ways that mental health in South Africa is understood and framed within the available literature. Through this process, this chapter will provide the building blocks with which to answer the research questions

This section will include eight major clusters of thought that the scholarship of this topic centres around. It is through these lenses of thought that mental health is understood and problematised. These eight topics will provide context and background to how mental health is represented in policy, which is imperative in analysing South African mental health policy in Chapter 5. All these conceptions understand the origin, expression, and management of mental health slightly differently. They will be expounded in the following order: the biomedical model; the law; politics and governance; policy; lower to middle income countries; poverty; culture; religion and spirituality.

The first two conceptions, biomedical and the law are grouped together as they both understand mental health through well-defined and precise parameters, as well as examining mental health as an individual issue. In contrast, the remaining six conceptions view mental health from a communal perspective. In these conceptions, mental health moves from being well-defined to a more nebulous and fluid concept that can be addressed in a multitude of ways.

A broad range of contextual factors such as cultural attitudes, political support, other health concerns, or the nation's socio-economic situation can direct the problematisation of mental health in policy. The eight conceptions covered below that are used to define and understand mental health all influence and direct South African mental health care policy. They are

influenced by each other, whether it be by using other frameworks as foundation from which to build upon, or as a reaction against.

A somewhat imprecise and slippery concept, mental health can and does occupy space in a large variety of fields. It is imperative to note the complexity of defining and understanding the concept. To a large extent, mental health remains difficult to understand, define, classify, diagnose, and treat. The variety of possible causes for mental health problems make the topic enormously challenging to pin down. So much of what is meant by mental health is dependent on the frame of reference used. The various frames of reference will also fundamentally influence how mental health is managed, on an individual and societal level.

Scott (2016:np) states:

> When one uses the term “mental health”, in a context where it means everything (e.g., concerning mental distress) the concept of health and ill-health subsumes all of the context. However, the concept has so much slippage when subjected to a detailed critical analysis, it deteriorates into a phantasm that continually haunts in the background, because the concept cannot contain or represent in an ideal way, when it reduces or reifies human experience in such a way.

2.2. Mental health and the biomedical model

The predominant context from which mental health is understood is the biomedical model, conceptualising the phenomena as an actual illness, a bodily dysfunction with a biological basis. This conception has dominated the discussion surrounding mental health since the very term was first used, both internationally and in South Africa. Habibis states that the largest room in the house of mental health is clearly psychiatry, and clinical research dominates the field (Habibis, 2005:310). The influence that this conception has on how the ‘problem’ of mental health is understood cannot be understated.

The biomedical model is very much the realm of psychiatry, neuroscience, and to a lesser extent, clinical psychology. Psychiatry is a specialised field of medicine where practitioners will diagnose, prevent, and manage 'mental disorders' (Alarcón, 2016). Psychology, the broader of

the two fields, is the study of behaviour and the mind (Brazier, 2018). A psychologist will treat a patient's symptoms through behavioural and cognitive change, as opposed to a psychiatrist who is more likely to focus on the medical management. There are different fields of psychology, such as educational, social, cognitive, developmental, and forensic (Brazier, 2018). There are other fields and sub-fields in the biomedical model, and all contain somewhat contrasting conceptions and theories of the causes and cures of mental health problems.

The terms 'mental health' or ‘mental illness’ are products of the biomedical model that comes loaded with historical and conceptual baggage. The very semantics of the field are influenced by the biomedical model. The word 'illness' suggests that one should look for aetiology and symptoms to diagnose, and cures to treat mental health problems (Ceusters & Smith, 2010:1). An individual 'diagnosed' with a mental illness will go for 'treatment' or receive 'medication', these terms indicate that mental health is a medical problem that can be solved through a treatment regimen. For this reason, mental health problems are labelled as ‘mental illnesses’ in this section.

Indeed, the very separation between the parts of self, the 'mind' and the 'body', is considered by some to be product of Western biomedical models of psychiatry (Bendelow & Menkes, 2006; Moncrieff, 2008; Fernando, 2010; Parle, 2003; Kendler, 2009). Fernando argues that even the boundary between disorders of the mind and the body is in itself a cultural construction which underlies the categorisation of illness which we have classed as 'mental' (Fernando, 2010:37). Griesinger was the first to state that 'all mental illnesses are cerebral illnesses' (Griesinger, 1882:14). Since then, the biomedical conception has to some degree dominated the mental health discussion, internationally and in South Africa (Moncrieff, 2008:217). Within this framework, mental health and illness have increasingly been seen in terms of 'purely physical phenomena, which can only be treated through medical expertise' (Parle, 2003:117).

The international classification of mental illness that South African mental health care workers use on a day-to-day basis, has continued to be a contentious issue. Without delving into the philosophical complexities of the topic, there is a debate around whether mental illness is a disease of the 'brain' or of the 'mind'. Szasz (1979) notes the contrast between the two views. A disease of the brain is a result of some neurological defect and physicochemical processes that manifest themselves in physical and/or mental symptoms (Szasz, 1979:122). In contrast, disharmony in the 'mind' is inextricably linked to the social and ethical context in which it is

made; influenced by 'conflicting personal needs, opinions, social aspirations, values, and so forth' (Szasz, 1979:122). While these two positions are not mutually exclusive, there is a tendency for medical professionals to rely on one mode of explanation more than the other when attempting to understand or explain mental illness.

The Diagnostic and Statistical Manual of Mental Disorders (DSM – 5) has noted the conceptual difficulty of defining precise boundaries, stating that there is no definition that adequately covers all the complexities of mental illness (American Psychiatric Association, 2013:20). The term simply lacks a consistent working definition, as it has been defined by a number of terms, including, 'distress, disadvantage, disability, inflexibility, irrationality, and statistical deviation' (Swanepoel, 2015:3240). Each term is a helpful indicator for mental illness, but none covers the concept completely or is applicable in every case (Swanepoel, 2015:3240).

The cause(s) of mental health problems are under intense debate; researchers are still looking for answers in neuroscience, genetics, epigenetics, and neurodevelopment. To date there are no definitive answers or conclusive identifiable biomarkers for mental disorders (Banner, 2013, Stein, Phillips, Bolton, *et al.*, 2010; Maj, 2013). However, the advances in genomics and brain imaging in the last few years have resulted in the strengthening of biomedical psychiatry and have 'contributed to the reification of mental disorders as illness of the brain' (Malla, Joober & Garcia, 2015:147). It is common practice in the clinical psychology field to inform patients and the public that mental health problems are caused by an imbalance in the neurotransmitter pathway system, despite the fact that this has not yet been definitively proven (Margraf & Schneider, 2016:1116).

This in turn has influenced and been influenced by medical practitioners and several mental health awareness initiatives and campaigns (Pescosolido, Martin, Long, *et al.*, 2010). These programmes were intended to educate the public as to the neurological causes of mental health prob so as to increase treatment support and lower stigma of mental health problems. In the last two decades, mental health awareness campaigns have been filled with lists of discernible symptoms, biochemical etiological theories, and 'the basic argument that mental illnesses are diseases, no different from others amenable to effective medical treatment, control, recovery' (Pescosolido, *et al.*, 2010:3).

In South Africa, where the stigma and lack of awareness surrounding of mental health problems

are widespread, there is a push to equate mental health problems with physical illness to lessen the controversy around the topic (South African College of Applied Psychology, 2019). In a recent attempt to raise awareness on mental health, Lewis stated that mental disorders cannot be treated by ‘a change of attitude, and that a failure of the brain is just the same as a failure of the heart, liver, or lungs’ (Lewis, 2017). The South African Depression and Anxiety Group (SADAG) indicate a similar position, stating that like any chronic condition, 'mental illness can be managed successfully through disease management' (Hamdulay, n.d.).

Despite the difficulty of pinpointing physical indicators or 'proofs' of mental illness, classification methods have been developed to determine the type and severity of mental illness. The main diagnostic tools for defining and diagnosing mental illness are the Diagnostic and Statistical Manual of Mental Disorders (DSM – 5) and the International Classification of Diseases (ICD – 10). These two classification systems were produced by the APA and the World Health Organisation (WHO), respectively. They are widely used internationally and in South Africa to diagnose mental disorders (Vahia, 2013:221). The classification of mental illness has profound knock-on effects on the conceptualisation of mental health on an individual and societal level. A diagnosis of a certain mental illness can change an individual’s perception of themself, their community’s attitude towards them, and their dependence on health care facilities. This will be expanded on in this chapter.

The DSM – 5 defines mental disorders as including one or more of the following factors:

1. A behavioural or psychological syndrome or pattern that occurs in an individual;
2. Reflects an underlying psycho-biological dysfunction;
3. The consequences of which are clinically significant distress and disability;
4. Must not be merely an expected response to common stressors and losses (e.g. the loss of a loved one) or a culturally sanctioned response to a particular event; or primarily a result of social deviance or conflicts with society (American Psychiatric Association, 2013:20).

According to the DSM – 5, there are 20 major identified diagnostic classes of disorders[7].

[7] Neurodevelopmental disorders, schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma- and stressor-related disorders, dissociative disorders, somatic symptom and related disorders,

Banner (2013) outlines the complexity of the diagnostic process. This classification method uses the categorical approach to diagnosing mental disorders. This means that in order to be diagnosed with a disorder, the individual must exhibit a specific number of symptoms to qualify for a particular diagnosis. When these classification systems describe symptoms or behaviours, they are not understood in the traditional sense in terms of a physical process; but rather self-reported observations, and are thus not necessarily indicative of biological or cognitive functioning (Banner, 2013:510).

The ICD – 10 differs from the DSM – 5 in that it is not specifically focused on mental illnesses, listing a multitude of diseases, disorders, injuries, and other related health conditions for statistical purposes (WHO, 1992). The ICD – 10 states that mental disorder is 'not an exact term', although is generally used '...to imply the existence of a clinically recognisable set of symptoms or behaviours associated in most cases with distress and with interference with personal functions' (WHO, 1992:5). The ICD – 10 system provides prototype descriptions of disorders along with diagnostic guidelines from which clinicians must base their decision on; also known as the dimensional approach to diagnosing (Burns, 2014:66).

Both of the ICD – 10 and DSM- 5 have come under intense critique on a number of issues, as the classification of mental health is not an exact science with a strong biological basis. These include the categorical versus dimensional approach to classification. Briefly, this is the tension between diagnosing people with mental illness within clearly distinguished diagnostic categories, and classification based on broader underlying 'spectra' where each spectrum 'links together a range of categorical diagnoses and patterns (Maser & Akiskal, 2002). Both of these approaches' present difficulties.

As mentioned, the categorical approach requires an individual to exhibit a certain number of particular symptoms in order to qualify for a diagnosis. Burns (2014) notes the complexity of such a diagnostic system. A diagnosis is made by examining the number and duration of symptoms, and presence of functional impairment. However, individuals often exhibit multiple behavioural, emotional, and cognitive symptoms that may overlap more than one category, or

feeding and eating disorders, elimination disorders, sleep-wake disorders, sexual dysfunctions, gender dysphoria, disruptive impulse-control and conduct disorders, substance-related and addictive disorders, neurocognitive disorders, personality disorders, paraphilic disorders, and medication-induced movement disorders (American Psychiatric Association, 2013).

are deficient in quality or quantity to meet diagnostic criteria for a category (Burns, 2014:67). In addition, certain mental disorders develop gradually over time, displaying a variety of different symptoms. If an individual is diagnosed incorrectly or fails to be diagnosed at all, they will not access the appropriate treatment as soon as possible, or perhaps ever. They will also be seen as entirely legally culpable, and not receive medical insurance for treatment (Burns, 2014:67).

The dimensional approach has also come under critique. When diagnosing someone on a sliding scale, there is a danger of medicalising a range of normality, as the line between mental health problems and what is 'normal' becomes blurred (Burns, 2014:67). While this approach could reduce stigma towards people living with mental health problems (PLWMHP) as it implies a level of continuity between illness and normality, it could increase stigma for those who are situated closer to the realm of normality. This approach risks medicating normality in a bid to make sure everyone receives treatment (Burns, 2014:67). Both these systems make it immensely difficult to make a definite diagnosis.

This makes defining and conceptualising mental health in policy that much more complex. If the classification of mental health is as nebulous and controversial as it appears in the biomedical context; how much more difficult is the task of policy-makers to understand the ‘problem’ of mental health as it affects South African citizens?

A further critique of the classification systems, and to some extent the biomedical model, is the degree of cultural dissonance between the classification systems and all countries in which it is used (Burns, 2014; Pickersgill, 2012; Michalopoulos, Unick, Haroz, *et al.*, 2015). While both systems were developed in consultation with 'developing countries' during the revision phase, Burns points out the inevitability that they will reflect more closely the perspectives and values of the 'developed countries' (Burns, 2014:66). This critique will be expanded upon more thoroughly further along in this chapter.

When mental illness is seen predominantly as a biological disease, prescribing medicine is more often than not, the first port of call, ideally in conjunction with a form of psychotherapy. In South Africa, managing mental illness through psychopharmacological means is encouraged by the DoH (Lund, Kleintjes, Campbell-Hall, *et al.*, 2008:11). The diagnosis of a mental illness often leads to a prescription of psychotropic drugs that are capable of affecting the mind,

emotions, and behaviours (Shiel, 2018). Current medical treatments, specifically psychopharmaceutical interventions, for mental illnesses are palliative; managing symptoms rather than curing them (Insel & Scolnick, 2006:3). In many cases, specifically with 'moderate' mental illnesses, an individual can take psychotropic drugs for a period of time and wean themselves off the medication without any recurring symptoms. With more 'serious' mental illnesses, it is necessary to take the medication for the duration of their lives.

As making definite diagnosis with mental illness is complex, so too is finding the correct medication and dosage. However, when used correctly, psychotropic drugs can allow for the management or alleviation of symptoms that enable PLWMHP to function more 'normally'. The biological model of managing mental illness generally surpasses other models and treatments in efficiency and practicality (Grover, Chakrabarti, Sharma, *et al.*, 2014:382). Factors such as perceived efficacy, benefit from the medication, or the necessity for taking the treatment result in positive attitudes towards the medication. This positive attitude is aided by both PLWMHP and their caregivers being properly educated on the need for using the medication (Iseselo & Ambikile, 2017:9).

Ideally, the prescription of psychotropic drugs would be preceded and followed by psychotherapy, but due to insufficient availability of comprehensive psychotherapy, psychotropic drugs is generally the only option for PLWMHP in South Africa (Margraf & Schneider, 2016; Petersen & Lund, 2011). In LMICs where psycho-social management is limited as a result of few mental health practitioners, pharmacological therapy with severe mental illness cases[8] is the most common treatment method in many government funded health facilities (Iseselo & Ambikile, 2017:2).

The danger of over-medicalisation is amplified in a LMIC context where there is not always the political, social, legal, and economic systems to protect the individual (Burns, 2014:66). Regulations of the pharmaceutical industry vary from country to country, and in particular, LMICs, control over the conduct of the industry is limited. The specifics of South African legislation regarding pharmaceutical industries will be expanded upon in Chapter 3.

The biomedical model of mental health influences all other conceptions of mental illness in

[8]Including schizophrenia, bipolar disorder, and major depressive disorder.

this chapter to some degree. The dominance of this school of thought is invaluable in laying the groundwork for analysing how mental health is understood in policy. The conceptual hegemony of this school of thought can be seen in the field of law where mental illness is used as a defence. The medical field is heavily relied upon to determine the relevance of such a defence.

2.3. Mental health and the law

As mental health is generally understood as a psychiatric concept falling within the biomedical model, it is inevitable that this concept overlaps with others. This influence can be seen in the theory and practice of South African criminal jurisprudence and law, particularly the defence of mental disorder and diminished responsibility. Law and policy as social phenomena result from the same entity (Cerar, 2010:2), closely entwined in a symbiotic relationship. Understanding how mental health is conceptualised in the law aids our understanding of the concept as represented in policy.

Burchell (2014) expands on mental health as conceptualised in the legal field. Mental illness was first recognised as a legal defence in Roman law where mentally ill individuals were grouped together with young children as lacking criminal capacity, and were thus exempt from punishment (Burchell, 2014:271). This marked the beginning of the legal practice to categorise the mentally ill as a distinct subgroup within the penal system (Arrigo, 2002:105). The traditional, legal term used for this defence is 'insanity', but has since changed to the defence of mental disorder or pathological incapacity. It is worth noting that the word pathological derives from the Greek word '*pathos'*, meaning suffering. By extension, the word pathological has since come to connote disease, and can apply to mental or physical symptoms equally (Burchell, 2014:271).

Legally, mental disease or defect may deprive persons of the capacity to appreciate the wrongfulness of their conduct. It may also deprive them of the capacity to control their conduct (Burchell, 2014:271). The fundamental premise of this argument is that certain individuals are the victims of a condition that causes them to behave in a particular manner. As such, they cannot be entirely blamed or punished for their conduct while afflicted by the illness or disease.

This is an affirmative defence, used to exempt the accused from full criminal liability ("Criminal Law", 2012).

South African law[9] states that a mental illness that affects the cognitive or conative capacities so as to deprive the victim of insight into the wrongfulness of their conduct or of capacity to control their actions according to that insight, constitutes 'insanity' or 'pathological incapacity' (s78(1) of Criminal Procedure Act 51, 1977). Mental illness that does not deprive them of this capacity, cannot fall within the boundaries of insanity (Burchell, 2014:286). The specifics of this definition will be expanded upon later in Chapter 3.

Since mental illness is a psychiatric term, Burchell states that it is inevitable that there is overlap between the legal and psychiatric concepts of mental illness (Burchell, 2014:275). South African law, to a large extent, has been and is informed by scientific psychology (Fontaine, 2012). However, as much as the law makes use of psychiatric concepts and classificatory systems, the two fields are not a perfect fit.

Since the terms 'insanity' and 'pathological incapacity' are legal concepts used to describe certain mental states in order to excuse criminal liability; they lack scientific precision (Burchell, 2014:275). Determining whether someone is pathologically incapable of realising the wrongfulness of their actions is thus a subjective matter. The DSM – 5 classificatory system cautions that more than a DSM – 5 diagnosis is required for an individual to meet the legal requirements of pathological incapacity (American Psychiatric Association, 2013:20). As not all mental illnesses deprive the sufferer of insight and control,[10] the question of whether the defence of pathological incapacity applies is answered not only by a psychiatric classification, but by the law and evidence (Burchell, 2014). As the decision of each case will depend on the specific facts and medical evidence, Rumpff (S vs Mahlinza, 1967:417) warned that it is impossible and dangerous to attempt to define any general symptom by which a mental health problem could be recognised as a mental 'disease' or 'defect'. Indeed, Fingarette (1966:232) goes as far as to say that there is no legal definition of mental illness at all, and that the courts and legislators have generally assumed that mental illness falls within the purview of the

[9]Specifically, the Criminal Procedure Act 51 of 1977, Section 78.

[10]For example, severe forms of schizophrenia would be seen as rendering an individual as pathologically incapable, but anxiety disorders and phobias would not.

medical field. The law does not dictate the criteria of clinical illness, but it does determine what forms and severity of psychopathology are exculpatory (Swanepoel, 2015:3245).

The lack of a formal legal definition of mental health is displayed in South African legislation. Mental illness is defined in the *National Mental Health Care Act 17 of 2002*, as 'a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health practitioner authorised to make such diagnosis' (National Mental Health Care Act 17, 2002:10). As the symptoms and severity of mental health problems differ, there is no clear distinction between mental illnesses that meet the criteria of criminal non-responsibility and those that do not (Burchell, 2014:276).

Burchell (2014) notes that the absence of a formal classificatory system presents a variety of nuanced legal and ethical challenges. In cases where judges are not sensitised to the multitude of mental health problems and the degrees of severity or there is no medical practitioner to make a clinical diagnosis, a defendant with a sub-diagnostic mental disorder may be held wrongfully culpable. Widening the diagnostic borders would also present challenges, where an offender might be afforded a lesser sentence or even acquitted on the basis of minor or feigned symptoms (Burns, 2014:67).

The conception of mental health in the field of law is by no means set in stone. As seen in this section, whether mental illness is a factor in an individual's defence is determined on a case-by-case basis. Mental illness is seen as an individualised problem, (a result of an individual's capacity or control of their actions), rather than a result of any systemic or communal factors. This is contrasted by the remaining six conceptions which conceptualise mental illness collectively.

2.4. Mental health and politics

What the first two conceptions of mental health have in common is that they focus primarily on mental health from an individual perspective, largely disconnected from any social structural analysis (Leighton, 2004:22). The 'problem' of mental health in these two conceptions, is tackled on a case-by-case basis. This is contrasted by the conception that mental health is shaped by communal, social, cultural, and economic factors. Mental health can be

understood as a ‘problem’ for the government to solve on a national scale, where mental health is influenced and influencing the political realm.

Sontag (1978:58) notes the value in treating mental health as a societal and political issue:

> The notion that a disease can be explained only by a variety of causes is precisely characteristic of thinking about diseases whose causation is not understood. And it is diseases thought to be multi-determined (that is, mysterious) that have the widest possibilities as metaphors for what is felt to be socially or morally wrong.

PLWMHP in South Africa are part of a social order, affected by social determinants. The social determinants of mental health problems are considered to be, 'the social and economic circumstances, including poverty, income inequality, interpersonal and collective violence, and forced migration' (Lund, Brooke-Sumner, Baingana, *et al.*, 2018:357). The national social determinants can be seen to be contributing factors to the prevalence and severity of mental health problems in a population.

At a macro level, the actions of the government and economy of a nation has an effect on the frequency and severity of mental health problems within a population. Individual-level factors (such as education, spending, capital investment), interact with national contextual factors (income inequalities and absolute income). In an international study aimed at exploring the prevalence of depression across countries, it was found that while individual-level factors did explain most of the variation in rates of depression; country level factors did make a contribution. These factors are inversely proportional to the country's economic development (Rai, Zitko, Jones, *et al.*, 2013:202). A systematic review on the social determinants of mental health showed that national economic decline, and the resulting effects on employment, income, and loss of social networks, have been associated with an increased risk of depression, anxiety, and alcohol abuse (Lund *et al.*, 2018:261).

Mental health as understood from a political and governmental perspective is a conversation that has become increasingly popular, both internationally and in South Africa. This conversation has resulted in a growing area of research linking South African mental health governance to sustainable development goals (Docrat, Besada, Cleary, *et al.*, 2019; Lund, Brooke-Sumner, Baingana, *et al.*, 2018; Patel & Kleinman, 2003; Egbe, Brooke-Sumner,

Kathree, *et al.*, 2014). Mental health and well-being were included in the UN Sustainable Development Goals in 2015 and was defined as a priority for global development (Lund, Brooke-Sumner, *et al.*, 2018:357). The WHO reported that social determinants such as inequality, education, and gender can influence the mental health of a community and nation (WHO, 2014a:8).

The placement of mental health on a country's list of priorities has a marked impact on mental health services. Governmental investment in mental health have been shown to increase the potential and productivity of PLWMHP and their families (Lund, Brooke-Sumner, *et al.*, 2018:357). Mental health, especially in LMICs, is often considered a low priority issue as compared to other issues such as poverty, education, and other health burdens. In South Africa, one of the main political priorities is the development and service provision of those previously disadvantaged by the Apartheid government (Omar *et al.*, 2010:4).

From a purely budgetary standpoint, government spending on mental health systems in LMICs is minimal, 1 – 2% of the health budget (Iseselo & Ambikile, 2017). The South African government has invested slightly more than the average LMIC, spending 5% of the total public health budget on mental health (with the provincial range of 2 – 7% of provincial health budgets) (Docrat *et al.*, 2019).

Mental health services are provided by the public health system, which serves roughly 84% of the population (Docrat *et al.*, 2019), through psychiatric hospitals, psychiatric clinics, primary health care (PHC) facilities, and, to a lesser extent, certain non-state actors. As mandated by the Constitution, both the national and provincial government are responsible for providing mental health services. The private health care system plays a smaller role in providing mental health services to a minority (Omar *et al.*, 2010).

The current trend of mental health care in South Africa has shifted toward an integrated approach. Integration is defined by the WHO as 'the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system' (WHO, 2008). Mental health services are integrated to PHC services and non-state actors through task-shifting (Janse van Rensburg, 2018:6). This approach is used in the attempt to make mental health care accessible to the entire population at multiple levels. Referrals and collaboration take place

between health care facilities and a variety of different actors, including but not limited to, private care, faith-based institutions, NGOS, and traditional healers (Janse van Rensburg 2018:14). These collaborative relationships operate both horizontally and vertically. Vertically, patients are referred up the tiered health system depending on the severity of symptoms. Horizontally, the government collaborates with non-state actors in the care of PLWMHP.

Task-shifting to NGOs is particularly prevalent in South Africa. The South African Federation for Mental Health, a national NGO, supplies a broad network of mental health services, including half of all community residential facilities (Omar *et al.*, 2010:4). The success of this task-shifting in a LMIC has not been comprehensively covered. However, it is suggested that mental health integration is poor (Janse Van Rensburg, 2018; Lund, Kleintjes, Kakuma, *et al.*, 2010; Petersen, 2000; Petersen, Lund, Bhana, *et al.*, 2012). The recent Life Esidimeni tragedy, where government outsourced the care of 1300 psychiatric patients to their families, NGOs, and other health care facilities resulting in the death of 143 patients from starvation or neglect, is a sobering testament of failed task-shifting and governance (Makgoba, 2017).

Conceptualising mental health from a political perspective is related to policy. The way in which a governing body manages the mental health of its population is demonstrated through its policy.

2.5. Mental health and policy

As the subject of this study is mental health and policy, this section will briefly outline the importance of how mental health is conceptualised, defined, and placed on the agenda. How mental health is represented in public policy is greatly dependent on the national and cultural milieu. The development and implementation of health policy in general has been described as 'complex, multi-level, continuous and driven, to varying degrees, by government, the public, including interest groups, and foreign agencies (Draper, Lund, Kleintjes, *et al.*, 2009:343). A variety of factors can influence how the 'problem' that the policy attempts to solve is conceptualised.

How government officials, policy makers, and bureaucrats conceptualise and prioritise mental health has a direct effect on the services that are provided for PLWMHP. Whether mental health

is placed in policy is somewhat dependent on where the general public's knowledge, understanding, and attitude towards it is. Stigma can contribute to the low priority of mental health and its place on the agenda, despite the high mental health burden. Stigma will affect whether advocacy groups or the general public will advocate for mental health to be on the policy agenda. It will also affect whether the policy makers themselves view mental health as a social priority (Omar *et al.*, 2010).

Goldman and Grob (2006:737) state the difficulties and consequences of simply defining mental health within a policy. Mental health policy is fundamentally shaped by the definition of mental health used in the policy. While the general trend is to place a higher priority on those people with severe and disabling conditions, there is also the increasing pressure 'favouring a broader concern for people at all levels of impairment' (Goldman & Grob, 2006:737). If policy makers make the scope too narrow, the policy risks excluding some who need care; make the scope too broad, and the people with a wide range of mental health problems put increased pressure on resources. The definition will also influence where and how mental health is placed within policy; whether it be integrated into mainstream health and social policy, or whether it is kept as a separate entity (Goldman & Grob, 2006:737). The allocation of staff and resources to mental health is a helpful indicator of how pressing a problem it is perceived to be by policy makers.

Creating relevant and up to date policy requires dependable, detailed, and locally sourced information on current resources and expenditures on mental health. A useful indicator of how urgent an issue mental health is perceived to be by policy makers is the comprehensiveness and regularity of government reports on allocation of resources to mental health services. This ‘reporting back’ is necessary for a variety of reasons: to measure the efficiency of existing services; to measure resource and access inequalities; to note priorities and plan for mental health services; to provide a baseline with which to measure future resource estimates; and for targeting specific health system constraints (Docrat *et al.*, 2019:707).

Unfortunately, in many LMICs, there are serious gaps in the data available. In a survey of 127 LMICs, only 51 could provide the total government expenditure on mental health. Those that did so did not account for regional variability, degree of policy implementation, and availability of services and resources (Docrat *et al.*, 2019; WHO, 2017). Problems such as this illustrate how conceptualising mental health in a LMIC context will present distinct challenges that will

affect how mental health is understood by policy makers.

2.6. Mental health and Lower to Middle Income Countries (LMIC)

As mentioned in Chapter 1, a large amount of the literature related to South African mental health care examines mental health through the lens of social and economic factors. This features both observational and intervention research. A systematic review of 289 articles showed the growing area of research in the social determinants of mental disorders. The social determinants of mental disorders are, 'the social and economic circumstances, including poverty, income inequality, interpersonal and collective violence, and forced migration' (Lund, Brooke-Sumner, *et al.*, 2018:357). These are understood to have a direct influence on the occurrence and severity of mental health problems in a population. Conceptualising mental health as a product of social and economic causes will influence a policy maker's approach in creating legislation. If policy makers understand mental health to be determined by socio-economic factors, the interventions proposed will be more in line with socio-economic development, rather than say interventions that are entirely medical in nature.

Social and economic factors are seen to have an influence on the mental health. People living in a LMIC in a lower socio-economic bracket are reported in having a greater amount of environmental stress to cope with as compared to people living in a high-income country (HIC). Suicide rates have been suggested to be highest in LMICs, and due to inadequate support systems, individuals and their families are disproportionally affected (Janse van Rensburg & Fourie, 2016:2).

Lower Middle-Income Countries are defined by the World Bank as those with a Gross National Income (GNI) per capita between $1 026 and $3 995. Upper middle-income countries are those with a GNI per capita between $3 996 and $12 375; high-income country is those with a GNI per capita of $12 376 or more (World Bank, 2020a). South Africa is considered to be an upper-middle income country by the World Bank and the WHO (World Bank, 2020; WHO, 2017). This income grouping using GNI per capita is helpful up to a point, being a useful indicator closely correlated with other measures for quality of life such as life expectancy and mortality rates of children. But it does not reflect inequalities in income distribution or a country's rate of development (World Bank, 2020b).

While South Africa is classified as an upper-middle income country, many of the challenges LMICs face regarding mental health care are very much a reality to the majority of the South African population who are reliant on the state for health services. The percentage of the population below the upper bound poverty line, 49.2% (Stats SA, 2019), is similar to other countries on a lower economic tier[11] (World Bank, 2019), as compared to other countries in the same economic tier[12] (upper middle-income countries). For the purposes of this study, South Africa will be included in the category of LMICs.

The context in which mental health care services operate varies from country to country. However, there are similarities in the difficulties that LMICs face, including deinstitutionalisation, the low priority status of mental health, and the associated lack of resources for mental health care, specifically at a primary care level (Draper *et al.*, 2009:343). The low priority of mental health care and the resulting lack of resources is exemplified in the disproportionate spending on mental health care across different regions, with LMIC spending US$ 1.53, upper-middle income countries spending US$ 1.96, and high-income countries spending US$ 58.73 per capita on mental health in 2013 (WHO, 2014b). According to the WHO (2017), South Africa spent $7.35 USD on mental health care per person. However, this statistic does not account for the extreme variation of spending, staff, and resources across provinces, in many cases there is little to no data available to even make comparisons on number of mental health professionals, community/non-hospital outpatient facilities, treated cases of severe mental disorder etc (Lund *et al.*, 2008:10). As seen, one of the chief challenges to PLWMHP in a LMIC is the poor provision of services and treatment.

Mental health places an additional burden on underdeveloped health systems, which are already faced with challenges as a result of poverty, conflict, and communicable diseases (Janses van Rensburg & Fourie, 2016:2). South Africa in particular is burdened with one of the highest rates of HIV/AIDS in the world (Central American Intelligence, 2016). There are also fewer mental health professionals available; South Africa has 1.52 psychiatrists per 100 000 people (WHO, 2017).

[11]Namibia 50.1%, Ghana 56.9%, Mauritania 58.8%, Botswana 60.4% (World Bank 2019).
[12]Mexico 34.8%, Russia 2.7% (World Bank 2019).

LMICs generally do not have the political, social, legal, and economic infrastructure to protect PLWMHP from mistreatment or neglect as compared to a HIC (Burns, 2014:66). The dangers of misdiagnosis have already been covered earlier in this section. However, these dangers are amplified within a LMIC context, where the individual does not have a safety net. There is also present the real danger of medicalising normality. As mentioned previously there is a degree of cultural dissonance between the classification systems and LMICs where the classification systems are used (Burns, 2014:66). As these the biomedical model and its classification systems were developed in HICs (in consultation with a small amount of LMICs experts), they will reflect a certain standard of 'normalcy' with which to measure mental health from. The danger is that an individual could be diagnosed with a mental illness when their reaction to environmental stress is entirely appropriate.

2.7. Mental health and poverty

A major component to the risk for common mental disorders in LMICs that has not yet been discussed is poverty. The relationship between poverty and mental health in a population will have an effect on what policy makers consider the problem of mental health. For the purposes of this study, poverty shall be defined as low socio-economic status (measured by social or income class), unemployment, and low levels of education (Lund, Breen, Flisher, *et al.*, 2010:517). Poverty and low socio-economic status also affect health status, health access, and health utilisation (Reiss, 2013:24).

An increasing amount of evidence from LMICs has linked mental health with poverty and social deprivation (Draper *et al.*, 2009; Patel & Kleinman, 2003; Saxena, Maulik, Sharan, *et al.*, 2004; Flisher, Lund, Funk, *et al.*, 2007; Saraceno, Levav & Kohn, 2005; Lund, Breen, Flisher, *et al.*, 2010). Poverty, much like certain definitions of mental health, is very much contextual. Definitions vary depending on the social, cultural, and political systems in a particular region (Patel & Kleinman, 2003:609). Lund notes the challenges this particular area of research presents: the need for more precise measurements of both poverty and mental health in epidemiological research in LMIC, greater diversity in the examination of the mental health consequences of poverty, examination of more diverse socio-economic strata, and a more thorough examination of the mental health consequences of inequality (Lund, 2015:97)

In a systematic review of 115 studies, most reported positive correlations between various poverty indicators, and Common Mental Disorders (CMD) in LMICs (Lund, Breen, *et al.*, 2010). The review shows a similar correlation between the socio-economic inequalities and mental health problems in children and adolescents. Persistently low or decreasing socio-economic status were considered to be major predictors of the beginning of mental health problems. Variables such as 'education, food insecurity, housing, social class, socio-economic status, and financial stress' in particular, were commonly associated with CMDs (Lund et al 2010:517). These results also revealed the challenges facing the socio-economically disadvantaged regarding restricted social mobility and the transference of poverty over generations. Future generations will be influenced by both the socio-economic deprivation of their parents and the increased risk of associated mental health problems (Reiss, 2013:24). These results demonstrate that the environmental stress that people living in poverty cope with, can increase the risk of mental health problems.

There are two major theories that attempt to explain the association between poverty and mental health: the social selection hypothesis and the social causation hypothesis. The social selection hypothesis assumes that PLWMHP descend down the socio-economic ladder because of their mental health problems and inability to function and fulfil expected obligations (Eaton, 1980:149). The social causation hypothesis assumes that mental health problems are the result of socio-economic deprivation (Reiss, 2013:25). Practically, the association is most likely a combination of the two hypotheses, mixed with environmental factors (Lund, Brooke-Sumner, *et al.*, 2018:360). This social selection verses social causation argument is a useful tool with which to examine the problematisation of mental health in a population. How policy makers understand the relationship between poverty and mental health, as a result of or a reason for socio-economic deprivation, will influence their proposed interventions.

2.8. Mental health and culture

The specific cultural context of a country will influence how mental health is represented in public policy. Culture has many intangible influences on what a population understands to be the cause, cure, or prevention of mental health problems. As policy does not function within a cultural vacuum, the population's cultural beliefs and attitudes will influence how mental health is conceptualised in policy. Mental health problems affect all race and cultural groups.

However, an individual's upbringing, culture, and education play a role in how and whether a mental health problem is acknowledged and medically treated (SADAG, 2020). As a result, this will have a great effect on how mental health is problematised in a larger population. For the purposes of this study, the race groups that the apartheid government enforced will be used[13], as that system still impacts the socio-economic reality for most South Africans.

As mentioned, the field of psychology is laden with historical and conceptual baggage; the separation of body and mind being one such conception originating in the 'West'. Modern psychology, as it has come to be understood, has been primarily conducted in Western Europe and North America (Martin, 2008:9). Psychology did not exclusively originate in the west, for example, in Asia, there is evidence of studies dealing with the inner workings of the mind as early as the 1880s (Turtle, 1989:69). The first psychology laboratory in South America was founded in 1916 (Ardila, 1982:106). However, much of the indigenous psychological research remains oral, unpublished, or is published in non-English language sources (Martin, 2008:9). Most African universities did not have psychology departments until the late 1980s, and those that eventually emerged used predominantly western theories. Academies attempted to insert African behaviour patterns into Western moulds, instead of exploring indigenous principles (Bame Nsamenang, 1993:173). As a result, South Africa has no national historical understanding of mental health (as defined by external standards) resulting from years of the concept saturating into the population's consciousness.

For many Black South Africans, mental health as understood by the biomedical field is not part of the cultural milieu. There is great cultural and ethnic variation and diversity with the South African Black communities. However, it has been said that common mental disorders such as depression and anxiety are "White diseases" (Shoba, 2018). The South African Depression and Anxiety Group (SADAG) has stated, 'for a long time, depression has been thought not to exist in and around Africans' (SADAG, 2020). This is due, in part, to a lack of education and awareness around mental health. Mental health problems can be perceived as a personal weakness. Other cultural barriers such as mistrust of medical health professionals and a reliance on community during times of emotional distress (another result of the apartheid system), can also cause a delay or prevent seeking medical treatment (SADAG, 2020).

[13] The apartheid government classified South Africans into four main racial groups: White, Black, Indian, and Coloured. This study will use the same classifications, as the divides across racial lines still greatly influence an individual's/community's perceived culture.

While other cultural groups in South Africa experience cultural barriers regarding mental health, the prevalence of depression among Black South Africans is under-investigated and under-reported when compared to other cultural and race groups (SADAG, 2020). The studies that which take ethnicity into account show a distinct difference in reports of psychological distress between Blacks and Whites (Jackson, Williams, Stein, *et al.*, 2010:12). This is due in part to environmental stress and the lower socio-economic situation that many Black South Africans find themselves in as a remnant of the apartheid system. Essentially, the mental health of ethnic groups in South Africa reflect the historical and current social stratification (Jackson *et al.*, 2010:12), and thus must be taken into account when attempting to understand the cause of mental health problems.

An element of mental health that is specifically prevalent in LMICs like South Africa is the stigma attached to mental health problems. Respondents from a study on four LMICs including South Africa showed poor understanding of mental health problems, with its prevalence often attributed to supernatural or spiritual causes (Omar *et al.*, 2010:3). Psychiatric stigma is perpetuated by family members, friends, employers, community members, health care providers and even policy makers. Stigma ranges from public, externalised stigma, to self-stigma, where it is internalised (Egbe *et al.*, 2014:2). PLWMHP encounter the social, psychological, and economic consequences of psychiatric stigma which can 'exacerbate low self-esteem, marginalisation from society, social isolation, social anxiety, poor social skills, difficulties in securing employment, and overall poor social support' (Egbe *et al.*, 2014:2). Stigma can hinder PLWMHP's treatment and integration into society. It varies in severity and is difficult to quantify, however its effects are far reaching, even affecting policy.

Stigma will also hinder the advocacy from the public for an improved mental health policy and services. If government officials, policy makers, policy advocates, and the general public do not see mental health as a high priority issue, then it will not be placed high on the agenda. Stigma or simple lack of awareness of mental health will also prevent civil society from advocating for policy development or implementation. In South Africa, while there are various mental health service groups, they generally provide support to PWLMHP, rather than advocate for policy change and development (Omar *et al.*, 2010:5). Advocacy groups and activism play a critical role in the formation of a country's policy; without them, an issue will not be considered as big a 'problem' to solve as compared to other more popular lobbying

issues.

2.9. Mental health, spirituality, and religion

A conceptualisation of mental health that is connected to the realm of culture is that of religion and/or spirituality. This will influence how mental health is problematised and affect the role that religious/spiritual communities have ‘solving’ it.

In a South African context, mental health problems are often understood from a spiritual or religious perspective. Dein *et al* (2010) notes that historically, religion, and spiritualism would be considered synonymous, but recent mental health literature differentiates the two. Religion is usually understood as socially based beliefs and traditions, often associated with ritual and ceremony. Conversely, spirituality generally refers to 'a deep-seated individual sense of connection through which each person's life is experienced as contributing to a valued and greater “whole”, together with a sense of belonging and acceptance' (Dein *et al,* 2010). Spirituality can also be considered far more inclusive than religion, as it can be expressed through art, poetry, and mythology, as well religious practices (Dein, 2010). Spirituality can generally be considered more holistic than religion, as spiritual beliefs and practices interact and inform every facet of human life (Chiorazzi, 2015).

Up until the 19th century, psychiatry and religion were closely intertwined. Religious organisations performed (and to some extent in South Africa still perform) many of the functions now associated with the psychosocial field: for example, taking care of the mentally ill and various forms of therapy: i.e., confessional, ritual purification, atoning for past transgressions. The separation of psychology and religion from a biomedical context, came when Charcot and his pupil Freud associated religion with hysteria and neurosis. The relationship between religion and mental health was considered to be irrational and outdated by the emerging field of western psychiatry (Dein *et al.*, 2010).

However, in the late 20th century studies emerged showing a change in attitude towards religion and psychology. Dein *et al* (2010) notes that systematic research into mental health, religion, and spirituality has grown dramatically, as has the field of psychology of religion. Quantitative studies have suggested that, overall, religious beliefs and involvement is conducive to stable mental health. 'Religious or spiritual problems' was introduced in the DSM – 4 as a new

diagnostic category in 1994, urging mental health professionals to not dismiss their patients' religious beliefs (Dein *et al.*, 2010). It should be noted that up till the last decade, the majority of the literature published in English does not focus on developed countries or religions outside of the Judeo-Christian tradition (Martin, 2008:2).

Religious institutions in South Africa offer support for PLWMHP in the form of prayer, counselling, and guidance, as well as supporting individuals and family's basic needs such as food or clothing collected in the community. This support is based on a religious understanding of mental health, that will reflect the institution's conception of the causes of mental health and illness in general.

The relationship between mental health and spirituality in South Africa is much more fluid as compared to religion and mental health. As mentioned, African spirituality is holistic. A sickness in the body could be related to an imbalance in an individual's social life or relationship to their ancestors (Chiorazzi, 2015). In many South African Black communities, mental health problems can be understood to be caused by 'witchcraft or demonic possession' (Shoba, 2018). Not all traditional healers treat people with mental health problems, but a study showed that some traditional healers around the country offered a range of services for PLWMHP in their communities (Lund *et al*, 2008). They differentiated three causes for mental health problems, with three corresponding treatments; biological, social, and spiritual. The social causes included personal and relational problems such as bereavement, rape, and substance abuse (Lund *et al*, 2008:153). The treatment would be a form of counselling, and in certain cases referral to social workers or the police. Spiritual causes of mental health problems included being bewitched by another, having angered the ancestors, or called to be a traditional healer. The biological and spiritual solutions are conflated, including, *muti* (traditional medicine), candles, herbs, incense, and making incisions (Lund *et al*, 2008:154). Many participants in the study stated that they believed traditional healers had a role to play in the support network for PLWMHP, but none believed that traditional healers could cure 'serious' mental health problems when compared to the medical field (Lund *et al*, 2008:154).

The connection between religion and/or spirituality and mental health in policy can be illustrated in the role that spiritual organisations are given in 'solving' mental health problems. This will be expanded upon in Chapter 3 which will outline significant South African policies that concern mental health, where religious organisations and traditional healers are mentioned

as ‘mental health care service providers’. The influence of all the above conceptualisations of mental health can be seen in the legislation, as the South African government proposes various methods, actors, and contexts with which to solve the ‘problem’ of mental health.

2.10. Conclusion

From the review of the literature, a consensus as to the definition, cause, and management of mental health is noticeably absent. While standardised definitions do exist in the biomedical and legal fields, these are subject to much debate and critique. Mental health can be approached from a variety of different angles, each of which a different ‘solution’. Even within these eight conceptions, there are disagreements as how to manage mental health problems. The biological model of mental health, e.g., propounds a variety of theories as to how to classify, diagnose, and treat mental illness (some of which contradict one another). Other conceptions, such as the legal and political, rely on other fields’ definitions and expertise (particularly the biomedical) to determine whether an individual is mentally healthy. In the biomedical and legal fields, mental health is defined individually and with great precision and specificity. The remaining six conceptions understand the phenomena more broadly, and from a more communal perspective, with a variety of suggested causes. South African based literature on mental health, the conception that there are social determinants of mental health linked with development goals has been slowly gaining traction. Linking mental health, culture, and religion has also gained popularity in the literature, with more scholars attempting to analyse how an individual’s culture and religion affects their understanding or reaction to the topic of mental health. Viewing mental health from an economic and developmental perspective can be seen in South African legislation.

Examining the literature surrounding South African mental health provides a basis with which to examine how mental health is represented in legislation. This review is imperative to the analysis stage as it provides clarity to the concept of mental health in a South African context. These eight conceptions of mental health will feed into the analysis of South African mental health policy in Chapter 5, answering the research question of how mental health is represented in policy, and the assumptions and conceptualisation that underly these representations. The policies that affect mental health services will be outlined chronologically in the next chapter. These two chapters will then be integrated into the broader research statement and sub-questions of the study in the analysis stage.

Chapter 3: History of Political Management of Mental Health Care in South Africa

3.1. Introduction

In Chapter 2, a variety of abstract conceptions of mental health were discussed. In this chapter, the recent history of mental health care in South Africa will be explored through the various legislation and policies. The South African government has produced these policies that affect the care that PLWMHP receive through state services. These documents will be detailed chronologically. The policies will give an indication of what the government believed was the problem regarding mental health and how they envisioned this problem could be solved. An exploration of the policies and government documents is a critical element of this study, as it lays the foundation for further analysis in Chapter 5. This will reveal the dominant representations of mental health in South African public policy, as well as the assumptions and conceptualisations that underpin these representations.

Not all the policies documented in this chapter will be used for analysis in Chapter 5. Only four out of the nineteen policies outlined in this chapter will be used in the analysis phase: The *White Paper for the Transformation of the Health System in South Africa of 1997*; the *National Mental Health Care Act of 2002*; the *National Child and Adolescent Mental Health Policy Guidelines of 2003*; and the *National Mental Health Policy Framework for 2013 – 2020*. They will make up what Foucault terms 'prescriptive texts', which are to be analysed through Bacchi's (2009) WPR analytical tool. However, it is still important to make reference to other government documents that influence mental health, as they will frame how mental health services fit into the greater government system.

The chapter will then detail several themes that have been identified in the policies and the surrounding literature that illustrate how the South African government perceive mental health as a problem. They include an emphasis on human rights, prioritised care of high-risk demographics, decentralisation of mental health care, and integration of mental health care to

community, private, and non-profit organisations. These themes will overlap with the perceptions of mental health as illustrated in Chapter 2.

The themes will also provide a dominant focus with which to view the existing literature critiquing mental health policy in South Africa. The chapter will identify how leaders in the field viewed mental health policy produced by the South African government and what they considered to be the relative strengths and weaknesses. It will then examine the various theoretical approaches that the literature on mental health policy has approached the topic, and where there might be a gap in the research for a different approach.

3.2. South African policy influencing mental health care

Bacchi's (2009: ix) definition of public policy as 'government programmes' is used in this study, along with the closely linked definition of governance as 'problematising activity' (Bacchi, 2016:8). Thus, published white papers, acts, policy guidelines, and policy frameworks are considered policy and are used in this study.

The policies examined can be categorised into three basic groups:

1. Policies regarding the fundamental rights of South Africans and government's responsibilities to those rights
2. Health care policies that address all South African citizens regardless of their mental health status
3. Policies specifically addressing mental health and PLWMHP

In South Africa, mental health legislation is shaped and formed by the first two types of policy. In the case where separate mental health policies do not supply specific information, it must be assumed that the general health care policies apply to PLWMHP as with all South African citizens dependent on the state health system.

Table 1: Chronology of Mental Health related policies in South Africa

Year	Policy Development
1965	Medicine and Related Substances Control Act, Act 101
1974	Medicines Act and the Pharmacy Act
1977	Criminal Procedure Act 51
1994	A National Health Plan for South Africa
1996	Republic of South Africa Constitution
1997	National Policy Guidelines for Improved Mental Health Care
1997	White paper for the transformation of the health system in South Africa
1997	Non-profit Organisations Act 71
2000	Primary Health Care Package
2002	Primary Health Care Package
2002	National Mental Health Care Act, no. 17
2002	District Hospital Service Package
2002	National Health Bill
2003	National Health Care Act
2003	National Child and Adolescent Mental Health Policy Guidelines
2012	National Integrated School Health Policy
2012	The Mental Health Summit adopted the "Ekurhuleni declaration"
2013	National Mental Health Policy Framework 2013 – 2020
2017	National Health Insurance (NHI) Policy

Source: The Author.

3.2.1. Apartheid mental health policy

The legislation of the apartheid government left an undeniable mark on every sphere of South African life, including mental health care. As the analytical tool used in this study is emphasises the role a country's specific social and historical context plays in the formation of policy, it is important to briefly outline the legislation created by the Apartheid government that still affects mental health care in South Africa.

Under the apartheid government, mental health care was similar to other LMICs under colonialist rule, where services were highly institutionalised and racialised (Lund *et al.*, 2008:16). The health care services were separated according to race groups. By the end of the apartheid regime, there were 14 separate health departments in South Africa all focused on hospitals rather than primary or community level services (Chopra, Lawn, Sanders, *et al.*, 2009:1026). The rights of the individual were secondary to the rights of society, as people with mental health problems were removed from society and placed in psychiatric institutions, often far removed from their families. Mental health legislation reflected this ethos, focusing on controlling and institutionalising the patients. Mental health services were entirely separate from other health care services and from most communities, centred as they were in urban-based facilities. If a PLWMHP was institutionalised, they had no hope for appeal or recourse from the law. The government alienated, stigmatised, and institutionalised PLWMHP (Burns, 2008:46).

These divisive mental health policies have, for the most part, been replaced with legislation built on an ethos of human rights. As a result of this overhaul, the Apartheid policy that is no longer in effect shall not be discussed. However, despite the massive overhaul of policy that accompanied the change to a democratic regime in 1994, there is still policy in effect that was instituted during the apartheid regime that influences mental health care. These policies are not specifically centred around mental health since all the apartheid mental health policies were jettisoned in favour of the new government's approach to mental health.

Medicine and Related Substances Control Act of 1965

One such policy is the *Medicine and Related Substances Control Act 101 from 1965*, with amendments, which remains the foundation upon which the South African pharmaceutical regulations are built. While this Act only makes one very brief mention of psychotropic medication; it still has important implications for PLWMHP. As mentioned in Chapter 2, managing mental health problems through psychopharmacological means is encouraged by the DoH (Lund, *et al.*, 2008:11). Thus, medicine regulations have a fairly large impact on PLWMHP.

Generally, the South African pharmaceutical industry is much more regulated than other LMICs (Krebs, 2018). The South African Health Products Regulatory Authority (SAHPRA) is currently the control body that the act stipulates must manage all health products. They ensure that where possible, relatively cheaper generic medicine is supplied to South African medical facilities (SAHPRA, 2020). This is controlled through the *Medicines Act and the Pharmacy Act (1974).* This includes psychotropic drugs that help manage a range of mental health problems. This means that PLWMHP are able to access more affordable medication at their closest medical facility to manage their mental health problems. The amendments to this act are in line with the shift towards decentralisation of mental health care.

Criminal Procedure Act 51 of 1977

Another policy originating in the Apartheid regime relating to mental health is *Sections 77 – 79 Criminal Procedure Act 51 of 1977*, as mentioned in Chapter 2. While there have been many amendments to this act, the section on mental health remains largely unchanged. *Section 78(1) of the Criminal Procedure Act 51 of 1977* states that a person who commits or makes an omission which constitutes an offence that suffers from a mental illness shall not be held criminally responsible. A mental illness that inhibits an individual from appreciating the wrongfulness of their actions or their implications at the time of the crime can either reduce the sentence or excuse the accused entirely (Criminal Procedure Act 51, 1977:62).

The Act does not provide a definition of mental health problems, rather it provides examples of what cannot be constituted mental illness (such as exogenous malfunctioning of the mind or intellectual disability). Whether an individual is capable of appreciating the wrongfulness of their actions is left to the medical practitioners to determine. At any point in the trial, the court can refer the accused for a psychiatric or psychological assessment. This is to be performed by a medical superintendent of a psychiatric hospital, a psychiatrist, or a clinical psychologist.

As mentioned, this was one of the two mental health related policies that was not jettisoned as the new government came into power. The first democratic election in South Africa brought in a government with an almost polar opposite approach to mental health care.

3.2.2. Post-apartheid mental health policy

The shift in public policy as a result of the regime change cannot be overstated. The democratic government's approach to public policy significantly differed from the apartheid government's. Post-1994, public policy was centred around nation building. The African National Congress's (ANC) agenda was used as a foundation, which concentrated on redistribution, reconstruction, and economic growth (Gumede, 2008). The majority of the social policies developed were focused on addressing challenges of poverty and under-development. With the change of regime came a new approach towards mental health care in South Africa. Based on a foundation of human rights enshrined in the Constitution, policy regarding the treatment and management of PLWMHP changed significantly. Health and social services were considerably expanded, particularly while the Reconstruction and Development Programme (RDP) was implemented.

A National Health Plan for South Africa 1994

The ANC produced the *National Health Plan for South Africa* in 1994 with the help of WHO and the United Nations International Children's Emergency Fund (UNICEF). This would form the basis of the South African health policy post-apartheid. The rights of all South Africans, including those with mental health problems and disabilities, took precedence. Echoing the WHO, mental health was understood as psychological well-being determined by 'social and material conditions as well as by physical, spiritual, and emotional health whereby people are able to conduct themselves effectively in social, interpersonal, and work relationships' (National Health Plan for South Africa, 1994:52). Many of the principles and methods of treatment in *National Health Plan for South Africa* can be seen in the following policies. These include the integration of care of mental disorders into primary and community levels wherever possible and the prioritised care of the 'high risk', those affected by violence, HIV/AIDs, the homeless, and vulnerable youth (National Health Plan for South Africa, 1994:53)

This policy also stated that mental health care should better reflect the cultural diversity of South African society. To this end, traditional healers were included as mental health care providers. This policy emphasised correcting past inequalities in mental health policies. This is an underlying theme that can be seen throughout all the policies to follow.

It is within this *National Health Plan* that the separation of responsibilities between the provinces and the national government was mentioned and the move towards decentralisation began. Each of the nine provinces has a Provincial Health Authority coordinating and implementing the directives from the National Health Authority who formulate strategy and policy. The DoH creates policies, and the provincial department uses them as a basis to form local programmes. Omar *et al* describes it as a semi-federal structure where provinces are given considerable authority (2010:2). Although collaboration with other national departments was heavily emphasised, the DoH was mandated with the responsibility of forming national health related policies (National Health Plan for South Africa, 1994:53).

Decentralisation in the health systems is the movement of decision making away from centralised control, and closer towards the users of health services. The concept is versatile; it can entail transferring power from a higher to a lower level of government, from the government to a legally autonomous state organisation, or from the government to a non-state organisation (WHO, 2019). Effective decentralisation ensures that centrally developed policies are translated into viable local programmes (Omar *et al.*, 2010:8). In the South African health system, decentralisation takes the form of the national government giving authority to the provincial departments, integrating care into district and PHC facilities, as well as task-shifting to non-state organisations. The effects of the decentralisation in the South African mental health system will be expanded upon further on in this chapter.

A distinction should be made regarding service provision within the South African health sector. While the focus of this study is mental health care provided by the state, it is important to note the non-state alternatives, as their involvement in South African mental health care is an integral part of the process of decentralisation. As mentioned in Chapter 1, these non-state alternatives include private care, faith-based institutions, NGOs, and traditional healers (Janse Van Rensburg, 2018: 14).

A dominant theme in the following policies is the integration of mental health care both vertically and horizontally, across government bodies and non-state organisations. While not the main focus of this study, the role of the private health-care sector is worth mentioning. The private and public health sectors do not work independently of one another. The South African public health sector serves roughly 84% of the population; the smaller private sector serves the minority that can afford health insurance (Docrat *et al.*, 2019:707). The private health care

sector is generally better equipped, staffed, and provides a higher quality of care to PLWMHP than the public sector (Janse Van Rensburg, 2018:5).

As mentioned in Chapter 1, NGOs also collaborate with the government to provide mental health care. In the absence of or in collaboration with state supplied mental health care professionals, non-medical institutions and organisations contribute to the mental, emotional, and spiritual well-being of South Africans, particularly among the rural and poorer populations (Wolvaardt, van Niftrik, Beira, *et al.*, 2008:230). South African NGOs operate with fewer restrictions than other LMICs (Janse Van Rensburg, 2018:51). The *Non-profit Organisations Act (71 of 1997)* established the relationship between the state and NGOs – a voluntary, registered, and collaborative relationship throughout all sectors of governance (Non-profit Organisations Act 71, 1997:2).

Constitution of the Republic of South Africa 1996

The Constitution substantiated the shift toward decentralisation, with Chapter 3 Section 40 separating national government from the provincial bodies. The Constitution, along with the Constitutional Court, the Bill of Rights, and the Human Rights Commission, created a foundation for the shift in patient care to a human rights-driven ethos. The impact of this change cannot be understated, as this legislative infrastructure underwrote all legislation written or amended post 1996.

The Constitution does not make any direct reference to mental health, other than a brief comment in the Bill of Rights regarding children's rights (Section 28, (1)(f)(ii)). However, there are three sections of the Constitution that specifically influence South African PLWMHP:

- Section 9, the equality clause, states that everyone is equal before the law and has the right to equal protection and benefit of the law.
- Section 24(1)(a) states that everyone has the right to an environment that is not harmful to their health or well-being.
- Section 27(1)(a) states that everyone has the right to have access to health care services.

- Section 27(1)(b) ensures that the State is to provide this access, 'the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of these rights'. (Constitution of the Republic of South Africa, 1994).

The emphasis on human rights can be seen throughout all the mental health legislation produced by the democratic government after 1994. Human rights form the foundation of the mental health care policy. The Constitution protects PLWMHP against discrimination and abuse.

The Constitution stipulates that PLWMHP should have access to health care services and that it is the prerogative of the state to provide such services. As the Constitution recognises all South African's right to health care, it can easily be assumed that this includes treatment and care for PLWMHP. The translation of these rights into practice is where the challenge lies. Policy makers and stakeholders must develop effective and feasible ways to integrate these rights into policies (Swanepoel, 2011:8). The perceived success of this mandate will be discussed further in this chapter.

National Health Policy Guidelines for Improved Mental Health in South Africa of 1997

The first stand-alone post-apartheid mental health policy was the *National Health Policy Guidelines for Improved Mental Health in South Africa* (1997b). These guidelines were not formally published or widely disseminated, and as such are unavailable for public use. Draper *et al* (2009) outlined the content within the policy guidelines with nine central points. The policy guidelines emphasised the role of inter-sectoral collaboration between government departments, NGOs, and CBOs in the planning of mental health services, which are to be integrated into general health care. Wherever possible, these services were to be available in the patient's communities or near to their families. Mental health and the prevention of mental illness were to be promoted through special programmes for 'at risk' groups. Partnerships were to be made with private mental health professionals and traditional healers to increase the 'service net' for those in need of care. The policy guidelines particularly emphasised ongoing training and supervision to facilitate the decentralisation and integration of mental health care (Draper *et al.*, 2009:348).

White Paper for Transformation of the Health System in South Africa of 1997

While these policy guidelines were produced, the reformation of the general health legislation took place. The general health legislation in question was the *White Paper for Transformation of the Health System in South Africa* (1997a). The White Paper had a separate chapter centred specifically on mental health. Its focus was predominantly on the provision of medication for those with severe mental health problems, rather than the detection or prevention of common mental disorders. The policy emphasised a programme of decentralisation and integration of mental health care into PHC facilities and CBOs according to PHC principles. This integration was one of the primary strategies of mental health care policy reform.

Integration into PHC facilities is a reoccurring theme throughout all the subsequent policies, albeit in varied specificity. The integration in this White Paper, as outlined by Petersen *et al* (2009) was limited to de-hospitalisation. As a result, patients would be screened and treated at a PHC level, with severe cases being referred to district hospitals. The DoH prescribed psychopharmacological management of chronic mental disorders (Lund, Kleintjes, Campbell-Hall, *et al.*, 2008:11).

PHC principles (first outlined in the Declaration of Alma Ata in 1978), consist of three components; 'meeting people's health needs throughout their lives; addressing the broader determinants of health through multisectoral policy action; and empowering individuals, families, and communities to take charge of their own health' (WHO, 2020). This approach emphasises a horizontal system of general services, which provides prevention and care for all health problems. This is in contrast to vertical systems which cater for specific health conditions (Elzinga, 2005:241).

Integrating mental health into PHC is a strategy used globally, particularly in LMIC settings (Eaton, McCay, Semrau, *et al.*, 2011; Janse van Rensburg & Fourie, 2016). There are many benefits to this strategy that should increase the accessibility of mental health care, and the quality and equality of the care received. It is assumed that by making mental health care services available in PHC clinics within the community will reduce the stigma attached to mental health problems as opposed to specialist institutions (Janse van Rensburg & Fourie, 2016). This is invaluable in a country where health services are largely provided at a PHC level (Chatora & Tumusime, 2004).

Primary Health Care Package of 2000 and 2002

The *Primary Health Care Package for South Africa of 2000* and the *Primary Health Care Package for South Africa of 2002* also highlighted the integration of mental health to PHC facilities. These general health policies showed that the PHC services were intended to form the base of a multitiered approach to mental health services. Mental health was included in those documents as one of the priority measures (Primary Health Care Package for South Africa, 2000a). The fundamental intention of these policies was to increase the scope of services and resources rendered at a PHC level, so as to lessen the burden on hospitals (Heunis, van Rensburg, Claassens, 2006:38). The scope of service was to be increased through collaborating with, and task-shifting to NGOs and community organisations.

District Hospital Service Package of 2002

The *District Hospital Service Package of 2002* substantiated this multitiered strategy, with the district and regional hospitals forming the secondary level of integrated services. Mental health was mentioned briefly in this policy, which stated that psychiatric hospitals would form the tertiary level of care, where more 'severe' cases of mental illness would be treated (District Hospital Service Package, 2002b)

National Mental Health Care Act No 17 of 2002

The *National Mental Health Care Act No 17 of 2002* was created in line with the international human rights instruments and WHO guidelines. This act made several important changes to the South African mental health care landscape. It reiterated the integration of mental health to PHC, with all medical practitioners tasked with providing mental health care services. This included outreach teams of psychiatry and clinical psychologists visiting primary and community health care facilities. Serious cases were to be admitted to district hospitals for 72-hours where the user would be assessed as to whether involuntary care, treatment, or rehabilitation was necessary. Mental Health Review Boards were established in every province to investigate human rights abuses and neglect, and allow for any mental health user to appeal decisions made by health care practitioners (National Mental Health Care Act 17, 2002).

National Health Bill of 2002

Promulgated in 2002 was the *National Health Bill of 2002,* a legislative framework to create closer cooperation between national, provincial, and local government health services. The district health systems were established for the provision of PHC throughout South Africa (National Health Bill, 2002). The bill was a precursor to the *National Health Act of 2003* and together the two policies legislated that free PHC services were now to be provided for those without insurance.

National Child and Adolescent Mental Health Policy Guidelines of 2003

The DoH developed a mental health care policy specifically targeting one of the 'at risk' groups in 2003. South Africa was one of the few countries in the world to have a separate child and adolescent mental health policy – the *National Child and Adolescent Mental Health Guidelines*. Developed in 2002 alongside the *National Mental Health Care Act*, the guidelines outlined very similar methods of care. The first point of care was the primary and community level, thereafter the district hospitals or psychiatric hospitals depending on the severity of the case. The provincial departments were required to create implementation plans, targets, and deadlines (National Child and Adolescent Mental Health Guidelines, 2003*)*. Ideally, this policy was intended to be the catalyst to the creation and implementation of child and adolescent mental health (CAMH) policies provincially. However, there is no evidence that any of the provinces have developed their own CAMH or implemented the national policy (Mokitimi, Schneider & de Vries, 2018:1).

National Integrated School Health Policy of 2012

However, mental health care was emphasised in the *National Integrated School Health Policy of 2012*. The guidelines provided a health service package for schools which included basic mental health and psychological risk assessments on all students at four different stages over the learners' 12 years of schooling. Mental health was listed among the range of factors that impact negatively on the development of children, just below HIV/AIDS (National Integrated School Health Policy, 2012).

National Mental Health Policy Framework and Strategic Plan from 2013 – 2020

In 2012, the DoH began developing a formal, strategic plan on mental health. The draft of this strategic plan was discussed and adopted at the National Mental Health Summit of April 2012, resulting in the *Ekurhuleni Declaration on Mental Health*. The document outlined the up-scaling of the mental health services provided (National Mental Health Summit 2012 participants, 2012). This document then formed the basis of the *National Mental Health Policy Framework and Strategic Plan 2013 – 2020.*

The *National Mental Health Policy Framework and Strategic Plan 2013 – 2020* was the first nationally endorsed mental health policy for South Africa. Based on WHO guidelines, this policy was intended to guide the various sectors in the promotion of mental health, prevention, treatment, and rehabilitation. The document outlined a range of cost-effective interventions. These economical methods are akin to what antiretroviral treatment is for HIV/AIDS. They include a combination of low-cost psychiatric drugs and interpersonal therapies.

The policy gives eight key objectives: district-based mental health service; institutional capacity; surveillance, research and innovation; infrastructure and capacity; mental health technology, equipment and medicines; inter-sectoral collaboration; human resources; and advocacy, mental health promotion and prevention of illness. As a national directive, this policy was intended to be a catalyst for the provincial departments to develop their own mental health care plan (National Mental Health Policy Framework and Strategic Plan, 2013).

National Health Insurance Policy of 2017

The final policy that directly influences PLWMHP is the *National Health Insurance (NHI) Policy of 2017*. This was a financial plan to move South Africa toward Universal Health Coverage (UHC). The policy aimed to create a major shift in the South African health care landscape. The new health care financing system was intended to provide essential health care to all South Africans, irrespective of their employment or financial status. All South Africans would then have access to a comprehensive health package. Mental health ranked high on the NHI's priorities. In terms of receiving phased NHI service benefits, mental health was prioritised alongside pregnant women, school services, and the elderly. The document

reiterated the treatment of mental health care users at a community and PHC level (National Health Insurance, 2017).

The NHI policy perfectly embodies the ideal of the South African government to redress past inequalities. In this specific case, it was to correct a health care system that was skewed in favour of the minority in both skills and resources.

As seen by the policies promulgated by the state post-apartheid, the South African government has been fairly consistent in their approach of PLWMHP care. The themes of decentralising mental health and redressing past inequalities through targeting those considered most vulnerable are present throughout all the polices. Treating users at a primary care and/or district level is a common refrain, as is the emphasis on incorporating local communities and NGOs into the care of PLWMHP.

The legislation becomes self-referential, with later policies acknowledging earlier policies as their foundation. The thematic consistency in the policies means one need not analyse all of them. As mentioned, this study will focus on the *White Paper for the Transformation of the Health System in South Africa of 1997*; the *National Mental Health Care Act of 2002*; the *National Child and Adolescent Mental Health Policy Guidelines of 2003*; and the *National Mental Health Policy Framework for 2013 – 2020.*

The policies chosen did not present themselves as the most obvious choices for analysis. This is not necessarily cause for concern, as Bacchi (2009:20) has said that 'given the almost endless variety and number of texts that could be selected, it needs to be recognised that choosing policies to examine is itself an interpretive exercise'. As a result, the choice of policies was based on an extensive review of the legislative documents. The four policies were chosen due to their specific focus on mental health, as well as their range across time. This will reveal the dominant problem representations over time and show whether policy has been consistent in terms of its representation of mental health.

The relative success of the mental health policies in providing effective mental health services has been critiqued by various scholars. This will be expanded upon in the next section.

3.3. Themes in mental health care policy literature

It is important to place this study within the existing analysis of South African mental health policy. This section will examine the literature produced by mental health care professionals and scholars, as well as policy analysts. It will focus on what these leaders of the field understand to be the biggest problem of the mental health landscape. This will be particularly useful for the next chapter as it will reveal whether there is an alternative approach to analyse South African mental health policy.

As cited in Chapter 1, the literature of mental health policy has been organised according to four themes: human rights, the prioritised care of high-risk demographics, decentralisation of mental health care, integration to general health care services, and task-shifting to NGOs. Each of these are dominant themes that have been discussed in the literature.

3.3.1. Human rights in relation to mental health

Among the literature examined for this study, there is much discussion surrounding the South African mental health policy's alignment to human rights standards. The emphasis on human rights can be linked to the theme of redressing past inequalities that was present throughout the post-apartheid government's policies. In mental health care, this was illustrated through providing equal care for all, prioritising the care of those deemed 'high-risk', and consulting a wide range of stakeholders to ensure that the policies reflected the diversity of the South African people.

In a publication focusing specifically on human rights and mental health, Burns (2011) reported that while the South African policies professed a commitment to human rights driven mental health care, there is still a significant 'mental health gap'. This resulted in the rights of PLWMHP to health care being violated through neglect. The commitment to human rights is seen in the *National Mental Health Care Act of 2002*, said to be one of the most progressive mental health policies in the world, specifically the sections relating to users' human and legal rights. Burns praises the shift towards decentralisation of mental health care towards PHC and community-based facilities. However, Burns (2011) determined that in practice, health and social services for PLWMHP remain 'grossly inadequate, under-developed, and under-funded'

(Burns, 2011:99). There is a gap between the attention and resources given to mental health care and the burden of suffering that mental health problems present. Burns states that this gap is made worse in an LMIC, where social determinants such as poverty, illiteracy, and income inequality can impact an individual's psychological well-being (Burns, 2011:109). Burns links the unrealised mandate of the MHCA of 2002 to human rights violations. Other authors, such as the authors cited below, may not overtly make this same connection, but they note a dissonance between what is stated in the policies and the resulting care the PLWMHP receive.

Docrat *et al* (2019) came to a similar conclusion as Burns. The situational analysis highlighted the establishment of the Mental Health Review Boards and the 72-hour assessment process in the *National Mental Health Care Act of 2002* for its alignment to international human rights standards. However, purely from a budgetary perspective, Docrat *et al* (2019) found that the reforms necessary to bring mental health services up to the human rights standard set by the policies have yet to be realised. Docrat *et al* (2019) credited this to a variety of factors that will be discussed later.

A situational analysis by Lund, Kleintjes, Campbell-Hall, *et al* (2008:192) saw respondents articulate the need for the human rights principles espoused in the *National Mental Health Care Act of 2002* to translate into 'implementation strategies'. It also noted the mental health gap between the burden of mental health problems and the resources provided by the government to combat it. Respondents stated that while the Act was aligned to international human rights standards, there was still concern as to the resources and political support provided to realise what is in the policies. Without the overhaul of services towards a community orientated approach with proper support from the government, the respondents confessed concern that mental health care would be 'vulnerable to human rights abuses' (Lund *et al.*, 2008:206). Respondents also felt that the funding of mental health service development in comparison to other priority programmes was 'inadequate' and could be seen as a human rights issue. The situational analysis attributed the mental health gap partly to a lack of political support for mental health prioritisation and can be linked to stigma among policy makers and stakeholders (Chapter 2). The low prioritisation is also attributed to mental health competing for support and resources with other high priority health concerns. It is suggested that this could be combated through active lobbying for political support (Lund *et al.*, 2008:13).

In general, many have criticised the low priority given to mental health by policy makers. Despite the burden of mental health and its formal recognition as a priority programme, many leaders in the field are of the opinion that mental health is placed unreasonably low on the South African policy agenda (Lund *et al.*, 2008; Draper *et al.*, 2009; Lund, Kleintjes, Kakuma, *et al.*, 2010; Lund, Kleintjes, Cooper, *et al.*, 2011). This has been linked to the notion of the rights of PLWMHP being infringed upon through neglect. The placement of mental health care on the political agenda is linked to the prioritised care of high-risk demography.

3.3.2. Prioritised care of high-risk demographics

The prioritised care of high-risk demographics is related to the social determinants of mental health. The policies identify certain demographics that are deemed 'higher risk' to mental health problems[14]. This section will review the literature on mental health problems and how South African mental health care policy caters for these 'high risk' groups.

Mokitimi, Schneider, and de Vries (2018) found in their systematic study a level of commitment on a national level to vulnerable groups, specifically children and adolescents, in the form of the *National Child and Adolescent Mental Health Policy Guidelines of 2003*. However, the study found that provincial departments, who are responsible for developing implementation plans, failed to 'actualise' what was mandated from the national policies. Mokitimi *et al* reported ' clear evidence of on-going neglect of CAMH policy development and implementation at a provincial level' in line with other LMICs (Mokitimi, Schneider & de Vries, 2018:14).

Kleintjes, Lund, and Flisher (2010) agree with Mokitimi *et al* findings in their situational analysis on CAMH policy in four LMICs including South Africa. It reported that while at a national level there was commitment to vulnerable groups, this did not translate into 'implementation plans' at a provincial level (Kleintjes, Lund & Flisher, 2010:134). The study found that the mental health of children and adolescents was low on the public health agenda,

[14] The *National Mental Health Policy Framework for 2013 – 2020* states that vulnerable groups targeted for 'specific mental health needs' include women, children and adolescents, the elderly and those living with HIV/AIDS (Republic of South Africa, 2013:27). The *National Child and Adolescent Policy Guidelines of 2003* states that vulnerable groups include children or adolescents who live in poverty, are from broken homes, have intellectual disabilities, have been subjected to abuse, are experiencing violence, or are addicted to substances (National Child and Adolescent Policy Guidelines, 2003:8).

and suggested lobbying for political support, as well as a stronger link between poverty and mental health.

In a situational analysis, Lund *et al* (2008) found gaps in the policies with regard to 'at-risk' groups. The study noted that a gendered approach to mental health was lacking in the polices, particularly the mental health implications of violence towards women and the care-giving role women perform across most sectors. It was also noted that there was a gap in the policy regarding the link between mental health and both HIV/AIDS and poverty (Lund *et al*, 2008).

In a paper focusing on perceived challenges in the South African mental health services, Lund, Kleintjjes, *et al* (2011) revealed that respondents felt the link between poverty and mental health was lacking in mental health care policies. They saw a 'need' for the relationship between poverty and mental health to be 'better articulated in policies and programmes' as well as a 'need to raise awareness of mental health in poverty alleviation programmes' (Lund *et al.*, 2011:28).

The literature in this section found that the South African mental health policies consistently emphasised the care of 'at-risk' demographics. However, the literature points to the policies' failure at an implementation phase to provide prioritised mental health care for those demographics.

3.3.3. Decentralisation of mental health care to provinces

The penultimate theme highlighted in literature is that of decentralisation. The process of decentralisation in South Africa takes the form of shifting mental health from nationally led institutionalised services, to provincially and district led services that emphasise the role of PHC facilities.

As mentioned in this chapter, decentralisation in health systems is the movement of decision making away from centralised control and closer to the users of health services. The concept is versatile; it can entail transferring power from a higher to lower level of government, from the government to a legally autonomous state organisation, or from the government to a non-state organisation (WHO, 2019). The policies highlighted earlier in this chapter focus on three

main forms of decentralisation in South African mental health care: national government giving authority to provincial health departments; integrating care to district, PHC, and community facilities; and task-shifting to non-state organisations. This section will focus on the integration into the national government to the provincial departments. The next section will focus on the integration of mental health care to PHC facilities.

One criticism that is levelled against South African mental health policy is the poor dissemination and communication between government bodies (Burns, 2008; Docrat *et al* 2019; Lund *et al*, 2010; Omar *et al.*, 2010; Petersen *et al.*, 2009). This is attributed partly to the decentralisation process of mental health as well as the lack regulated feedback processes between national and provincial departments. Effective decentralisation ensures that centrally developed policies are translated into viable local programmes (Omar *et al.*, 2010:8). Where decentralisation is ineffective, the flow of communication is stunted and local departments cannot adequately follow policy directives.

In a comparative study of four African mental health policy processes, Omar *et al* (2010:8) found that decentralising mental health care to regions, provinces, and districts was a common practice in LMICs. The system of the health sector affected how policy was implemented. Low capacity and poor implementation due partly to poor decentralisation were common problems that plagued all four countries, including South Africa. Omar *et al* found that effective decentralisation in South Africa was hampered by two major factors, firstly, provincial planners were often left confused as to their role and the extent of their authority, due to unclear guidelines from the DoH. Secondly, those in charge of planning mental health care at a provincial level were not senior management, and therefore without the necessary authority to influence resource allocation (Omar *et al.*, 2010:6). The results of this ineffective decentralisation process were seen to be 'fragmentation between policy development and policy implementation' (Omar *et al.*, 2010:8). Ineffective decentralisation also resulted in a lack of local capacity and expertise, both especially important when local programmes are the main focus of mental health services (Omar *et al.*, 2010:8).

In a qualitative study by Lund *et al*, (2010), respondents saw poor decentralisation as one of the major challenges facing the South African mental health care system. According to Lund *et al* (2010), decentralisation was predominantly ineffective. They found that there was often

confusion at a provincial level surrounding the policies the national government released. Without clear directives from the DoH, the provincial departments addressed mental health according to their own priorities, which was not placed high on their agendas (Lund *et al,* 2010:402).

Docrat *et al* (2019) partially attribute the failure of mental health care policies to poor decentralisation. The study found that the *National Mental Health Care Act of 2002* and the *National Mental Health Policy Framework of 2013 – 2020* were poorly promoted and communicated to the provincial departments. The provincial departments were also not provided with technical support around policy implementation. It was also found that within the policies there were no clear reporting requirements. As a result, there was limited up to date, local information regarding the burden of mental health problems, patterns of mental health service access, transfers, and resources or lack thereof. Docrat *et al* (2019) state that while the policies themselves were sound, the budgetary constraints and the lack of more general health sector transformations have not allowed for the policies to be properly actualised.

This is substantiated by Lund *et al*'s (2010) report on the provincial mental health services, where frameworks and guidelines were put in place at a national level, but failed at a provincial level due to poor communication and feedback protocols to and from the provincial departments. What resulted was inconsistent resource allocation and data collection, no standardised training of PHC staff in mental health, and no standardised protocol for intersectoral collaboration with other departments and organisations (Lund, 2010:402). This was echoed in Burns' report (2008:48), stating that among the provincial departments, there was poor understanding and knowledge of the *National Mental Health Care Act of 2002*, where health care workers were unfamiliar with medication and treatment protocols as well as referral options.

Poor decentralisation is also considered to be the cause of the wide variation of care between provinces. The provincial departments are often confused as to which policy directives to follow (Lund, *et al.*, 2010:396). This poor dissemination of communication also extends to the communication between the various governmental departments. In the *National Mental Health Care Act of 2002* and the *National Mental Health Policy Framework of 2013 – 2020*, there is an emphasis on inter-departmental collaboration on a national and provincial level. However, Burns noted that the roles and responsibilities of these other departments were not clearly

defined, and the provincial departments in particular, needed further clarification from the respective policies (Burns, 2008). The poor communication between the various government and non-governmental bodies also extends to the referral process, when a user is referred to or from a district or psychiatric hospital to a PHC facility or NGO. It is reported that often PHC workers were not given back-referral information as to how to manage a user coming from a higher tier of care (Petersen *et al.*, 2009).

The literature on the decentralisation of mental health care services to provincial departments has for the most part, found the process to be ineffective, due to unclear guidelines and directives from the national department, as well as poor understanding and implementation of the policies from the provincial departments.

3.3.4. Integration of mental health care to PHC

Tied to the theme of decentralisation of mental health is the integration of services to PHC facilities and district hospitals. Petersen has published several papers on this very topic. Worth noting is her paper (2000) that analyses the shift towards comprehensive integrated PHC in South Africa. She found that while the policies' mandate to integrate mental health care to PHC facilities has been actualised to some extent, the mandate has been 'narrowly interpreted as only adding psychiatric care to the workload of primary health care personnel' (Petersen, 2000:322). Petersen states that adding mental health care to the already over-burdened and poorly supported PHC workers has resulted in demoralised work force. She stated that the PHC workers tended to approach mental health care through a 'biomedically orientated approach' that is in contradiction to the 'primary health care principles' espoused in the policies (Petersen, 2000:332).

In a study examining the task-shifting approach to primary mental health care, Petersen *et al* (2012) noted that some progress has been made towards decentralised integrated primary mental health care since 1997. The study highlighted the introduction of the 72-hour observation period and referral system, as well as the policies' mandate to provide psychotropic drugs at PHC facilities. However, the study found that there are significant gaps in integration process, particularly the insufficient support for PHC clinic nurses when managing psychiatric patients, and the uneven delivery of psycho-social rehabilitation programmes in rural areas

(Petersen *et al.*, 2012:43). The study suggested that additional community-based workers and mental health counsellors at PHC level should monitor all non-specialist health workers, so as to close the service gap (Petersen *et al.*, 2012:50).

Schneider *et al*, (2016), examined the the status of the integration process of mental health to PHC facilities. While they commended the *National Mental Health Care Act of 2002* and the *White Paper for the Transformation of the Health System in South Africa 1997* for their committement to integrating mental health care, the study found that implementation of these policies was hampered by the 'lack of human and financial resources to address the treatment gap' as well as the fact that the limited resources provided to mental health care 'remain concentrated in large psychiatric hospitals with a predominantly vertical model of care' (Schneider *et al.*, 2016:156).

In a qualitative study examining stakeholders' perceptions on South African mental health services, Lund, *et al* (2011) found that the integration of mental health to PHC facilities has been inadequately achieved. The stakeholders attributed this failure to 'the stigmatising attitudes many general health care professionals have towards mental illness and those affected' (Lund *et al.*, 2011:30). The study also found PHC professionals were unable to care for mental health care users as the policies prescribed due to 'heavy workloads, human resource constraints, lack of training of PHC staff, and lack of infrastructure at primary health care level' (Lund *et al.*, 2011:30). As a result of the poor integration, the study showed that the predominant form of in-patient mental health service provision is still based in institutions, rather than PHC facilities (Lund *et al.*, 2011:35).

On the whole, the literature has found the process of decentralising mental health care to PHC facilities as mandated by the policies to be marginally successful. However, the literature also found significant gaps in treatment at a PHC level as a result of poor resources, training, and support provided for PHC personnel to treat mental health problems as the policies envisioned.

3.4. Public policy analysis framework used in literature

The majority of the literature examined found a level of government commitment to mental health care as seen in the policies. However, the literature found gaps in the service provision

of mental health care. Most of the authors in the literature examined do not explicitly define their approach to analysing mental health care policy in South Africa. Systematically grouping policy analysis approaches is a challenging task due to the limited number of articles, the diversity of topics examined, and the often-descriptive approach of many of the articles too. However, it is possible to identify their approaches through examining the authors stated intentions for their work and the methods they intend to use.

While some of the literature focuses on the policy content and development (Lund, Kleintjes, Campbell-Hall, *et al.*, 2008; Mokitimi *et al.*, 2018; Omar, Green, Bird, *et al.*, 2010), the majority of the studies focused on policy implementation rather than analysing how mental health's representation is constructed within the policy.

The majority of the literature reviewed showed a tendency toward analysing policy through what Howlett et al (2009:8) termed as a 'positivist' approach, whereby the analyst will attempt to 'understand why a policy was not implemented as intended and evaluate the outcomes of the policy' (Howlett *et al.*, 2009:7). This is an outcome-based analysis that focuses on the gap between 'actual input and the expected output of a programme' (Stame, 2004:58).

The emphasis on the disconnect between the content of the policies and their implementation, indicates that the literature predominantly analyses mental health policy through a policy stagist or stages heuristic approach. This positivist approach, as outlined by Howlett & Ramesh (1995:12), analyses policy through breaking up the complex process into a number of stages. The stages, as originally formed by Laswell (1956), are: agenda setting; recognition of problem; consideration of options; agreement on an option; legislation; implementation. Generally, most South African mental health care articles have a stronger focus on the later stages of implementation, rather than on policy development. Overall, the literature presents fairly broad descriptions of national-level experiences, sometimes only depicting a narrative of those experiences, rather than describing, e.g., the experiences of provincial, district, or even PHC facilities.

The form of analysis used in the literature critiques mental health policy choices and is generally aimed at providing alternatives or solutions to the problem they perceive. However, the literature does not analyse how South African mental health care policy comes to define the 'problems' represented and how those representations of the problem shape the solutions

presented. There is a gap in the research for an examination of how the policy represents mental health and how that shapes the solutions and interventions to the perceived problem.

3.5. Conclusion

This chapter gave an overview of the South African government's response to mental health through the major policies published. There are several major themes that feature consistently throughout the policies affecting mental health post-1994. They include the emphasis and foundation of human rights-based care that extends to all levels and sectors of mental health care - the rights of users are placed paramount in all the policies. Other themes include the decentralisation of mental health care to a variety of governmental and non-governmental bodies, the integration of mental health care into PHC, and the development of community-based care. These themes are in line with the values of redressing past inequalities and attempting to provide a foundation of mental health care for all South Africans. The approach to mental health as seen in the policies shall be analysed using the analytical tool expanded on in Chapter 4.

The majority of the policies outlined are a product of the DoH. The placement of mental health within the health department purview is indicative of how mental health is understood. The fairly recent connection made in the policies between mental health and development goals (specifically poverty alleviation) in the last decade is also worth remarking on, as it perhaps demonstrates a shift in policy makers' attitude. Four of the policies will be analysed in Chapter 5 so as to reveal the dominant problem representations found in mental health policies and the assumptions and conceptualisations that underpin those representations.

The literature analysing mental health care policy was then examined and grouped according to themes. The general consensus was that while the national government has shown a level of commitment to mental health care, the policies were ineffective as a whole due to failure at a particular stage. This stage was generally found to be the implementation stage of the policy. However, reference was made to the placement of mental health on policy makers' agenda and the lack of specificity and clear expectations within the polices. There is room for analysis of the policy content and how mental health is represented.

Chapter 4: Theoretical foundations and analytical tool

4.1. Introduction

The theoretical foundations of a study will affect how research is conceptualised, conducted, analysed, and presented. In this chapter, the analytical tool chosen to examine mental health policy will be discussed. The foundational framework explored will prove valuable insight when addressing the research problem and answering the research questions. Primarily, how is mental health problematised in South African public policy?

This chapter will provide an overview of the philosophical underpinnings of Bacchi's WPR approach (2009) with particular reference to post-structuralism. It will then explore the notable figure of Foucault and his influence in the field of policy analysis theory, specifically his work on the relationship between power and the production of knowledge. The WPR approach will then be briefly outlined, followed a discussion on the questions used in this study and the manner in which they will be applied in Chapter 5.

The chapter will then delve into the theory of the approach developed by Bacchi known as the 'What's the Problem Represented to be' (WPR) approach which will be used as the analytical tool (2009). The approach's simple technique is outlined, followed by an exploration of the three core premises that form the basis of Bacchi's tool; seeing policy as discourse, the construction of problems and governing through those problematisations, and the interruption of this process through the WPR approach. Furthermore, attention will be devoted to how the WPR approach has been used in the past, focusing specifically on health policies.

4.2. Theoretical foundations of Bacchi

It is important to provide contextual orientation in the field of public policy analysis. Togerson (1986) provided a suggestive definition of public policy analysis: 'broadly conceived, policy

analysis may be said to comprise those activities aimed at developing knowledge relevant to the formulation and implementation of public policy' (Torgerson, 1986).

There is no 'one size fits all' method when it comes to analysing public policy; however, there are certain techniques and theories that are suitable for particular policy problems (Howlett *et al.*, 2009). A range of conceptual theories have been developed in an attempt to understand the field. The theoretical foundation that informed Bacchi's WPR approach (2009) and thus is most useful for this study, is post-structuralism.

4.2.1. Post-Structuralism and Bacchi

Post-structuralism is the theory of discourse, knowledge, and language (Agger, 1991:112), focusing on the production of knowledge. It challenges any framework that presumes some kind of internal structure or rationality to an entity, whether it be a text, policy, or the family structure (Hoffman, 1992:4).

When looking at policy analysis theory according to post-structuralism, it works from one central assumption; that policy analysis is not based on hard truth. Instead, it is based on social and political phenomena which are formed and inexplicably linked to their meanings. These meanings are constantly shifting and changing in different directions. Policy is the outcome of the complex process of inscription and re-presentation (Gottweis, 2003:249). Post-structuralism is the philosophy upon which Bacchi relied upon heavily when developing her WRP approach to policy analysis that shall be used in this study.

Foucault, a leader and trailblazer in this philosophical movement, established alternative methods of examining the emergence of problems. He is also the leading influence of the theoretical underpinning of the analytical tool used in this study.

4.2.2. Foucault's influence on Bacchi

Foucault, a historian and social theorist, developed a mode of critique known as genealogy, a method of examining the emergence of history. This mode of critique is part of Foucault's work examining the dynamics between power and the production of knowledge (Foucault,

2003). Genealogical analysis questions 'problems' coupled with 'solutions' ready at hand. Instead of accepting what is considered the state of things or a grand meta-history, Foucault encourages his readers to concern themselves with submerged problems that condition us without our conscious realisation. Through the process of genealogy, we are shown how the 'normal state of being' or discourses, come to be recognised as such (Koopman, 2013). By questioning how histories, knowledge, and practices emerge, one can extend the possibilities of analysis (Hook, 2005:24).

Foucault sought to 'problematise' discourse. The term 'problematisation' is used by Foucault in two ways; firstly, he uses it to describe his analytical method of examining how an issue is 'questioned, analysed, classified, and regulated' within a specific context (Foucault, 1970 as cited in Deacon, 2000:127). Secondly, Foucault uses the term to describe the process of how certain phenomena become a problem and how they are shaped within that discourse (Foucault, 1985a:115 as cited in Bacchi, 2012:1).

Foucault's notion of problematisation is expounded upon by Bacchi (2012) using Foucault's work '*Madness and Civilisation: A History of Insanity in the Age of Reason*' (1988). In his book, Foucault seeks to problematise the concept of madness, that is to question 'how and why very different things in the world are gathered together, characterised, analysed, and treated, as for example, "mental illness"' (Foucault, 1985a). Problematisations are not purely conceptual, mental phenomena; rather, they emerge from practices (Bacchi, 2012:2). Practices refer to the reasonable background for actions, the preconceived, socially sanctioned collection of rules that determine an individual's manner of viewing, judging, imagining, and performing (Deacon, 2000:128).

Using Foucault's example of 'madness', it is possible to note how the concept is problematised by the practices used to deal with the 'mad'. By answering the questions that Foucault (1969) poses, it can be determined how 'madness' was understood, classified, and regulated within a specific context:

> How madmen were recognized, set aside, excluded from society, interned, and treated; what institutions were meant to take them in and keep them there, sometimes caring for them; what authorities decided on their madness, and in accordance with what criteria; what methods were set in place to constrain them, punish them, or cure them; in short,

> what was the net-work of institutions and practices in which the madman was simultaneously caught and defined (Foucault, 1969 in Eribon, 1991).

Foucault found that practices can be analysed through 'prescriptive texts'. These are the regulations and legislation written to provide rules, opinions, and suggestions as to how to act. The process of problematisation starts with analysing practices through these prescriptive texts. This is followed by examining the historical process of the practice's development which has produced the problematised object, such as madness (Bacchi, 2012:4).

As seen in the next section, the method of examining the construction of problems through practices is the conceptual bedrock upon which Bacchi bases her WPR approach. Bacchi develops Foucault's theme of problematisation and uses it to analyse policy, where policy documents are the prescriptive texts from which problematised phenomena can be examined (Bacchi, 2012:3).

4.3. Bacchi's WPR approach

Bacchi first introduced the WPR approach in her 1999 book '*Women, Policy, and Politics'*. The analytical framework was originally used to interrogate the construction of policies that were seen to relate specifically to women. It has since then been applied much further afield, as shall be seen in this chapter, such as in the critique of policy analysis theories and as a method of analysing governance.

The fundamental premise of the WPR approach is that every policy contains within it an explicit or implicit understanding of what the 'problem' is. This is known as the 'problem representation', of a policy. The problem representation will reveal a kind of change implied in a particular policy (Bacchi, 2009: ix). Problem representations can be linked Foucault's notion of problematisation. At its most basic, the approach is based on the principle that the way we view or think about something, will affect what we think should be done about it (Bacchi, 1999:9). Based on post-structuralism, the approach is a practical means of examining how policy shapes meaning and problematisations (Goodwin, 2012:25). The approach is centred

around six guiding questions and an addendum as defined by Bacchi (2009:2). The goals of each question have been outlined by Carson (2018).

Table 2: **Framework for policy analysis**

	Question	Goal
1	What's the "problem" of (e.g., discrimination, abortion, mental illness, etc.) represented to be in a specific policy or policies?	To identify the implicit problem representation in the specific policy
2	What presuppositions—necessary meanings that underpin an argument—and assumptions (ontological, epistemological) underlie this representation of the "problem" (*problem representation*)?	To identify and access the conceptual logic that forms the basis of a specific problem representation. Conceptual logic refers to the meanings that must be in place for the representation to make sense
3	How has this representation of the "problem" come about?	To examine the conditions that have allowed a particular problem representation to form and become legitimate.
4	What is left unproblematic in this problem representation? Where are the silences?	To reflect and consider those issues and perspectives that are not given voice in the policy.
5	What effects (discursive, subjectification, and lived) are produced by this representation of the "problem"?	To identify the effects of a certain problem representation. This includes the discursive, subjectification, and lived effects of the problematisation.
6	How and where has this representation of the "problem" been produced, disseminated, and defended? How has it been and/or can it be questioned, disrupted, and replaced?	To identity the way in which the certain problematisations have become dominant in order that they can be questioned, debated, and if necessary, disrupted.
	Apply this list of questions to one's own problem representations	This addendum is intended to identify the researcher's own problem representations and check their own role in the production of discourse.

(Table adapted from Bacchi 2009:2; Carson, 2018).

These questions are interrelated and overlap to some extent. As a result, Bacchi notes that not all questions need be used in an analysis, as the direction the analysis takes will determine which questions are foregrounded (Bacchi, 2009). For the purposes of this study, Questions 1 and 2 will be used.

As mentioned, this study will be utilising Questions 1 and 2 of Bacchi's WPR approach to analyse South African mental health care policy. These questions are used in this study as they identify the problem representation in the polices and reveal the assumptions that they are based on. The remaining four questions are more concerned with the genealogical aspect of problem, that is, how this problem representation came about, and the implications of the problem representation. This does not fall within the scope of this study and can be reviewed elsewhere. This section will briefly outline the two questions that will be applied in Chapter 5 and how they will provide structure in answering the research question on how mental health is represented in South African mental health policy.

4.3.1. What's the Problem Represented to be?

The first question that Bacchi asks in her WPR approach is intended as a 'clarification exercise' (Bacchi, 2009:2). The logic behind the question is that by examining what a policy intervention proposes to change will reveal how the issue is thought about. The WPR approach recommends 'working backwards' from the provided solution to reveal what the problem is represented to be (Bacchi, 2009:3). In the analysis stage, this study will analyse the provided solutions to mental health problems and work backwards to reveal the policies' implicit problem representation. This question is based on the premise of problems being constructed and shaped, rather than existing outside of the policy process.

Bacchi states that problem representations are usually located in a web of related policies that need to be part of the analysis (Bacchi, 2009:4). This study analysed such a web of related policies focused on mental health care in order to locate the dominant problem representation, made challenging by policies often containing more than one problem representation. As a result, Bacchi encourages identifying dominant problem representations that run throughout the selection of policies and analysing those. This study has identified five dominant problem representations throughout all four selected policies and analyses them accordingly.

4.3.2. What assumptions underlie this representation?

The second question applied in this study examines the assumptions that underpin the identified problem representation. The term 'assumptions' or 'presuppositions' refers to the 'background knowledge' that is taken for granted, or rather the 'epistemological and ontology assumptions' (Bacchi, 2009:5). Through analysing the assumptions of the problem representations, the analyst can identify the 'conceptual premises or conceptual logic' that the problem representation is based on (Bacchi, 2009:5). Conceptual logic is defined by Bacchi as 'the meanings that must be in place for a particular problem representation to cohere or to make sense' (Bacchi, 2009:3). This is particularly important with regard to answering one of the secondary research questions as to how mental health policy is conceptualised.

This question involves a search for 'deep-seated cultural values, a kind of social unconscious' (Bacchi 2009:3) that form a problem representation. An example of a deep-seated cultural value as seen in a policy intervention could be the *Prevention and Combating of Hate Crimes and Hate Speech Bill of 2016*. The bill is based on a particular history and context where what is now considered hate crimes and hate speech were endorsed and legislated by government. The interventions contain a deep-seated assumption about what is considered hate crimes and speech in light of South Africa's troubled history.

The question also focuses on the creation of binaries or dichotomies, where 'what is on one side of the binary is excluded from the other' (Bacchi, 2009:7). Normally, one side is privileged or favoured over the other. Examples of binaries include: public/private, capable/incapable, accessible/inaccessible, economic/social, communal/individual. Bacchi states that binaries simplify complex relationships and as such need to be noted when they appear in polices and 'how they function to shape the understanding of the issue' (Bacchi, 2009:7).

The question also focuses the analysis on key concepts such as 'health' or 'welfare' that are 'abstract labels that are relatively open-ended' (Bacchi, 2009:8). As a result of their ambiguity, these concepts are often debated as people imbue them with meaning. Just the phrase 'health' is contested; whether health is understood as 'general well-being' as opposed to 'the absence of disease', will affect the proposed interventions (Bacchi, 2009:8). This study will analyse certain key concepts in mental health care policy according to this question, particularly 'mental health', 'community', and 'holistic'.

4.4. Premises of WPR Approach

Beutler and Fenech (2018) have outlined three basic premises that form the basis of the WPR approach. These premises will be used in this study to provide a framework to the theory behind the WPR approach and will expand upon the questions and goals above.

4.4.1. Policy as discourse

The first premise of the WPR approach is the recognition of policy-as-discourse (Beutler & Fenech, 2018). This premise relates to Question 2 of the WRP approach. The focus of the WPR approach on interpretations or representations necessitates a focus on discourse used to frame an issue. Every description of an issue is an interpretation that involves judgement and choices (Bacchi, 1999:1). This can be linked to the Foucauldian notion that discourse is socially constructed by language and practice. Discourse carries meaning as generated by its context. Bacchi proposes that policy documents, like all discourse, contain implicit or explicit meanings and values (Bacchi, 2016:9), favouring a certain position and silencing another (Lancaster & Ritter, 2014:82). Policy functions as governmentally sanctioned discourse, where both problems and solutions are constructed (Bacchi, 2009:39).

As Foucault theorised, policy-as-discourse, understands policy as the product of socially constructed practice (Foucault, 1970). Shifting to a discourse-based understanding of policy encourages an open-ended method of critically analysing policy. This method allows for an incisive and thorough evaluation of policy agendas, particularly those that seem blatantly obvious (Bletas & Beasley, 2012:2).

This perspective is based in post-structuralism, in that nothing is taken for granted and language is inextricably linked to the formation and disruption of discourse. The objects, subjects, and problems of a policy are dissected and problematised. Axiomatic concepts such as ‘poverty’, ‘well-being’, ‘crime’, ‘community’, ‘mental health’, are studied by the governmental practices and discourse that produced them (Bacchi 2016). This line of focus is particularly useful for studying complex concepts such as mental health that are shaped by their contexts as mentioned

in Chapter 2. What is understood as mental health must not be taken for granted and must be critically examined in South Africa's particular socio-political context.

The principle of policy-as-discourse is contrasted by the policy-as-text theory. Policy-as-text understands policy documents to be logical and objective responses to fixed problems that were waiting to be addressed and corrected by government. When attempting to determine whether a policy has been effective, a policy-as-text analysts will ask problem-solving questions, such as 'what has this policy done to fix the problem?' or 'where has the policy succeeded or failed?' (Beutler & Fenech, 2018:19). Bacchi argued that this type of problem-solving approach produces a narrow understanding of the policy problem, and suggested an alternative problem-questioning approach (Bacchi, 2009:266).

By underlying the importance of knowledge practices, Bacchi's approach works to interrupt the assumption that problems are undisputable starting points for policy development. The WPR approach provides an alternative method of critiquing policy. It emphasises the potential policy analysis has to examine how meaning is constructed and spread through policy processes.

4.4.2. Problems constructed

The second premise of the WPR approach, as outlined by Beutler and Fenech (2018:19), is that social 'problems' are constructed through policies and that society is governed by these problematisations. This premise is centred around Questions 1, 3, and 4 of the WPR approach. According to the positivist stance, policies are often seen as reactive, in that the government reacts to a certain pre-existing problem by creating a policy that will provide a solution. In direct contrast to this, Bacchi places the policy-maker in an active role as the creator of a particular way of understanding an issue (Bletas & Beasley, 2012:4). Policy makers do not discover societal problems, instead they create them (Bacchi, 1999:9).

Problems are identified through working backwards by looking at the stated solutions within the policy in order to reveal what is represented to be the problem. This method is based upon Foucault's genealogical approach, starting with the present, and working backwards to understand how the present came to be. Examining the 'history' of a problem representation

can reveal the unpredictable and varying journey phenomena take before being framed as a problem. What key decisions were made which took this issue in a particular direction? Which competing representations were disregarded in favour of this one? What conditions allowed for a particular problem representation to emerge and become dominant? (Bacchi, 2009:10).

However, it is noted that policies do not actually 'create' problems. The government does not go out of their way to produce mental health problems or poverty, or actively seek to represent a 'problem' in a certain way (Bacchi, 2016:8). Original intent is not the focus of this mode of analysis. In fact, the approach is not concerned with what the policy makers believe is the best course of action or what they originally intended the policy to produce. This line of thought does not contribute to the discussion of the problem representations in the policy (Goodwin, 2012:32). For example, a policy maker may believe that a community-based health care system is desirable, but this does not necessarily mean that this belief or intention will translate into the problem representation. Instead, the WPR approach states that policies make a problem exist according to the discourse surrounding the phenomenon, thus allowing policy makers to set up the parameters in which they respond to the 'problem' (Beutler & Fenech, 2018:19).

The WPR approach encourages its users to reflect on the ways in which problems take shape, who shapes them, and how they are legitimised. The phrase 'What's the Problem?' is intended to catalyse an analysis that questions any policy as to its representation of the 'problem' and the effects of these representations. This requires a comprehensive examination of the policy, as the 'problems' represented are not always officially declared by government as an issue that needs improving. Bacchi states that instead, problems are often implied or assumed (Bacchi, 2009:x). The representations of problems are based on interpretations and assumed knowledge produced by the context's discourse, offering certain 'forms of subjectivity' (Bletas & Beasley, 2012:22).

This ties into the Foucauldian genealogical mode of critique as to the emergent and contingent characteristics of history. Tracing the history of a problem can show the transient nature of issues that are often taken-for-granted. Additionally, it allows analysts to appreciate the power dynamics that result in the success of one problem representation over another (Bacchi, 2009:275). Problems in policies are shown to be historical and emergent in nature, as can be illustrated through certain legislation across various contexts.

Goodwin (2012) provides examples of phenomena that has emerged historically as a public 'problem'. In Australia, it has been noted that certain problems, such as hate crimes, homosexuality, and smoking have over time, moved from the private realm, to the public, becoming social issues that are seen to deserve governmental consideration and intervention (Goodwin, 2012:27). Problems have also been shown to vary according to culture, the relatively recent emergence of child obesity as a public problem in high-income democracies is illustrative of this fact (Goodwin, 2012:28).

In South Africa, the emergence of the problem of hate speech as a phenomenon that the government must monitor is indicative of this trend. The *Prevention and Combating of Hate Crimes and Hate Speech Bill* can be seen to emerge from a discourse condemning racism and discrimination. Hate speech and discriminatory behaviour existed long before the current government classified and condemned it. South Africa's previous regime saw no problem with discriminatory behaviour. In fact, legislation promoted it. The specific history and culture of South Africa has resulted in a discourse where the current government feels that this behaviour constitutes a problem that falls within the realm of their responsibility. This is not to say that any of these issues do not exist or that they should not be monitored. Rather, it is worth noting how problems tend to emerge from a variety of histories and contexts. The same social condition can be seen by some as a social problem needing rectifying, e.g. child obesity or discriminatory behaviour, and by others as a proper and appropriate state of being (Merton, 1971:799).

The representation of a problem that emerges from a specific context, results in material and observable practices. The interpretations are interventions, as the interpretation will contain within it recommendations for action (Bacchi, 1999:1). Simply defining a concept or practice assigns it to a particular purpose. In order to state what a word means, one makes a claim as to how the word ought to be used (Tanesini, 1994:207). This leads to the second part of this premise, where a particular society is governed by problematisations. This is where the WPR approach shift from language to lived, everyday practice, and connects socially constructed discourse to experienced reality.

The second premise notes that society is governed by the problematisations, which leads to an interesting conversation related to power, participation, and knowledge production. Foucault (1985b) states that power is linked to the extent in which an individual or group participates in

the production of knowledge and problems. Whosever problem representation is dominant sets a precedent as to how a certain problem should be solved. The amount of power an individual or group of people have is directly proportional to their ability to take part in the discourses and problematisations that shape their society (Foucault, 1985b as cited in Dickerson, 2010:354).

Governing takes place through these problematisations, and can be described as 'problematising activity' (Bacchi, 2016:8), as policy cannot fix anything without first 'problematising its territory' (Osborne, 1997: 174). By defining the parameters by which a phenomenon can be thought of, governing bodies can significantly impact the way people function in a particular society. Thus, when attempting to understand how governing takes place, it is imperative to study how 'governing practices' problematise phenomena (Bacchi, 2016:12).

The way in which Bacchi defines governing is pointedly different from the more traditional policy analysis theories. According to traditional approaches, governing can be defined as 'what governments do or refuse to do?' (Dye, 1972:2). In contrast, the WPR approach considers governing to veer more within the realm of discursive practices and the shaping of problems by those in power. This disregards the notion of governing being limited to deliberate action, instead, governments can 'intervene' in people's lives without being seen to directly 'act' (Bacchi, 1999:3).

Governments intervene through discursive practices, often indirectly. Olsen states that the decisions governments make, actively or passively, influence the circumstances that create the environment in which we make the decisions of our day-to-day lives (Olsen, 1985). Bacchi uses the example of a government tacitly refusing to provide state-funded childcare or abortion clinics. Through the way in which parameters are constructed to limit how an issue is talked about, or indeed not talked about, governments are intervening in our lives all the time, even when they are not seen to in the traditional sense (Bacchi, 1999:134).

As the definition of governing is so broad, the scope of analysis goes beyond the more traditional understanding of power; such as political institutions and networks. Governing includes a wide array of social institutions and 'expert' groups from diverse fields that reinforce the predominant discourse. This is especially prevalent in mental health policy where a policy

problem will be formed and substantiated by experts from fields including psychology, psychiatry, epidemiology, and health advocacy. It is also important to examine how much a policy relies on what Bacchi terms as 'professional knowledges', such as psychological diagnostic criteria, in determining a problem representation (Bacchi, 2016:9). Thus, when examining problem representation, Bacchi encourages analysts to include these institutions in their examination of how problems emerge and maintained (Bacchi, 1999:45).

Governmental intervention through problem representation takes place through a variety of subtle framing methods. These include but are not limited to: subject positioning, simplifying complex relationships, and leaving certain issues unproblematic.

A discussion can be had on the concept of who is held accountable for solving a problem and how policy shapes this accountability. This is known as subject positioning. Subjects can be positioned as either the active subject or the passive object. Subject positioning was illustrated in the section regarding problems 'emerging', as certain issues were shown to move from the realm of 'private' responsibility, to 'public'. Bacchi notes that labelling items on the political agenda 'private' or 'public' can change whether policy makers consider taking steps necessary or even appropriate. If an item is framed as private, it moves beyond the sphere of governmental responsibility. If it is framed as public, the government could, according to the surrounding discourse, justifiably intervene (Bacchi, 1999:3).

Shapiro (1992) examines this framing device in relation to the problem of 'traffic congestion'. Typically, the problem of 'traffic congestion' is grammatically presented as passive. This is a pre-existent problem that policy makers must find a solution to. Shapiro argues that this mode of problematisation ignores greater social determinants such as 'segregation, housing, shaping of the labour force, city planning, and so on' (Shapiro, 1992:99). The analyst must pay close attention to how problems are framed, as even the grammar used sends a political message. Approaching a problem with the understanding that all policy problems are inherently political will yield more complex and nuanced results.

Policy can shape problem representation through shifting accountability to certain groups of citizens, instead of others. In a study by Goodwin (2012), policy makers set out to promote women's equality in senior management positions. The problem was represented as the under-representation of women in the workplace. Simply by how the policy is phrased, the problem

and thus the responsibility to take action, was placed on women. Therefore, the solutions provided including child-care programmes and management training courses, were intended to promote women to upper management. An alternative problem representation could be 'the over-representation of men in senior management'. If this was perceived to be the problem, interventions would be dramatically redirected toward reducing male dominance in senior roles (Goodwin, 2012:31). By simply rephrasing a sentence and switching active and passive roles, the problem representation is fundamentally changed, as are the policy recommendations.

Additionally, policies create binaries and groupings of people according to the problem representation. Groups such as 'the consumer', 'the delinquent', 'the caring mother', and 'the literate citizen', are all subject roles that are actively formed by policy discourse. People are placed into binary groups by policy discourse according to a multitude of categorisations: race, gender, deviancy, mental health status, economic status etc (Bacchi, 2016). Predominantly, these groupings and binaries disregard complex structural determinants and diminish an individual's identity and history to a one-dimensional role, thereby simplifying complex relationships (Bacchi, 2009). The WRP approach questions the casting of certain groups of people into subject roles through the policy process. Bacchi posits that instead of assuming that a policy's subject is an autonomous social actor, we must instead view the subject as a being continuously shaped by specific discourses (Bacchi, 2016:9).

The WPR approach is concerned by how and how not subjects and issues are discussed in the policy. Question 4 of the WPR approach asked whether there is anything left unproblematic, and where any perspectives or voices not made visible. This points to one of the WPR approach's greatest strengths. Instead of simply analysing what is said in the policy, Bacchi places equal importance on what is not said, which can often be more illuminative. Problem representation is viewing an issue through a certain lens and disregarding an alternative perspective. To advocate for a certain representation of the problem is to ignore another. Leaving particular issues unproblematic or silenced is an exceptionally effective and subtle method of limiting the conversation to a certain problematisations.

In order to answer these questions and make visible that which is not featured in a policy, the process of historical and cross-cultural comparisons can expose how problem representations reflect particular cultural and institutional contexts (Bletas & Beasley, 2012:33). This was illustrated in a cross-cultural study comparing how subjects are positioned in mental health

policies in New South Wales (NSW) and Hong Kong. By comparing the two countries' documents, Cui *et al* (2019) found that the more collectivist orientated Hong Kong was centred around protecting the many from the few 'patients' that are generally considered to pose a risk. As a result, opportunities for PLWMHP to voice their experiences was comparatively limited by the problem representation. In contrast, the more individualist NSW policy, centred around a human rights ethos, gave the 'consumers' of mental health services a greater degree of agency and opportunity to voice their experiences through the problem representation.

The ways in which policy shapes problematisations are too numerous and complex to fully dwell on in this study. To some extent, problematisations and their framing processes change from one policy to another. Each policy problematisation will result in a particular effect specific to that context. The effects of these problematisations are to be discussed in the next section.

4.4.3. WRP interrupts

The final premise as outlined by Beutler and Fenech (2018:19) is that the WPR approach works to interrupt these problematisations. This premise is highlighted in Questions 5 and 6. By questioning a policy's problem representation, the WPR approach exposes the lived, subjectification, and discursive effects of a certain problematisation. These effects can be both material or symbolic. Bacchi explains that the lived effects are the practical day-to-day implications of the problem representation; the subjectification effects are the consequences of the ways subjects are shaped by discourse; and discursive effects are those that place limitations on what can be thought and said about an issue (Beutler & Fenech, 2018:19). The real-life consequences of how a problem is represented in discourse are examined and critiqued, and thus interrupted.

To interrupt a representation of a problem, one must explore how and where it has been produced, disseminated, and defended. This entails an examination of the institutions, 'experts', and social groups that are reinforcing the discourse in question. As mentioned, Bacchi states that health policy in particular is formed and substantiated by 'professional knowledge' (Bacchi, 2016). Including these groups in the discussion of problem representation will often provide useful insight as to how the problem is perceived and perpetuated.

By noting the production and resulting effects of a problem representation, the analyst can pose alternative suggestions as to how a policy problem might be represented. This can be seen in the brief examples provided above, specifically the policy proposal regarding the under-representation of women in senior positions. The alternative proposal will invariably provide a problematisation from a markedly different perspective as compared to the original policy proposal.

Moreover, this leads to the conversation regarding the political nature of the policy process and research. According to Bacchi and her theoretical contemporaries, the analyst has an active, political role to play, not only in the production of discourse, but in the disruption of it. As Carson (2018) notes, research is never just a description of a problem; it is a political process. Simply by identifying the emergent nature of a problem representation and the effects it has, the analyst is implying that there are alternatives to the current problematisation. Suggesting an alternative proposal is in itself, a political act.

The WPR approach places a responsibility on policy makers and those who analyse policy to become more attentive as to what is included, what is left out, who is given a voice, what is silenced, and what are the effects of these silences? Bacchi makes no attempt to hide the normative agenda of her approach. The assumption in using the WPR approach is that problem representations profit some at the expense of others. Her intention is to expose and challenge those representations and suggest that there are alternative ways phenomena can be thought about that does not entail this harmful effect (Bacchi, 2009:45). The WRP approach unapologetically sides with the marginalised, given the historic tendency to side-line people from affected communities (Carson, 2018).

The analyst that makes use of this method will inevitably find themselves emphasising that which has been side-lined. The analyst's aim is to consider the extent with which the policy proposals, including one's own alternative policy proposal, has either reproduced or interrupted governing through problematisations that result in marginalisation of some form (Bacchi, 2016:12). Bacchi promotes critical self-reflection, or as she terms it, reflexivity.

4.4.4. Reflexivity

Understanding the political nature of knowledge production prompts analysts to subject their own work to the same scrutiny they are subjecting to policy. The analyst is not separated from their context's discourses. They are as much shaped by it as the policies they are analysing. In light of the analyst's active interference with the representation of problems, this process of problematisation requires a fair amount of self-awareness, or what Bacchi (2012) terms, 'reflexivity'. Reflexivity is related to the addendum found in Bacchi's WPR approach (2009:48).

Our everyday lives are operated within practices and problematisations that are difficult to distinguish, let alone to distance oneself from and analyse. However, the process of problematisation necessitates questioning the objective and accepted order of being. This requires the analyst to critically reflect on their own practices and internalised problematisations. For example, a highly politicised, white South African female with a tendency to understand her surroundings through the lenses of gender and race must be aware that she will problematise certain issues through those lenses and that this will seep into her research. This process is necessary as the analyst is not simply presenting the world as it is, but actively involved in the production of what is 'true' (Bacchi, 2012:4).

To become cognisant of our own presuppositions and biases, Bacchi encourages reflexivity. To this end, self-scrutiny is built into the WPR approach as an addendum, where the analyst must apply the WPR approach to their own assumptions, as they too play an active role in establishing what is perceived as 'true' and 'real' (Bacchi, 2012:2).

The aim of problematisation is not to identify strengths and weakness in a particular prescriptive text, or situate ourselves for or against what the text proposes. Rather, it is to expose or gain access to the system of rules that we adhere to without realising it (Bacchi, 2012:5, Simon, 1971:73). Becoming aware of the internal rules that govern our lives, is in itself a political intervention. By analysing a 'problem' and how it was generated by social practices, one becomes aware of how the 'problem' has become known to be 'true'. This places the analyst in a peculiar position of power. Bacchi (2012:6) states that the analyst that problematises phenomena is not opening a window to the world, but rather, interfering with it.

They are part of the active process of mediation between the 'problem' and its representations. Thus, the analyst needs to be aware of the consequences of their work in the representation of problems.

4.5. WPR applied to mental health or policy

This analytical tool can be used to analyse specific policy documents as well as more general government commitments and instruments such as censuses or programmes addressing homelessness (Bletas & Beasley, 2012). As mentioned, it has been used in a wide range of fields to critique a variety of policies, from childcare affordability in Australia (Bletas & Beasley, 2012), to drug usage in England (Brown & Wincup, 2020), and to the termination of the quarantine period in Iran (Seddighi, Dollard & Salmani, 2020).

The WPR approach has been used to analyse mental health policy, specifically the comparative study to critique how PLWMHP are positioned in mental health policies from Hong Kong and New South Wales (NSW). The cross-cultural study found that the subjects were shaped by their unique socio-political and culture contexts as either 'patientised' individuals reliant on professionals, or as 'traumatised' individuals given the responsibility to guide the process of recovery (Cui *et al.*, 2019).

The approach has been used in South Africa to critique a wide range of policies. It was applied to basic education policy documents, finding that the inequalities resulting from apartheid are considered to be the 'roots' of the problem represented by the Department of Education (Goddard, 2018). It has also been used to critique policies related to young children with disabilities (Philpott & Muthukrishna, 2019). This study found that the problem represented were the social barriers that these 'vulnerable 'children faced. The effects of this problematisation and its subject positioning were that children with disabilities were portrayed as passive subjects with little say as to if or how they would be 'included' into spaces they have previously been denied.

These South African papers are useful, as they provide insight into the discourses that inform how phenomena is problematised. It is worth noting that in all studies based in South Africa

without exception, note the emphasis on human rights and addressing the injustices of the past in the policies. As noted in Chapter 3, this emphasis is carried through into mental health care policies. To date, there has yet to be any research produced that analyses South African mental health policy using this analytical tool. This displays a gap in the research and an opportunity to explore unfamiliar territory.

4.6. Conclusion

Bacchi's endeavour to develop a practical method of analysis has made her WPR approach applicable in a wide range fields beyond the original scope. It can be used to critique not only policy, but cultural practices, public debates, and economic plans, etc. The approach's reflective component makes the analyst cognisant and wary of their own problem representations and to factor in the politics inherent in their process of research.

There are many policy analysis theories situated in the post-structuralist, Foucauldian world that could have adequately served as the theoretical foundation for this study. However, Bacchi's tool surpasses them due to its elegantly simple combination of theoretical, discursive, and practical elements. It deftly acknowledges the deep-seated theoretical premises, whilst simultaneously recognising how those premises effect people practically. Therefore, it was chosen for this study due to its suitability to analyse a complex topic such as mental health both conceptually and materially.

This chapter has provided a brief background on the theoretical underpinnings of Bacchi's WPR with particular reference to post-structuralism. The work of the philosophical leader of these theories, Foucault, was discussed, with particular reference to the relationship between power and the production of knowledge. The WPR approach was then briefly outlined, followed by an expansion on the questions used in this study and how they will be applied in Chapter 5.

This was subsequently followed by a discussion on three premises that Bletas and Beasley have provided: perceiving policy as discourse, the construction of problems and how governing

takes place through these problem representations, and how the approach interrupts by revealing the process.

Examples were given as to how the WPR approach has been used in the past, noting the gap in the research with regards to this analytical tool used to problematise South African mental health policy. The analysis of said mental health policy using the WPR approach will be the subject of Chapter 5.

Chapter 5: The findings of the WPR analysis as applied to South African public health policy

5.1. Introduction

This chapter will analyse South Africa's mental health policy. It will apply elements of Bacchi's (2009) 'What the Problem Represented to be?' approach, specifically Questions 1 and 2. As mentioned in Chapter 3, the policy documents that will be analysed are the *White Paper for the Transformation of the Health System in South Africa of 1997*; the *National Mental Health Care Act of 2002*; the *National Child and Adolescent Mental Health Policy Guidelines of 2003*; and the *National Mental Health Policy Framework for 2013 – 2020*.

The chapter will examine the dominant problem representations, that were recognised across all four of the policy documents. Problem representations refer to the understanding of the problem in any policy, or the implicit and explicit problem diagnosis (Bacchi, 2009:xii). The problem representations in this study are identified as: the separation of mental health services from general health services; lack of intersectoral collaboration in mental health services; the disconnect between communities and mental health services; the link between poverty and mental health problems; and the infringement on the human rights of PLWMHP. The dominant problem representations found in South African mental health policy, as well as the assumptions and conceptualisation of mental health will be revealed, thereby answering the research questions of this study.

As noted in Chapter 3, mental health policy comprises of different policy documents. Some of the documents are specific to mental health, while other may include mental health as it forms part of the broader health system. These policy documents were chosen due to the overlap in dominant problem representation.

5.2. The dominant problem representations in mental health policy

These dominant representations of the problems of mental health are expressed explicitly or are found embedded within the given solution to the problem. The explicit problem diagnoses are consciously identified by policy makers as a normative commitment to a policy goal (Bacchi 2009:141). The implicit problem diagnoses are found through the presented solutions, and working backwards to illuminate the implied problem representations behind those solutions (Bacchi, 2009:3). These representations contain within them assumptions and taken-for-granted truths that will be examined through Bacchi's tool 'What the Problem Represented to be?', outlined in Chapter 4. In the findings, Bacchi's questions, 'What's the "problem" represented to be in a specific policy or policies?', and 'What presuppositions and assumptions underlie this representation of the problem representation?' will be used to analyse mental health care policies (Bacchi, 2009:2).

Each policy contains various problem representations. It should be noted that not all the problem representations in the policy documents will be discussed. This is not because they are not important, but rather because they are not dominant and do not feature throughout all four of the policies. As much of the content of the policies was discussed in Chapter 3, this chapter will not delve deep into providing extensive background into the policies.

5.2.1. Mental health care separation from general health care services

The first dominant problem representation found in the four policy documents is that mental health services are not integrated into general health care services (specifically PHC care services) and are as a result, inaccessible. Integration, as mentioned in Chapter 2, is the management and delivery of health services, aimed at supplying a continuum of care across different levels of the health systems (WHO 2008). The South African health system, along with mental health services, was significantly restructured after the change in regime, as outlined in Chapter 3. A substantial change was the integration of mental health services into general health care services.

In its preamble, the *White Paper for the Transformation of the Health System in South Africa of 1997* explicitly states what it considers the problem to be. As a result of 'state neglect and abuse' (referring to the apartheid government), mental health care programmes are 'centralised and exclusive', resulting in a 'fragmented service' separated from general health care services (White Paper for the Transformation of the Health System,1997:84). It states that the methods used, which were largely 'custodial and based on medical therapy', were generally only accessible to the wealthier, urban population and are 'inappropriate and inaccessible' to the majority of South Africans (White Paper for the Transformation of the Health System,1997:84).

The explicit problem representation is that mental health services are separated from other health services due to the exclusionary and centralised nature of the care provided. It explicitly states that the methods of care used are considered inadequate and unsuitable for the mental health needs of the South African population, due to their lack of accessibility. It explicitly states that this is a result of the previous government's policies, framing them to be problematic. The implicit problem representation is that mental health care under the new government must work in contradiction to the previous government's approach. The White Paper implies that mental health treatment that is custodial and based on medical therapy is inadequate. It is implied that these methods of care are problematic, not because they are ineffective, but rather because they are not accessible to the poorer, rural population.

The policy guidelines therefore suggest an intervention of comprehensive and community-based mental health service based on 'PHC principles', that is integrated into all levels of health services, 'to avoid verticalisation' (White Paper for the Transformation of the Health System, 1997:84). Using Bacchi's (2009:3) method through working backwards from the presented solutions, several problem representations were found. The first is the implicit problem representation that mental health care is understood to be separate from general health care services, resulting in a 'vertical' form of health service delivery. This is implied to be problematic. The use of the term 'verticalisation' invokes the two contrasting methods of health service delivery: horizontal and vertical. Horizontal delivery refers to public health systems that provide comprehensive PHC, whereas, vertical delivery implies 'a selective targeting of specific interventions not fully integrated in health systems' (Msuya, 2004:2). A clear binary is presented; a

horizontal health care delivery system based on PHC principles, or a vertical health care delivery system with separate interventions that target specific health problems. As defined in Chapter 4, binaries are described by Bacchi as one side being privileged, thus excluding another (Bacchi,2009:7). One form of delivery is not necessarily better than the other, although the policy is representing horizontal delivery as superior. The framework is explicitly moving away from vertical health care delivery, indicating that horizontal health care delivery is preferred.

The framework then states that mental health care must be 'integrated' with other health care services, as 'based on PHC principles' (White Paper for the Transformation of the Health System, 1997:84). As stated in Chapter 1, this refers to the mode of care that addresses the broader determinants of health through intersectoral policy, empowers users, and meets people's health needs throughout their lifetime (WHO, 2020). This is a holistic conception of people's health, based on a variety of factors including physical health, sense of agency, and social situation. PHC facilities will generally provide treatment for 'common diseases' (KwaZulu-Natal DoH, 2019). By stating that mental health care should be integrated into PHC services, the White Paper is representing mental health as a common condition much like any other treated at a PHC level, e.g., TB, HIV/AIDS etc. In applying the second question of Bacchi's (2009) approach, one can note an assumption that mental health is a common health condition/problem that can affect many, rather than a specialised or rare health condition that affects few.

The *National Mental Health Policy Framework for 2013 – 2020* shows the same dominant problem representation. It states that mental health services should be 'integrated into all levels of the health system', and should be made 'accessible to all people, regardless of geographical location, economic status, gender, or social condition' (National Mental Health Policy Framework, 2013:20). A special emphasis is placed on the mental health services being incorporated into PHC, in order that 'essential health care (is) made accessible at a cost a country and community can afford' (National Mental Health Policy Framework 2013:8). The framework states that this integration will 'reduce exclusion and social disparities in health, is people-centred, intersectoral, collaborative, and promotes the participation of all stakeholders' (National Mental Health Policy Framework, 2013:8).

By applying the first question of the WRP approach, the explicit and implicit problem representations are revealed. The implicit problem representation is that because mental health services are separate from PHC services, mental health care has thus far been inaccessible for certain South Africans, as a result of their geographical location, economic status, gender, or social condition. The implicit problem representation is that because mental health care is not available at PHC facilities, mental health care is inaccessible, exclusionary, and has produced social disparities. The framework also implies that mental health services that are separated from essential health care services are not affordable for the community (which is not defined) nor sustainable for the country to finance. It is assumed that by incorporating mental health care into PHC services, they will become accessible to all South Africans. It is also assumed that mental health services will be improved by the accessibility of services, rather than by other means, such as improving the quality of services through training of personnel. It is implied that by incorporating mental health care into PHC services, the factors that previously prevented people from receiving care, such as social condition, economic status etc, will no longer present a barrier to mental health care services. This does not take into account other barriers that may prevent people from using mental health services, such as lack of awareness, cultural bias, or stigma.

The dominant problem representation of mental health services not being integrated into general health care services, specifically PHC services, is present throughout all four documents, both explicitly and implicitly. The next section will examine another form of integration, specifically that of intersectoral collaboration with other departments and non-state actors.

5.2.2. Poor intersectoral liaison and co-ordination of services

This section will focus on the dominant problem representation that the health sector, more specifically the DoH, is unable to address mental health and its social determinants without collaborating with other sectors. As mentioned in Chapter 3, mental health care has historically fallen under the jurisdiction of the DoH. This section will analyse the DoH's choice to include other governmental departments and non-governmental actors in mental health services.

The *White Paper for the Transformation of the Health System in South Africa of 1997* explicitly represents the problem as mental health services being 'ill-equipped to intervene effectively'. It goes on to state that this is partly due to 'poor intersectoral liaison and co-ordination of services' (White Paper for the Transformation of the Health System in South Africa 1997:84). The assumption within this explicit problem representation is that mental health services do not intervene effectively because of poor co-ordination with other sectors and stakeholders. This can be contrasted to other potential reasons mental health services could not be intervening effectively, such as the state of a poor understanding of local mental health needs, lack of resources, or ineffective treatment plans. This problem representation explicitly states that the DoH, the body responsible for mental health, cannot provide effective mental health interventions without intersectoral liaison and coordination. It confines the problem to the nature of the relationship the DoH has with other departments and non-state actors.

The White Paper then provides the solution to this explicit problem representation of 'broadening the range of stakeholders' to include 'private practitioners, traditional healers, NGOs, and religious groups' so as to share the 'burden of mental health care' (White Paper for the Transformation of the Health System in South Africa 1997:84). Applying the first question in the WPR Approach, it can be seen that the implicit problem representation is that mental health services have a narrow range of stakeholders. The range of people working towards relieving the burden of mental health problems is not broad enough without engaging stakeholders from a variety of fields. As the policy states that mental health is the responsibility of the DoH (White Paper for the Transformation of the Health System in South Africa 1997:84), it is implied that its interventions are not comprehensive enough to bear the burden of the country's mental health needs. It is assumed that liaising with other stakeholders will increase the effectiveness of mental health services. This problem representation also indicates that the problem of mental health is not one that can be wholly dealt with through medical means. It implies that mental health is not confined purely to the medical field and requires a multi-disciplinary approach.

The *National Child and Adolescent Mental Health Policy Guidelines of 2003* states that its interventions must be 'collaborative and integrated within the government departments, NGOs, grassroots community structures, and family units,' (National Child and Adolescent Mental

Health Policy Guidelines, 2003:2). It emphasises that its interventions are to be 'holistic', taking into account 'every context and area of development, and not simply address one aspect or problem' (National Child and Adolescent Mental Health Policy Guidelines, 2003:7). The implicit problem representation is that interventions has thus far been confined to one government department, and have not been partnered with other governmental departments or sectors. It implies that this lack of collaborative care is problematic. The guidelines also imply that mental health services are atomistic and address only one element of mental health, as opposed to a holistic approach addressing the whole. It has already been referenced in this chapter that the apartheid legislation confined mental health care to the health sector in a highly medicalised approach that was focused primarily on symptom relief (National Mental Health Policy Framework, 2013:8). Thus, it can be assumed that the guidelines are referencing the previous interventions which were highly medicalised and focused predominantly on symptom relief. It is implying that this approach is problematic and no longer suitable.

The *National Child and Adolescent Mental Health Policy Guidelines of 2003* states that the DoH must 'co-ordinate and liaise with NGOs, CBOs, and the private sectors in order to reduce the impact of risk factors and enhance the effects of protective factors of mental health' (National Child and Adolescent Mental Health Policy Guidelines, 2003:16-17). The risk and protective factors of mental health are said to exist in 'biological, psychological, and social domains' (National Child and Adolescent Mental Health Policy Guidelines, 2003:5). The guidelines imply that there are risk factors consisting of biological, psychological, and social determinants. It implies that these risk factors cannot be addressed without collaborating with non-state actors. The implicit problem representation is that the DoH cannot effectively reduce the impact of these risk factors by itself. This, along with the problem representation that the DoH must collaborate with non-medical actors, implies that attempting to solve the multi-dimensional problem of mental health through the medical means alone, is ineffective.

Within the values and principles of the *National Mental Health Policy Framework for 2013 – 2020,* the policy states that in order to address the 'social determinants' of mental health, 'collaboration between the health sector and several other sectors, including Education, Social Development, Labour, Criminal Justice, and Human Settlements' must take place (National Mental Health Policy Framework, 2013:20). The framework explicitly states that the problem of

mental health consists of social determinants. Social determinants, as mentioned in Chapter 2, include 'the social and economic circumstances, including poverty, income inequality, interpersonal and collective violence, and forced migration' (Lund, Brooke-Sumner, *et al.*, 2018:357). The Framework then implies that the multiple social determinants that affect mental health mean that it is too complex a problem to be solved by one sector unaided and thus needs to be addressed from multiple angles. It also implies that the health sector alone cannot address these social determinants effectively. Those sectors that are emphasised in terms of collaboration with the health sector reveal an implicit problem representation. They reveal what is represented to be the social determinants of mental health, i.e., education, social development, labour, criminal justice, and human settlements. The implicit problem representation is that these sectors most affect mental health, as opposed to other sectors, such as the Department of Women, Youth, and Persons with Disabilities, or the Department of Traditional Affairs.

The White Paper goes further describe the collaborative programmes to be spearheaded up by the health sector that are ‘proven low-resource interventions that adopt a task-shifting approach’. These programmes are described as particularly effective in ‘low-and middled-income countries’ that are ‘less well-resourced’ (National Mental Health Policy Framework, 2013:15). As cited in Chapter 1, task-shifting is the collaborative relationship between health care facilities and a variety of actors that operate both horizontally and vertically (Janse van Rensburg 2018:7). The White Paper implies that the problem of mental health care is related to a lack of resources as a result of being a LMIC. The implicit problem representation is that the health sector is operating with limited resources. By providing the solution of a task-shifting approach, the White Paper is implying that the health sector is unable to effectively intervene without sharing the load with other actors. It is implied that the government is operating in a low-resource setting.

This section has examined the dominant problem representation that the DoH is unable to effectively address mental health on its own. The given solution to this problem found in the four mental health policies is collaborating with other governmental departments and non-state actors using a multidisciplinary approach to address the various determinants of mental health.

5.2.3. Disconnect between communities and mental health services

This section will outline the dominant problem representation seen throughout all four policies of the disconnect between mental health services and communities. It will show that the four policies understand mental health as a communal issue. Understanding mental health as a communal problem implies that the locus of mental health care provided by the government is the community. Government will address mental health collectively, rather than understanding mental health as an individualistic problem that is largely disconnected from broader social structures. This approach to mental health is demonstrated by the partnerships the government will attempt to foster with communities to combat a specific problem. The intention behind this approach is to build capacity so that local people can take action over time and across issues (Center for Community Health and Development, n.d.).

Before the problem representation is outlined, it is worth noting that in none of the policies is the term 'community' defined or explained. The closest it comes to providing an explanation is defining community-based care as 'care that is provided outside of institutional and hospital settings, as near as possible to the places where people live, work and study[15] (National Mental Health Policy Framework, 2013:6). It can thus be assumed that communities are the places where people live, work, and study. It can refer to 'any group of persons whose rights in land are derived from shared rules determining access to land held in common by such group, and includes part of any such group' (Averweg, 2018). All four policies purposely set a low threshold as to what constitutes a community so as not to 'set any pre-ordained qualities of the group of persons or any part of the group in order to qualify as a community' (*Elambini Community and Others v Minister of Rural Development and Land Reform and Others*, 2018). Bacchi (2009:8) warns that abstract concepts such as the term 'community' are relatively open-ended and thus are often imbued with meaning due to their ambiguity.

The *White Paper for the Transformation of the Health System in South Africa of 1997* explicitly states that communities have been 'neglected and abused by the state for decades' (White Paper

[15]Community based care has also been described as non-residential and non-hospital care; the shift of balance of care from hospitals to the community in a way that reasserts family responsibility (Evandrou, Falkingham & Glennester, 1990).

for the Transformation of the Health System in South Africa, 1997:84). The White Paper states that mental health care is largely 'institutionalised', which is neither 'appropriate nor accessible to the majority of the population, especially those in rural areas' (White Paper for the Transformation of the Health System in South Africa, 1997:85). The White Paper is referring to the apartheid government's mental health care policies. The implicit problem representation, a re-occurring theme from the previous section on integration, is that mental health care under the new government must work in contradiction to the previous government's approach. This demonstrates the importance of taking into account the history of a particular context, which relates to Bacchi's (2009:39) notion of policy being formed by discourse. South Africa's unique history influences mental health care services. The explicit problem representation is that certain communities have been neglected insofar as mental health services are concerned. The policy explicitly states that institutionalised care is not accessible nor appropriate for the majority of the population, especially rural communities. This implies that a major element of why institutionalised mental health care is problematic is due to its lack of geographic accessibility to groups of the population.

The White Paper then highlights the importance of involving communities in the planning and implementation of mental health services, stating that the 'active participation of various stakeholders, especially the communities', is especially integral to the implementation process of mental health services provision' (White Paper for the Transformation of the Health System in South Africa, 1997:85). This is particularly important, as the policy states, so as to align mental health care policy 'with local needs' (White Paper for the Transformation of the Health System in South Africa, 1997:86). Implicitly stated in the White Paper is that communities are not involved in the process of mental health care based in their own communities. The implicit problem representation is that communities have thus far not been part of the planning and implementation processes of mental health, either because they have been prevented from doing so or because they have not wanted to. The policy implies that mental health care policy is not aligned to local needs and requires community involvement in order to provide the care the community needs. This problem representation is based on the assumption that by involving communities in the planning and implementation of mental health services, care will be more in line with the mental health needs of that community. It also assumes that communities are aware of their mental health needs and are more or less in agreement as to what those are. This

problem representation does not take into account potential stigma and bias towards mental health within the communities.

The *National Mental Health Care Act of 2002* states that services should be provided in a manner that 'facilitates community care of mental health care users' (Republic of South Africa, 2002:9). The implicit problem representation is that mental health services have been provided apart from mental health users' communities. It is implied that PWLMI are treated without their communities' involvement and that this is not ideal. The problem representation implies that communities are not involved in the care of those with mental health problems living among them. This problem representation is based on the assumption that when PLWMHP are cared for in their communities, their mental health will improve. It is assumed that community-based care is the best setting for care. This problem representation places the community in a vitally important role in mental health care.

In an explicit representation of the problem, the *National Mental Health Policy Framework and Strategic Plan 2013 – 2020* states that deinstitutionalisation has progressed without the 'necessary development of community-based services' (National Mental Health Policy Framework, 2013:16). Deinstitutionalisation, as described in Chapter 1, is the movement of mental health care away from mental hospitals to community-based settings (Taylor Salisbury *et al.*, 2016:2). The problem is explicitly stated that community-based services have not been developed enough so as to replace institutions as a site of care. Community-based services are explicitly represented as the necessary, preferred option of care that replaces institutions. This problem representation indicates a shift toward preferring community care over institutionalised care.

One of the main objectives of the Guidelines, is that it will 'empower local communities, especially mental health service users and carers, to participate in promoting mental wellbeing and recovery within their community' (National Mental Health Policy Framework, 2013:19). The implicit representation of the problem is that local communities are disempowered and thus cannot participate in mental health promotion and recovery. It implies that local communities need external encouragement to become empowered to participate in mental health care promotion. It implies that local communities are not active participants in mental health care

activities. A further implicit problem representation is that community involvement will improve the mental health of the PWLMI living in that community. Community involvement results in improved mental well-being.

The *National Mental Health Policy Framework and Strategic Plan 2013 – 2020* goes on to state that mental health services must work through 'task-shifting partnerships' with communities to form community-based services, in order that 'people with mental illness will be integrated into normal community life' (National Mental Health Policy Framework, 2013:19). The implicit problem representation is that mental health services are not partnering with communities. It implies that community-based services must be formed in conjunction between the government and communities. It also implies that people with mental health problems are not integrated into 'normal' community life, as a result of mental health services being separate from their communities. This problem representation assumes that PLWMHP are not integrated into their communities because they are not being treated in their communities. It assumes that once they are treated in community-based services, they will become integrated. This problem representation does not take into account that communities may not wish to integrate with PLWMHP due to other reasons, such as cultural bias or stigma attached to mental health problems.

This section has examined the dominant problem representation seen throughout all four policies of the disconnect between mental health services and communities. The given solutions to this problem are the creation of community-based facilities and encouraging the involvement of communities in planning and implementing of mental health care policies. The dominant assumption in the problem representation is that if PLWMHP are treated within their communities, their mental health will improve.

5.2.4. Poverty linked to mental health

This section will focus on the dominant problem representation of mental health problems being strongly associated with poverty, with one often leading to the other. It will show that the four policies conceive of mental health as socio-economic problem, one that influences and is

influenced by economic development. As mentioned in Chapter 2, poverty is defined as low socio-economic status (measured by social or income class), unemployment, and low levels of education (Lund, *et al*, 2010:517). Poverty and low socio-economic status also affect health status, health access, and health utilisation (Reiss, 2013:24).

In the *White Paper for the Transformation of the Health System in South Africa of 1997,* it explicitly states that poverty is a 'major determinant' of the mental health status of 'individuals, households, and communities' (White Paper for the Transformation of the Health System in South Africa, 1997:5). The explicit problem representation is that poverty is a major contributor to mental health problems. The individuals, households, and communities living in poverty are at an increased risk of mental health problems because of their socio-economic status.

Moreover, the White Paper states that 'gains' in mental health will only be possible if 'RDP's attack on poverty through economic development succeeds' (White Paper for the Transformation of the Health System in South Africa, 1997:5). The White Paper is making reference to the RDP, a socio-economic policy framework intended to reduce inequality (White Paper on Reconstruction and Development, 1994:4). The implicit problem representation is that the mental health of a population is determined by the levels of poverty in the country. The policy implies that mental health can be improved through the RDP's economic development plans. It implies that any progress made with regard to mental health will be overtly linked to the socio-economic status of the country. It implies that 'gains' in mental health are not possible without economic development. This implicit problem representation confines the solution to mental health problems to national economic development, rather than to other potential factors, such an increased availability of psychotropic medication, mental health training programmes for all health workers, or mental health awareness campaigns.

This problem representation could be based on one of two assumptions. The first assumption that as the country's economic status improves, the government will increase public mental health spending, thus improving mental health. This assumption is a matter of some contestation, as it has been proven that economic development does not always automatically lead to more resources being directed towards public mental health (Gupta, Methuen, Kent, *et al.*,

2016:418). The second assumption is that as the country's economic status improves, less people will live in poverty and thus be vulnerable to the mental health problems that may emerge from that.

The *National Child and Adolescent Mental Health Policy Guidelines of 2003* explicitly states that poverty is a risk factor that could 'increase the probability of mental health difficulties' (National Child and Adolescent Mental Health Policy Guidelines, 2003:4). The Guidelines are explicitly linking the problem of mental health difficulties to poverty, stating that living in poverty could result in mental health problems. It proposes certain interventions that centre around 'creating opportunities for employment, schooling, promoting the acquisition of life skills, and reduction of socio-economic inequalities' (National Child and Adolescent Mental Health Policy Guidelines, 2003:20). These interventions are similar to the RDP's goals that endeavour to promote sustainable development (Reconstruction and Development Programme White Paper, 1994:20). These goals imply that the problem of mental health can be solved by socio-economic goals. This indicates that the Guidelines understand mental health to be affected by socio-economic determinants.

The *National Mental Health Policy Framework for 2013 – 2020* explicitly states that mental health problems are linked to poverty, stating that 'poor mental health is often associated with poverty, violence, and other adversities and vulnerability, while good mental health is an important contributor to social and economic development' (National Mental Health Policy Framework, 2013:48). The explicit problem representation is that poor mental health and poverty are interrelated. It implies poor mental health problems can lead to poverty and other related adversities. The Framework implies that poor mental health can inhibit social and economic development. The problem representation implies that mental health is a socio-economic problem, rather than a health or cultural problem.

The *National Mental Health Policy Framework for 2013 – 2020* describes the relationship between poverty and mental health, describing it as a 'vicious cycle'. It explicitly states that poverty can lead to mental health problems: those exposed to the 'stress of living in poverty' are at an 'increased risk of developing mental disorders' (National Mental Health Policy

Framework, 2013:13). It then states that PLWMHP are at an increased risk of descending into or remaining in poverty due to 'increased health expenditure, lost income, reduced productivity, lost employment and social exclusion due to stigma' (National Mental Health Policy Framework, 2013:13). The explicit problem representation is that poverty and mental health feed into one another and that those who find themselves situated in either state, are at a greater risk for the other. The policy implies with its use of the phrase 'vicious cycle', that without some form of intervention, the cycle is almost impossible to escape from. It also states implicitly that by solving one of these problems, it is possible to reduce the risks of the other. Several things are assumed about mental health in this problem representation; that mental health problems are stigmatised, and that this stigma can result in reduced productivity and income, loss of employment, and social exclusion. This representation of mental health describes it as a socio-economic problem.

The stated solution to breaking the cycle of poverty and mental health problems includes 'addressing the social determinants of mental illness' through 'improving daily living conditions and reducing inequalities' and 'providing access to education and skills development, income generation opportunities, housing support, and social insurance' (National Mental Health Policy Framework, 2013:26). By using Bacchi's (2009) method of working backwards, the implicit problem representation is revealed: mental health problems are influenced by daily living conditions and inequalities. The Framework implies that poor living conditions and inequalities can exacerbate or result in mental health problems. It is implied that the cycle of poverty and mental health problems are caused or exacerbated by inaccessibility to education and skills development, income generation opportunities, housing support, and social insurance. There is an assumption that by providing accessibility to these elements, mental health would improve. Thus, poverty is associated with inaccessibility to opportunities for socio-economic development. This conception of mental health is one based on socio-economic factors, rather than biological or cultural factors. As this representation of the problem is constructed of socio-economic factors, rather than a collection of symptoms, the decision on behalf of the DoH and its partners to address the problem through developmental strategies is entirely logical.

This section has illustrated the four policies' representation of the problem of mental health as it relates to poverty. It has shown that policies view the two problems as linked, feeding into

one another forming a 'vicious cycle'. The policies imply that mental health is thus a socio-economic problem, one that can be solved through interventions directed towards economic upliftment.

5.2.5. Infringement on the human rights of PLWMHP

This final section will focus on the dominant problem representation of the rights of PLWMHP not being upheld. As mentioned in Chapter 3, the South African Constitution's emphasis on human rights formed the basis of mental health policy. The effect of this cannot be overstated. In all four of the policies, the Constitution is referenced in the preamble/introduction as a fundamental basis for mental health care.

The *National Mental Health Care Act of 2002* states in its preamble that the act was created in order to put measures in place to 'promote the rights and interests of mental health care users' (National Mental Health Care Act, 2002:8). The Act emphasised the rights PLWMHP have to governmental provided 'protection' from 'exploitation and abuse' (National Mental Health Care Act, 2002:1), freedom from 'discrimination due to their mental health status' and 'receiving care according to the standards equivalent to those applicable to any other health care user' (National Mental Health Care Act, 2002:18).

There are several points worth noting from the emphasised rights in the Act above. Firstly, the Act states that PLWMHP have the right to be free from discrimination. This implies that the PLWMHP are being discriminated against due to their mental health problems. Secondly, the Act goes on to state that PLWMHP are entitled to state provided protection from exploitation and abuse. It is the explicit mandate of the state to provide this protection. The Act implies that PWLMI are in need of protection because of their mental health status. Finally, the Act states that PLWMHP are to receive care equivalent to any other health care user. The implicit problem representation is that PLWMHP are not receiving the same standard of care as other health care users, implying that they are treated differently because of their mental health status. The Act is implying that PLWMHP should be treated like any other health care user, grouping them

in the same category. The Act is thus implying that mental health is grouped alongside other health services and that is it not distinct or separate from them.

Additionally, the *National Mental Health Care Act of 2002* provides interventions intended to prevent the rights of PWLMI being infringed upon. Foremost of these is the formation of Review Boards. The Act states that Mental Health Review Boards must be established in every province to 'advocate for the needs of mental health service users and uphold and protect their human rights' (National Mental Health Care Act, 2002:22). The implicit problem representation is that PWLMI require their rights being upheld and protected by a separate party. The Act implies that PWLMI cannot effectively advocate for their needs or uphold their rights by themselves and require external support.

Furthermore, the Act states that the Review Boards must consist of 'a mental health care practitioner, a magistrate, an attorney or an advocate; and member the community concerned' (National Mental Health Care Act, 2002:22). The implicit problem representation is that a Review Board must consist of these members in order that the most important aspects of mental health are considered. The implicit problem representation is that these three conceptions; legal, medical, and social or communal are the more important lenses through which to view mental health. It implies that mental health decisions require representatives from these three fields/conceptions, rather than representatives from one field alone.

The *National Child and Adolescent Mental Health Policy Guidelines of 2003* states that the rights of children need to be recognised in order for 'optimal mental health to become a possibility' (National Child and Adolescent Mental Health Policy Guidelines: 2003:8). The implicit problem representation is that mental health is inextricably tied to human rights. It is based on the assumption that if a child and adolescent's, or indeed any person's, human rights are not recognised, achieving 'optimal' mental health is not even a possibility.

The *National Mental Health Policy Framework for 2013 – 2020* affirms what the *National Mental Health Act of 2002* stated about the protection of basic human rights of PLWMHP being

connected to their mental health status. It makes reference to the *National Mental Health Care Act of 2002*, and states that the human rights of PLWMHP are to be protected through the implementation of the Act. It then goes one step further, it states that the rights to 'education, access to land, adequate housing, health care services, sufficient food, water and social security, including social assistance for the poor, and environmental rights' are to be pursued on a basis of 'progressive realisation' (National Mental Health Care Act, 2002:20).

The explicit problematisation is that the socio-economic rights of PLWMHP should be respected and realised by the government, ranging from their social and intangible rights, to physical rights. The phrase progressive realisation implies some level of tangible and immediate obligation of the state. It entails that the concept recognises that 'the full realisation of socio-economic rights would not generally be achieved in a short period of time. The obligation on the state is therefore "to move as expeditiously and effectively as possible" towards full realisation.' (Chenwi, 2013:744). The implicit problem representation is that the socio-economic rights of PLWMHP are the responsibility of the state, and that they are not being met adequately. It also implies that through the realisation of these rights, the mental health of PLWMHP will improve. The assumption is that human rights and mental health are inextricably linked, and that mental health is near impossible to achieve without the full realisation of PLWMHP's rights being recognised.

This section has examined the dominant problem representation of the rights of PWLMI not being fully realised or promoted. The solutions to this problem include establishing Mental Health Review Boards to advocate and uphold said rights, and pursuing the rights of PLWMHP on a basis of progressive realisation.

5.3. Conclusion

This chapter discussed the findings of applying Bacchi's (2009) WPR approach to the four policies: The *White Paper for the Transformation of the Health System in South Africa of 1997*; the *National Mental Health Care Act of 2002*; the *National Child and Adolescent Mental*

Health Policy Guidelines of 2003; and the *National Mental Health Policy Framework for 2013 – 2020*.

The chapter unpacked the dominant problem representations that were recognised across all four of the policy documents. These problem representations are identified as: the separation of mental health services from general health services; lack of intersectoral collaboration in mental health services; the disconnect between communities and mental health services; the link between poverty and mental health problems; and the infringement on the human rights of PLWMHP. The chapter elucidated the explicit and implicit problem representations within the four policy documents, as well as presented some of the assumptions that underlie these problem representations.

Through the identification of the various problem representations, this chapter showed that the four policies are interrelated and that there is a level of consistency to the South African government's representation of mental health. Particularly with regard to their emphasis on integrating mental health care to different levels of government, a variety of different stakeholders, both state and non-state. It also showed the policies' emphasis on providing mental health services that are accessible to all and in close proximity to the communities where people live, work, or study. The chapter also presented the policies' understanding of mental health shift from a predominantly medical conception to a socio-economic conception of mental health, whereby a person's or community's mental health is affected by socio-economic factors. Finally, the chapter disclosed the connection between human rights and mental health in the policies.

The findings within the chapter answered the research question, 'How mental health is represented in South African mental health policies', through critically engaging with the dominant problem representations identified and examining the assumptions that these problem representations consist of. Mental health is represented as socio-economic problem in that social and economic determinants are by and large, seen to most influence mental health. Thus, the correlation between mental health and poverty, as represented in the policies, is strong. Mental health is also understood to be a problem that is too broad for one department or field to effectively solved. It is a problem that must be solved from multiple angles, with special focus on the role of communities.

Chapter 6: Conclusion

6.1. Overview of study

The main objective of this study was to establish how mental health is problematised in South African public policy. It aimed to identify the assumptions that underlie how mental health is represented, as well as to describe how mental health is conceptualised in the policies. An analysis of the literature revealed that mental health is conceptualised in a variety of ways, each of which frame the context in which mental health is understood. It was shown that the context in which mental health is conceptualised, influences how the 'problem' of mental health is represented in policies and what 'solutions' are provided.

A review of the work conducted on South African public policy showed that the focus of the literature was invariably centred around the implementation of the policies and the resulting service delivery inadequacies. The literature did not investigate how mental health is conceptualised and constructed in mental health policy, revealing a gap in the research that this study aimed to fill.

A post-structuralist approach to analysing mental health policy was used, as post-structuralism is centred around analysing the construction of meaning and discourse. Situated within the post-structuralist theory, is Bacchi's (2009) 'What's the Problem Represented to be?' (WPR) approach. This analytical tool was used to investigate how the 'problem' of mental health is constructed in the policies. Two out of the six questions were used to critically analyse the problem representation of mental health in the chosen policy documents, 'What is the problem represented to be?' and 'What assumptions underpin this problem representation?'

Four policies were identified for analysis using the WPR approach: The *White Paper for the Transformation of the Health System in South Africa of 1997*; the *National Mental Health Care Act of 2002*; the *National Child and Adolescent Mental Health Policy Guidelines of 2003*; and the *National Mental Health Policy Framework for 2013 – 2020*. By analysing the documents

through the analytical tool, this study identified the explicit and implicit problem representations. Five dominant problem representations were found across all four policy documents. The assumptions underpinning these problem representations were examined, as well how mental health is conceptualised. This examination then filled the gap in the literature on how mental health is represented in South African public policy.

Chapter 2 provided an overview of the literature regarding how mental health is conceptualised and understood. The literature was organised into eight lenses through which mental health is viewed: the biomedical model of mental health; South African jurisprudence; governance; policy; lower to middle income countries; poverty; South African culture; and spirituality and religion. Each of these lenses view the origin and expression of mental health slightly differently. For example, while the medical model understood mental health is comparable to any other 'disease', mental health as understood through the lens of governance is the product of social determinants related to socio-economic factors. Mental health is also conceptualised as a highly individualised 'problem' in the medical and legal conception, versus the remaining six that understand mental health as a communal issue, determined by societal factors. The chapter found that conceptualising and defining mental health is a contentious issue. Hence, the management and solutions presented to solving the problem of mental health are similarly contentious and multi-faceted. As a result of the various ways mental health is conceptualised, each of these eight conceptualisations emphasised a slightly different approach to the management of mental health problems. This laid the foundation for the analysis section of the study where the problematisations of mental health policy are influenced and directed by these conceptions of mental health.

Chapter 3 then outlined all of the policies in South Africa that affect mental health care services, providing a brief synopsis on the various policy documents that were either focused specifically on mental health, on health in general, or provided a foundation on which health care services. The brief summary of the various policies revealed that there were several themes that were consistent across the policies affecting mental health post-1994. These included an emphasis on human rights as a basis for all mental health care services; the decentralisation of mental health care to a variety of governmental and non-governmental bodies; and the integration of mental health care into primary health care (PHC) facilities and community-based organisations (CBO). The chapter then examined the existing literature analysing South African mental

health policy. The literature was organised into four themes: the link between human rights and mental health; the prioritised care of high-risk demographics; the decentralisation of mental health care to provinces; and the integration of mental health care to PHC facilities. The various approaches the literature used when analysing mental health policy was examined. This revealed that the majority of the literature analysed South African mental health policy through a positivist, stagist lens. This revealed a gap in the research, as to date, no analysis of the mental health policy critically engaged with the problematisation and conceptualisation of mental health in South African mental health policy.

Chapter 4 explained the analytical tool that was used to analyse South African mental health care policy. It examined the philosophical foundations upon which Bacchi's WPR approach is based, specifically post-structuralism and its emphasis on the production of knowledge. Foucault's influence on the WPR approach was discussed, with particular reference to his use of the term 'problematisation'. Bacchi's WPR approach was then outlined, with particular emphasis on the two questions used in this study: 'What is the problem represented to be?' and 'What assumptions underlie this representation?' (Bacchi, 1999). The questions produced both explicit and implicit problem representations. The implicit problem representations were produced through analysing the proposed interventions and working backwards. The premises behind the WPR approach were discussed in reference to the six questions as outlined by Bacchi. Three premises organised the theory surrounding the WPR approach: policy as discourse, the construction of problems, and the interruption of the WPR approach. The first premise expanded on the notion of policy as discourse, whereby policy is created within a specific social context constructed by language and practice. The second premise outlined Bacchi's view that problems are constructed by policy-makers, as opposed to problems being viewed as pre-existent. These problem representations govern society. The third premise emphasised the normative nature of the WPR approach in that it works to interrupt these problem representations through exposing the lived, subjective, and discursive effects of a problem representation. Furthermore, it summarised the concept of reflexivity that Bacchi incorporates into the WPR approach. Reflexivity highlights the role of the analyst as an active participant in the process of constructing problem representations. The chapter then noted the application of the WPR approach in critiquing a wide range of policies. Bacchi's tool has been used to analyse South African public policy, along with mental health public policy in Hong Kong and South Wales.

At the time this study was written, there has yet to be any analysis on South African mental health public policy using this particular analytical tool.

Chapter 5 applied the WPR approach, specifically Questions 1 and 2, to the four policy documents. These documents were the *White Paper for the Transformation of the Health System in South Africa of 1997*; the *National Mental Health Care Act of 2002*; the *National Child and Adolescent Mental Health Policy Guidelines of 2003*; and the *National Mental Health Policy Framework for 2013 – 2020.* The analyses of the documents exposed five dominant problem representations that were found across all four policy documents. They were: the separation of mental health services from general health services; lack of intersectoral collaboration in mental health care services; the disconnect between communities and mental health care services; the link between poverty and mental health problems; and the infringement on the human rights of PLWMHP. The dominant problem representations were expressed both explicitly and implicitly, and illustrated the assumptions and axiomatic elements in the documents. The analysis in this chapter showed that the South African government is fairly consistent in terms of their approach to mental health. Throughout all four policies is an emphasis on integrating mental health services to general health care services, particularly PHC facilities. There is also an emphasis on involving a variety of stakeholders from various fields to ensure that mental health care is accessible.

6.2. Findings

This study is guided by one primary question and two secondary research questions. The primary question asked ‘What the 'problem' of mental health in South African national health care policy was represented to be?’. The secondary questions asked ‘What assumptions underpinned those representations?’ and ‘How is mental health conceptualised in those policies?’. These questions revealed the explicit and implicit problem representation found in the policies.

6.2.1. Primary research question

Through applying Bacchi's WPR analytical tool to four policies, this study was able to reveal how mental health is represented in the policies. The analyses of these documents displayed five dominant problem representations that were consistent across all the four documents.

The first of the dominant problem representation was the separation of mental health services from generally health care services, specifically PHC services. The policies indicated that as a result of this separation, mental health services are inaccessible and inappropriate for the majority of the population. The given solution was to incorporate mental health services into every level of health care according to PHC principles.

The second dominant problem representation was poor intersectoral liaison and co-ordination of mental health services. The policies stated that the range of stakeholders involved in the development and implementation processes of mental health care was too narrow, and as a result, mental health services were less effective and could not address all the determinants of mental health. The given solution to this problem was to collaborate with other governmental departments, NGOs, and CBOs in a task-shifting approach.

The third dominant problem representation was the disconnect between communities and mental health services. The policies indicated that communities have been neglected in terms of mental health services that are both accessible and aligned to local needs. They state that PLWMHP are treated apart from their communities and as such, find it difficult to be fully integrated. The given solution was to develop community-based services with the involvement of the communities themselves.

The fourth dominant problem representation was the link between poverty and mental health. The policies stated that the relationship between poverty and mental health is a 'vicious cycle'. Poverty can lead to a greater risk of mental health problems, and mental health problems can lead to a greater risk of poverty. The given solution to this problem is interventions focused on economic upliftment.

The fifth and final dominant problem representation found in South African mental health public policy, was the human rights of PLWMHP not being upheld. It was found that the policies considered PLWMHP to be discriminated against due to their mental health status and denied access to a variety of basic human rights. The policies linked mental health to fully realised human rights, implying that one cannot have one without the other. The given solutions to this problem were the formation of the Mental Health Review Boards and the progressive realisation of the rights of PLWMHP by the government.

6.2.2. Secondary research questions

The first of the two secondary questions was focused the assumptions that underpinned how mental health was represented. There are two key assumptions that emerged from the policies, one of which is related to the role of communities in the mental health care process. The assumption found in the policies was that communities are separate from the mental health care process and that PLWMHP are separated from their communities due to the mental health problems. They assumed that community involvement in the planning and implementation of mental health care services would result in the services becoming more aligned to the community's needs, as well as PLWMHP becoming integrated into their communities. Community involvement is assumed to lead to improved mental health care services.

The second key assumption embedded within the problem representations is related to the relationship between mental health and poverty. The policies assumed those living in poverty are more likely to be at risk for mental health problems. They also assumed that escaping poverty would increase the mental health of a person or community. The policies assumed that breaking the 'vicious cycle' of poverty and mental health problems is possible through economic development; and that by improving the economic status of the country, the mental health of the population would also be improved.

The problem representations in the four policies reveal how mental health is conceptualised, thus answering the second of the two secondary research questions. Analysis of the documents showed that mental health is understood as multi-dimensional problem that must be targeted

from multiple angles. The policies make a conscious shift away from understanding mental health as a purely medical problem. Mental health is understood to be a problem with biological, psychological, economic, and social determinants, which must be targeted holistically. The policies emphasised the effect of socio-economic determinants on mental health by implying that socio-economic development would improve the mental health of a population, while socio-economic inequalities would worsen mental health. This indicated that the policies conceptualise mental health as a socio-economic problem, relating to the interaction of social and economic factors. The socio-economic factors found in the policies that were said to exacerbate mental health problems included poverty, daily inequalities, and social exclusions, while those said to improve mental health included education, skills development, and income generation opportunities.

The policies implied that the problem of mental health could be solved through improving the socio-economic status of the country. This is due to the fact that the interventions proposed in the policies, such as poverty alleviation programmes and economic development schemes, were not specific to mental health. It can be assumed that these interventions will be applied to the broader population, rather than specifically PLWMHP. The policies thus imply that by developing policies that will improve the socio-economic status of the whole country, the government is improving the lives of PLWMHP and the mental health of the entire population. While these aims are admirable, there is a danger that the specific needs of PLWMHP will be overlooked in the pursuit of these broader goals.

6.3. Limitations and areas for future research

This study fulfilled its aim of identifying the policies problem representations and the assumptions that underlie them, using two of Bacchi's WPR approach questions. However, future research could apply the remaining four questions and the addendum of Bacchi's WPR approach to South African mental health care policies to provide a more in-depth analysis of the effects of the problem representations in the policies. These four questions would reveal what remains unproblematic in the problem representations, the effects produced by the problem representation, and the way in which the problem representations have become dominant (their genealogy) (Bacchi, 2009:19). Additionally, the study could focus on the self-

reflective aspect of the WPR approach found in the addendum (Bacchi, 2009:19), in which the analyst's own problem representations are taken into account and comprehensively examined.

This study focused on problem representations as seen in South African mental health policy from a national level. The availability of provincial mental health policies prevented the analyst from any in-depth analysis, as only one in nine of the provinces had produced their own stand-alone mental health policy document. However, the study would likely improve by the addition of the provincial documents revealing how mental health is problematised through provincial implementation plans.

Furthermore, future research could also focus on one policy to analyse through Bacchi's WPR approach, as opposed to the four that were analysed in this study. This will result in a more comprehensive and in-depth analysis of the problem representations in one policy document. It will also significantly simplify the process of analysis, as tracking themes of problem representations across four policy documents is a complicated task that may have diminished the emphasis of certain problem representations in individual policy documents. However, this study was able to analyse the problem representations of mental health in South African public policy across a period of time, revealing the government's dominant problem representation over a period of more than a decade.

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